A discourse analysis of recovery stories

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Abstract

Following a rise in people ‘speaking out’ about their recovery and thus challenging traditional psychiatric ideas of chronicity, the recovery approach has become a central guiding vision within mental health services. This thesis comprises two parts. The first part applies a genealogical method to conduct a genealogical analysis of the recovery approach through exploration of UK policy within the last decade. This explores the conditions of possibility for its emergence in UK policy and mental health services and its growth. In the second part, a Foucauldian discourse analysis is used to analyse stories of recovery. Recovery stories are collected from organisational websites in the third sector and public sector. Subject positioning and power/knowledge implications are discussed in light of eleven discursive constructions: personal interpretation, personal responsibility, socioeconomic opportunity, self-management, an ongoing process, expertise and sharing stories, professional embodiment, fulfilment through work, living well without work, acceptance of illness and acceptance by others. These ‘personal’ testimonies might reflect wider discourses in the mental health system. The research shows the powerful interests at play under the discourse of recovery, and the promotion of particular ‘truths’ that this brings with it. Counter to this are smaller sites of resistance. Implications are discussed for clinical practice and further research.

Contents

1. Introduction

My story is not a pleasant one; it is neither sweet nor harmonious, as invented stories are. It tastes of folly and bewilderment, of madness and dreams, like the lives of all people who no longer want to lie to themselves.

– Herman Hesse, Demian

1.1. Overview

This chapter will provide an exploration of the recovery movement, moving from its early progressive emancipatory history of patient voices toward its present day dominating hold over national mental health policy and services. The chapter begins with an overview of what is meant by ‘recovery’. It will then go on to outline a genealogy of the recovery movement using formal UK government policy to support an adequate grasp of its changing definition, and how this translates in its meaning for services and for those ‘recovering.’

1.2. Introducing recovery

The usage of ‘recovery’ has become widely recognisable and commonplace within the field of mental health, but it is a relatively recent term within the context of the history of ‘madness’ and mental health more generally. This section will begin to make sense of recovery’s roots and its evolving conception.

Recovery is often cited as a movement, and to have first emerged in the aftermath of the civil rights movements in the United States (Allott *et al.*, 2002). People who had been patients of psychiatric services began to speak out about their experiences within the psychiatric system, of their ‘illness’ and, significantly, of their recovery (Roberts, 2016). There was a necessary and admirable growing outrage within the psychiatric patient community about being written off by services as people who were ‘chronically ill’ and therefore deemed as unable to recover. They began to challenge longstanding psychiatric authority and expertise. Alongside this, various social and academic movements have been noted within the academic literature, shaping the landscape to enable the recovery movement to rise in prominence, a landscape including consumerism, anti-psychiatry and women’s liberation. These movements might be seen as having been ‘counter discourses’ or sites of resistance to mainstream discourses in society at the time.

Consumerism in healthcare. The development of consumerism in general healthcare has been shown to have had an impact on the emergence of mental health patients ‘speaking out’ (McLean 2003).

The rhetoric of consumerism started to appear in healthcare policies under the Conservative government in the late 1980s and 1990s. Its emergence can be traced to the first ‘Griffiths Report’ (Department of Health and Social Security, 1983) which proposed the need for the NHS to be responsive to what it termed its “customers’ needs”. The NHS and Community Care Act (Department of Health, 1990) presented a discourse of commercialised language, using such terms as ‘client’ and ‘consumer’, in the context of a rising culture of competition between services (‘internal markets’). The culture of the NHS was said to be shifting away from professional preference and decision-making to one informed by the voice of its users (Gabe, Bury & Elston, 2005). This was also seen in the introduction of the first Patient’s Charter (Department of Health, 1991) which aimed to be more responsive to the voice of those using services (through proper investigations of complaints, for example), and provided a set of rights for users and standards for services.

Patients, consumers, survivors, service users… People? The discourse within psychological and psychiatric literature uses different terminology for speaking about people who use mental health services, namely patients, consumers, survivors, service users. Generally speaking, the term ‘patient’ in its traditional usage has indicated someone who takes up position as a passive recipient of medical care, and thus the shift to talking about ‘consumers’ is argued to have brought with it a more empowered position where people are active customers who can choose their care (McLean, 2000; Speed, 2006). Consumers tend to occupy a position where they are in receipt of psychiatric services and are ultimately accepting of this (albeit challenging of it to an extent), whereas ‘survivors’ resist the psychiatric discourse, they are survivors *of* psychiatric treatment, and in this way, are active in encouraging social and political change (Speed, 2006). The term ‘service user’ is most common in contemporary literature, and seems to be a term that is most neutral, describing a relationship with a service. Each ‘type’ of service user has a bearing on how one constructs and makes sense of their mental health difficulties (Speed, 2006).

In this thesis these terms are interchangeably used to reflect the different movements and times as they are discussed.

Anti-psychiatry. Preceding consumerism had been the emergence of the anti-psychiatry movement in the 1960’s led by psychiatrists such as R. D. Laing, Thomas Szasz and David Cooper in the UK. Although different in their approaches, they shared central ideas which questioned mental illness as a construct, the ‘medicalisation of madness’ and the power held by psychiatry over patients. Anti-psychiatry gained rising interest from disaffected psychiatric patients. This body of work seemed to be matching some people’s own experiences of their mental health, treatment and recovery, which all too often ran counter to the dominant discourse of medical psychiatry (Desai, 2005). The anti-psychiatry movement brought with it alternative ideas that could enable people to ‘recover’ without the use of psychiatric coercion, diagnosis or medication. Laing sought to make madness comprehensible, and his work had become popular and a key part of the British ‘counter-culture’ of this time (e.g. Laing, 1960; Laing & Esterson, 1964). A space was opened up where madness/distress could be something that was not so distant or alien, but rather experienced by everyone at times, and could be understood as a meaningful response to the course of one’s life.

Women’s Liberation. Around the same time as anti-psychiatry, the Women’s Liberation movement of the 1960s and 1970s saw women turning to their own experiences as primary resources for political action. ‘Private’ experiences of women’s oppression and suffering were told through collective strategies. This had the effect of challenging and politicising the so-called ‘private’ status of their stories. This feminist movement was observed to be *“the first radical movement to base its politics – in fact, create its politics – out of concrete personal experiences”* (Morgan, 1970). Such a movement turned issues which had been private and shaming, such as the practice of abortion, into being re-considered as social and political issues. There was a rising acceptance, albeit a fragile one, within society that it was ok, and important, to speak up from positions of oppression.

Also in response to this was the beginning of an academic interest in feminist therapy and women’s mental health as internalised responses to social and political injustices (e.g. Herman, 1992).

Stories of resistance, stories of survival. In 1970 in the US, the Mental Patients Liberation Movement was formed. As part of their work they had distributed ‘controversial’ flyers to patients within hospitals. The flyers contained personal testimonies of people’s experiences of psychiatric services, aiming to highlight the problematic and oppressive mental health treatment they had received. The flyers stated:

> *"Ex-patients are full of anger at what has been done to them, but alone and unorganized this anger is not expressed and is often turned inward against oneself. Our anger is the fuel of our movement, and when we come together, acknowledging our identity to ourselves and to each other, we will have made the first and largest step in striking back at our oppressors."* (Mental Patient's Resistance, 1970)

It spoke to the person who was feeling lost within the system, to re-engage with who they were as an individual, and to transform this experience into collective action to make changes. Autobiographical accounts of people with serious mental illness soon began to emerge after this, which spoke out about the 'private' sphere of feeling oppressed and disempowered by the psychiatric system.

Judi Chamberlin who had been part of the Mental Patients Liberation Movement advocated and fought for the rights and dignity of people with mental illness, and began to reclaim 'madness' as something that was OK or even to be proud of. Chamberlin (1978) wrote an honest and deeply personal account of this idea, but also of her own illness, her recovery and the injustices she received whilst under the supposed care of the psychiatric system. At the heart of her book was an argument that real empowerment of patients, through challenging the psychiatric system, was imperative to their recovery, and it became a manifesto for 'survivor' groups.

1.3. Early stories of recovery

The first explicit personal account of 'recovery' is commonly cited to be Patricia Deegan's (1988) account of her experience of living with a diagnosis of schizophrenia and her recovery. She has been credited as starting the recovery movement (e.g. Roberts, 2016). Although ex-patient survivor narratives, such as Chamberlin's, had begun to emerge in the years before, Deegan is first to explicitly attempt to describe an idea of personal recovery, particularly of its differentiation from psychiatric rehabilitation. Drawing from her lived experience she wrote about how patients can recover a new and valued sense of self and purpose, which allows them to become active and responsible in their own rehabilitation. Deegan refers to this as a profoundly personal experience laced with hope and the will to act on this hope. She wrote, *"the goal of recovery is not to become normal. The goal is to embrace the human vocation of becoming more deeply, more fully human"*.

Deegan's (1996) later work on recovery reflects greater influences from existentialism, through her focus on the struggle to find meaning and hope when in the grip of despair, as well as drawing on humanistic psychology. She calls for her audience of mental health professionals to *"seek wisdom, to move beyond mere recognition of illness, and to wholeheartedly encounter the human being who comes for help"* (Deegan, 1996, p. 92). Deegan talks movingly of the utter despair she has of the psychiatric institutional treatment she received, and the necessity of having a 'survivor mission' which helped in her struggle to hold on to a sense of hope.

Lovejoy (1982) published an account of her own recovery from 'chronic schizophrenia' six years prior to Deegan's, but this is much less commonly referenced. Her personal account also challenged the chronicity of schizophrenia, citing her capacity for hope as central alongside the necessity of taking control of her symptoms.

In Esso Leete's (1989) account of her personal experience of twenty years of living with a diagnosis of schizophrenia she focuses on the need to *"accept and deal with mental illness"* (Leete, 1989, p. 200). Unlike Chamberlin she does not reject the chronicity of schizophrenia or express a dissatisfaction with her psychiatric treatment (which perhaps explains why it was published in the *Schizophrenia Bulletin* journal). She makes references to fighting a daily battle and a sense of vulnerability and incompetence, which are juxtaposed with newer feelings of confidence, survival and taking responsibility. Her account speaks of the discounting of patients' voices, and she urges the elimination of stigma of the mentally ill through changing public attitudes. However, she seems to primarily locate the responsibility of tackling stigma in patients themselves, to find the inner strength to surpass their own self-stigma (*"conquer[ing] stigma from within"* p. 199) so as to show the way for the public.

Writing of her personal experiences at the same time as Leete, Rae Unzicker (1989) offers a different understanding of her relationship with her 'madness', recovery and of stigma. Through her poetic and richly subjective writing Unzicker captures the depth of feeling involved in the *"stultifying process of madness"* and its *"never-ending pain"* (p. 71), but without romanticising misery. She speaks gratuitously of being given a copy of Chamberlin's *On Our Own*, and how she connected with Chamberlin's story of suffering and survival which then ignited a rage and anger about the psychiatric 'treatment' she had received and the *"stigmatizing and counterproductive"* (p. 76) dominance of psychiatric diagnosis. The reader hears of how she left behind both her *"miserable childhood"* (p. 75) and psychiatric services in exchange for loving and real human contact – but lets us know about the horror, shame and challenges on the way. Unlike Leete's account, Unzicker draws on the 'personal is political' discourse like Chamberlin does, and alludes to the value of collective movements, such as the Mental Patients Liberation movement.

Where the field of psychiatry is notable as predominantly male and paternalistic, it seems particularly interesting that all the early key recovery players, and writers of these early recovery stories, were women.

There is much variety in these recovery narratives, but as Pilgrim and McCranie (2013) note, there are central discourses of recovery being not only about the individual plight, but also of public issues – tackling stigma, social isolation or treatment from services. However, the variation and ambiguity between accounts of something called recovery can already be seen to be present.

1.4. Recovery as guiding vision

Since these recovery narratives, rare for their time, the notion of recovery has increasingly been taken up by both patients and professionals, and continued to be written about, defined and refined in many ways. A crude search of peer-reviewed journal databases shows that there has been a prodigious increase in 'recovery' being covered in academic papers since the 1980s.

William Anthony, a psychiatrist and director of the Centre for Psychiatric Rehabilitation in Boston, US, became interested in the emerging concept in the early nineties. In his seminal paper, he developed a definition of recovery, introducing the concept as a *"vision that will guide the mental health system in this decade"* (Anthony, 1993, p.521).

Anthony's oft referenced definition of recovery was an attempt to capture and synthesise the themes from the earlier personal recovery narratives:

> *"Recovery is…a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even within the limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."* (Anthony, 1993, p. 527)

Anthony continues with the following rather less well-referenced verse:

> *"Recovery from mental illness involves much more than recovery from the illness itself. People with mental illness may have to recover from the stigma they have incorporated into their very being; from the iatrogenic effects of treatment settings; from lack of recent opportunities for self-determination; from the negative side effects of unemployment; and from crushed dreams. Recovery is often a complex, time-consuming process."* (Anthony 1993, p. 527)

It seems that within Anthony's full definition there is as much attention paid to the hopeful, positively life-changing experience as there is on the sheer struggle that this process necessitates. There is also a hint at external challenges ('opportunities' and 'unemployment'), but these are left somewhat vague, without, for example, broader explanations of why there might be a lack of opportunity for people in recovery.

Anthony goes on to spell out 'basic assumptions' of recovery-informed services. One of these is that *"recovery can occur without professional intervention";* that professionals *"can facilitate recovery; the task of the consumer is to recover"* (Anthony, 1993, p. 531). This can be read as empowering for individuals, but also as the beginning of a loosening of responsibility of professional services. Anthony also introduced the assumption that a recovery vision does not commit to one theory of the causation of mental illness, stating *"recovery may occur whether one views the illness as biological or not"* (p. 532). This reflects the differing views of the earlier recovery narratives. However, for those that were outwardly challenging and rejecting of the 'chronicity' of 'illnesses' such as 'schizophrenia' (e.g. Unzicker, 1989) it might have seemed to be a problematic statement. We can see that the varying, and at times contradictory, investments appearing with the concept of recovery are starting to show.

1.5. Defining recovery

Conceptualising recovery is a confusing and contradictory endeavour. The notion of recovery can seem diverse and, as noted by an early recovery advocate, it has an *"illusory"* quality (Anthony, 1993, p. 528). As this chapter has begun to illustrate through a brief look at the genesis of the concept in survivor stories, it seems to mean different things to different people.

Recovery's ambiguity in definition, alongside its appearance as a benign concept, makes it easy for its use to be adopted for competing purposes or even rendered meaningless (Pilgrim, 2009; Howell & Voronka, 2012; Beresford, 2015). As such various groups and researchers have endeavoured to grasp the make-up of this thing called 'recovery'. Many reviews of the recovery literature have captured central themes, often referred to as 'principles', so as to contribute to a definition of recovery (e.g. Ridgway, 2001; Stickley & Wright, 2011; Leamy, Bird, Boutillier & Slade, 2011). These reviews identify several core themes of recovery including constructs such as hope and optimism, empowerment, finding meaning to one's life and distress, and connecting with others.

A distinction is proposed between *personal* recovery and *clinical* recovery (Slade, 2009a). While clinical recovery emerges from a medical discourse where the 'expertise' of mental health professionals is deployed, personal recovery is an individually defined concept emerging from those with lived experience (Slade, 2009b). Similarly, Davidson and Roe (2007) distinguish 'recovery in' as a personal, subjective experience, from 'recovery from' as a clinical, biomedical standard. Distinctions have also been made between internal and external processes of recovery (Jacobson & Greenley, 2001). Slade (2009a) defines clinical recovery as a 'sub-set' of personal recovery, which has been noted as serving to strengthen the concept of clinical recovery, and thus deters a critique of biomedical authority (Harper & Speed, 2012).

Pilgrim (2008) contributes some clarity amongst the vagueness and diversity of the concept. He proposes three ‘usages’ of recovery. The first of these he refers to as *“old wine in new bottles”* (p. 479) as it embraces recovery but within the limits of a biomedical discourse: with the correct treatment, recovery from serious mental illness is possible. The second usage he associates with the term ‘rehabilitation’ and community/social care, where patients are supported to recover through developing coping and social skills to support them to live a full life with optimal wellbeing. The third version noted by Pilgrim is most closely aligned to a social model and is emancipatory in its essence, where ‘survivors’ reject coercive and abusive psychiatric practice and professional expertise in favour of liberation, human rights and their own expertise-by-lived-experience. The early accounts of Chamberlin and Unzicker seem closely aligned with this emancipatory account of recovery, whereas Deegan’s might be positioned closer to the second usage with her framing of mental illness as a disability that needs to be overcome. Leete’s seems somewhere between the first and the second usage as she seems content with her psychiatric treatment, positioning her battle as more to do with an acceptance of her illness.

A recent review of qualitative literature (Robertson-Stuart, Tansey & Quayle, 2017) explored how service users experience the process of recovery. The findings confirmed that ‘optimistic’ themes of recovery, such as empowerment, hope and finding meaning, accounted for the majority of recovery experiences in the literature. However, interestingly, Robertson-Stuart, Tansey and Quayle (2017) also found another major theme which they called ‘difficulties’ to be within the majority, which had been largely left out of previous reviews. The findings highlighted the ambivalence and struggle involved in many people’s experiences of recovery, which featured in all the papers reviewed. These struggles involved practical matters such as financial and interpersonal relationship problems, as well as internal psychic struggles. This validation of the battle involved in the recovery journey with its inherent psychic and systemic complexities is largely overlooked in current mainstream recovery literature, but is in fact there in many of the early narratives (e.g. Deegan, Unzicker) and even within Anthony's vision in the early nineties. Indeed, Topor, Borg, Di Girolamo & Davidson (2011) argue that the personal aspect of recovery is enabled through the social environment, society and contributions from others.

Pilgrim and McCranie (2013), following a critical sociological review of the recovery movement, offer four proposed meanings of, or approaches to, recovery. These are proposed as: a personal journey, a critique of services, therapeutic optimism, and a social model of disability. Although conceptualised separately it is argued that these different groupings often co-exist in practice. The four conceptualisations as imagined by Pilgrim & McCranie (2013) are shown here:

1. *A personal journey.* Although this definition has been driven by users of services, this seems to be favoured by all. As its personal nature suggests, it suggests a different journey for each individual according to what, for them, constitutes a meaningful life. It emphasises the *process* of recovery, empowerment and individual meaning.
2. *A critique of services.* This is identified as a less common notion of recovery. Here, recovery is presented as a critique of orthodox psychiatric services and the iatrogenic harm imposed by them, and often proposes service reform. It emphasises choice, empowerment, reform, and upsetting the traditional patent-clinician dyad through

creating peer ‘experts’ (for an example see Daniel Fisher’s ‘empowerment model’, 1994).

3. *Therapeutic optimism.* This is close to Slade’s (2009a) ‘clinical recovery’, with a focus on clinical ‘outcome’ through reduction of symptoms from ‘illness’. Hope for recovery rests on the efficacy of treatments and services to provide these outcomes. It is associated with ideas of placing the problem within the individual and of medicalising madness and misery.
4. *Social model of disability.* This definition carries with it a political statement for social change (Beresford, Nettle & Perring, 2010). It focusses on changing oppressive and restricting societal structures which create disadvantage and barriers to recovery. Here, people recover not from something *within* but from ‘social exclusion’.

The discussion of the different definitions, conceptions and usages of recovery has begun to allude to some of the complexities in how it is used within, or how it is ‘enacted’ (McWade, 2016) through, the field of mental health, and thus what consequences it brings. As Pilgrim and McCranie (2013) discuss, the ambiguity in definition reflects the differing and competing agendas and interests of those making use of the concept. The following section will explore these complexities further through a look at critical perspectives on recovery.

1.6. Critiquing Recovery

The growing excitement of recovery as a guiding vision for modern day mental health services has also brought with it an increasing body of discontent from users of services, clinicians and academics. McWade’s (2016) use of ‘enactment’ (Mol, 2005, as cited in McWade, 2016) illustrates how recovery can be seen as not just a word with different meanings but as different enactments of different practices, each entrenched in varying relations of power. Versions of recovery are brought into being through practice. This body of critical literature is summarised here.

The strength of the ‘personal journey’ in recovery discourse has been critiqued as de-emphasising structural factors. Through its emphasis on the individual and their responsibility for change, there is a negation of social causes of emotional distress, such as poverty, lack of appropriate employment opportunities, and welfare reforms (Morrow, 2013; Harper & Speed, 2012; Rose, 2014). This process of individualisation clearly supports the dominant neoliberal climate (Morrow, 2013: Harper & Speed, 2012; McWade, 2016). One of the central principles of recovery, that of empowerment, positions the problem within an individual for them to ‘overcome’, thus excusing or silencing external factors (Poole, 2014).

The focus on the personal within recovery discourse is argued as negating the political causal dimensions (Pilgrim, 2008; Harper & Speed, 2012), which then has the effect of discouraging collective responses for change (Costa, Voronka, Landry, Reid, McFarlane, Reville & Church, 2012; Harper & Speed, 2012). The failure to engage with the social, economic and political obstacles that people face in their recovery, and indeed that contribute to their suffering in the first instance, is an important critique in an age of austerity measures (Beresford, 2015). In a further political dimension, Poole (2011) speaks of a ‘white and credentialed’ recovery movement which does not speak to factors of race and culture on mental health.

A continued investment in biomedical theories of mental health has been argued as present within mental health policy and legislation (McWade, 2016), where psychiatry still dictates the ‘official’ interpretation of recovery (Grant & Leigh-Phippard, 2014). The notion of recovery as empowering has been challenged by some commentators as a disingenuous claim, where instead the ‘empowering’ possibilities of recovery are only possible in terms of how they fit into the narrowly defined biomedical discourse (Poole, 2011).

Harper and Speed (2012) show that although recovery discourse is littered with positive, strengths-based language, this is *“implicitly reliant on a model of deficit”* (p.46). As such, the deficit model is perpetuated through the tonic of a strengths-based approach to care. It thus fails to challenge such a deficit model of mental health problems.

An important and pivotal development has been the formation of a user led activist group in 2014, named ‘Recovery in the Bin’, whose members are openly critical of the recovery model. The group have coined the term ‘Unrecovery’ (Recovery in the Bin, 2017) as a political statement in retaliation to the co-opted notion of recovery. Within a set of principles, they state that they are opposed to the way recovery has been colonised and used to ‘discipline and control’ users of mental health services. In this way, they highlight how this version of recovery has been a ‘gift’ to a neoliberal government agenda, because the stress is put on people to recover privately and be discharged from services instead of being adequately supported. This is a line of critique shared by others (e.g. Braslow, 2013; Poole, 2011; Morrow, 2013; Harper & Speed, 2012). Recovery in the Bin has been gaining increasing support from users, academics and clinicians.

Some commentators have argued how users of mental health services are encouraged to be ‘normal’ under the guise of recovery rhetoric (Rose, 2014). This ‘normalisation’ requires an adherence to recovery goals which fit within the norms of society, and are in this way judged as functional or correct, and therefore are not as ‘personal’ as they are intended (Rose, 2014). McWade (2016) builds on this, arguing that UK ‘recovery-as-policy’ enacts a form of citizenship which requires people to make the ‘right’ choices and that, in this way, they can be set up to ‘fail’ through making ‘wrong’ choices. McWade (2016) puts forth a case for how patients can become citizens only through their conforming to pre-determined norms and values. The terrible irony is that on the face of it they are free to choose, yet if they make the ‘wrong’ choice they are liable to be detained under the Mental Health Act (2007).

These critiques will continue to be called upon throughout the research.

1.7. Fragmenting Recovery: a genealogy of the recovery movement

As I have begun to discuss, unifying ‘principles’ of this new thing called ‘recovery’ had begun to emerge in early recovery narratives, and soon took hold as an almost given truth as it became crystallised in various definitions (e.g. Anthony, 1993). This ‘truth’, as can be seen, has begun to fragment and unravel through various critical commentaries. Using genealogy, this section engages in a further fragmenting, or deconstructing, of the unified version of recovery. It takes the view that contemporary recovery is the product of *“the accidents, the minute deviations – or conversely, the complete reversals – the errors, the false appraisals, the faulty calculations that gave birth to”* (Foucault, 1984, p.81) its existence as something valued by so many.

This genealogy is concerned with how the recovery movement has come to be central to mental health services today. It attempts to understand current practices around ‘recovery’ with the aim of *“grasping the conditions that make these [practices] acceptable”* (Foucault, cited in Mahon 1992, p.129).

Using a genealogical approach to understanding the concept of recovery as a discrete form of knowledge should help to gain an adequate grasp of, and suspend assumptions about, how recovery is known and used today within services. Furthermore, it should enable an understanding of how the contemporary recovery movement has been made possible.

Genealogy as methodology. Foucault has defined genealogy as a concept and methodology of critique, and in so doing redefines critical analysis. He (Foucault, 1988, p. 154) states that:

> *"Critique is not a matter of saying that things are not right as they are. It is a matter of pointing out on what kinds of assumptions, what kinds of familiar, unchallenged, unconsidered modes of thought the practices that we accept rest."*

The central hypothesis of genealogy is borrowed from Nietzche's "Genealogy of Morals" (1865) which describes the inextricable link between knowledge and power. Genealogy investigates knowledge, or taken-for-granted truths (e.g. theories or practices) in discourses by bringing to consciousness their buried historical and political underpinnings. It is not concerned with arriving at a 'truth', but rather with describing how discourses and knowledge are produced through various practices of power.

The genealogical approach builds on Foucault's earlier work and initial method of archaeology, and addresses some of the problems inherent in these earlier archaeological writings. Foucault's earlier archaeological approach was not abandoned, but rather it became a component of the genealogical method. His archaeology concerned itself with the conditions and rules that structured how discourses are produced (Howarth, 2000), but this focus on the internal dynamics of discourse was not sufficient to explain the development of discourses and their relationship with knowledge/practice and power (Hook, 2007).

Archaeology and genealogy can be understood as complementing one another as different phases within a methodological approach. In *The Archaeology of Knowledge* (Foucault, 1972), Foucault challenges the traditional ways of analysing knowledge in the human sciences through a concern with societal structures. His archaeology aims to uncover layers of society, providing a description of discursive events (Foucault, 1972).

The emergence of Foucault’s genealogical analyses followed his attempt at understanding the implications of the revolutionary events that occurred in France in May 1968. It seemed to Foucault that much of human existence that had been familiar and ordinary to daily life had become uncertain and open to questioning (Hook, 2007). His analyses focused on the tracing of the emergence of various discourses, as well as the intertwining nature of knowledge and power (May, 1993). Foucault came to view this knowledge-power relationship as a constitutive and creative force, which was a stark turn away from his earlier work and Marxist thinking which considered power as solely negative and restrictive (e.g. an exercise of repression by the state to ensure capitalist benefit).

Much of the social sciences had been rooted in positivism and liberalism, where there is an aloofness and separation between knowledge and power. Knowledge, or a scientific ‘truth’, is created independently from power and politics. For example, the psychiatric diagnosis of ‘schizophrenia’ is viewed by many within the ‘psy’ disciplines as a truth based in scientific evidence. That it creates huge power imbalances and stigma between those deemed to be schizophrenic and those treating them is then seen merely as an unfortunate consequence of this ‘truth’.

Marxism, however, takes issue with the separation between the two, arguing that knowledge is political, and that truth can liberate (May, 1993). Similarly, Foucault believed that knowledge is not produced independently from power. However, he said that to understand knowledge-power relationships we need to reveal how knowledge is claimed and power exercised. For Foucault, the relevance of power is in what it *creates* rather than what it denies or excludes. Subjects and subjectivity are an effect of power. The psy disciplines, the people they treat and the services provided are seen as a creation or by-product of power. For Foucault, different forms of subjectivity reveal varying exercises of power. In *Discipline* *and Punish* (1975/1991) and *The History of Sexuality I* (1990) Foucault shows how subjects are formed through epistemic and political practices. What subjects take for granted as knowledge is often entwined with shifting and subtle power relationships.

Power is described by Foucault as a phenomenon arising alongside the rise of technology, industry, and capitalism, and the knowledge that these practices bring with them. The mental health industry and psy-disciplines have been understood as related to power and control. For example through the practice of psychotherapy individual goals can be aligned with those of the state through the internalisation of the therapist and an establishment of a continual self-surveillance (Hook, 2007).

Through historical investigation genealogy disrupts and problematises natural or ‘taken-for-granted’ knowledge and practice. Rather these truths are seen as having a history or lineage which render them as remnants of previous events, discourses, practices and power. The genealogical task has been referred to as providing a ‘counter memory’ (Mahon, 1992). Foucault understood how disciplines such as psychology and psychiatry create their own idealised and selective histories which *forget* other beginnings, which a ‘counter-memory’ exposes (Visker, 1995).

Genealogy is used here as a methodology to trace historical and present-day discourses which impact on the way recovery is defined and developed, primarily through an exploration of contemporary UK mental health policy. The idea here is not to start with one assumption or truth of the concept of ‘recovery’ and what it means, but rather to be interested in what is invested in how recovery is talked about. This paper accepts that there *are* different truths and ways of thinking about recovery, and that undoubtedly some of these different truths have been and continue to be helpful and real for people experiencing recovery or for the professionals delivering recovery services. But it is also the case that there are a growing number of people who feel silenced by and unable to recover within certain dominating recovery ‘truths’, such as the ‘Recovery in the Bin’ collective. Alongside this there has been a rise in critical academic commentators as has been discussed. In contemporary society the dominant power is the state, and an important way it applies its power, and therefore establishes ‘truths’, is through its statutes and the dominant discourse of published policy. Using UK policy documents as representations of knowledge, this genealogy attempts to understand better how recovery has evolved into how it is used today.

Recovery made possible: recovery in policy. At the start of the twenty-first century, the policymakers of the New Labour government began to show their explicit support for the notion of recovery and its related themes of self-management, social inclusion and choice. Slade (2009a), a leading clinician and researcher into recovery, justifies recovery informed policy as important for recovery focused mental health services by explaining *“because that is what, at a policy level, has been identified as the goal of mental health services”* (p.74). This dubious logic of circular meaning gives the appearance of power/knowledge, but fails to question upon what knowledge and power these policies rest.

Policy and the process of policymaking is complex and involves a number of different people, responsibilities and interests (Ham, 2009). Although a single definition of policy has not been agreed (Cairney, 2016), generally speaking ‘policy’ connects politics with government activity and the public world. Policies generally adopt a position towards a particular topic, and contain value statements or guiding principles or rules on this topic, guided by an ‘expert’ position (Harrison & McDonald, 2008). In this way, they both reflect and inform the way that practice develops. For mental health users, as well as clinicians and services, mental health policy therefore holds a powerful influence over how daily lives are lived.

Policies contribute to the production and regulation of ‘truth’ claims, such as ‘recovery’. Exploring the adoption of recovery into policy documents allows for the telling of a story around how recovery has entered as a dominant discourse within contemporary mental health practice and how this continues to create new truths and practices. This genealogy explores the conceptualisation of recovery through British governmental policies from the beginning of the new millennium when ‘recovery’ was first explicitly mentioned as a concept within policy. Table 1 shows the policies under review.

Table 1

Policy documents included in the genealogy

Year	Title of policy	Organisational body
2001	The Journey to Recovery	Department of Health
2003	Competency framework for STR workers	Department of Health
2004	Emerging Best Practices in Mental Health Recovery	National Institute for Mental Health (NIMHE)
2005	Guiding Statement on Recovery	National Institute for Mental Health (NIMHE)
2009	New Horizons	Department of Health
2011	No Health Without Mental Health	Department of Health

2012	Liberating the NHS: No Decision About Me Without Me	Department of Health
2014	Five Year Forward View	National Health Service
2014	Closing the Gap: Priorities for Essential Change in Mental Health	Department of Heath

Community care. At the turn of the century, the Department of Health (2001) published ‘The Journey to Recovery’, first introducing the concept of recovery into government policy. The policy began by framing the deinstitutionalisation of patients from state-run hospitals to ‘community care’ as a natural process which had been inevitable. As outlined by McWade (2016), it made the case for celebrating the liberating effects of modern psychiatry and curative pharmacology through reflecting how *“new, more effective, medication became available”* which released patients from *“awful”* conditions of the past. Through the promise of *“modernising”* mental health care, ridding it of its *“decaying, depressing”* past of the institution, a discourse which plays into the illusion of history as only progressive and reconciliatory is adopted, thus obscuring other truth perspectives (Foucault 1977, as cited in May 1993). Deinstitutionalisation in this policy is framed as having emerged from scientific advances in treatment, and the new vision outlined is distanced from memories of the dehumanising practices of the past (McWade, 2016).

Deinstitutionalisation and the move to community care seems to have supported some conditions that made possible the emergence of the recovery movement as it has been adopted in *The Journey to Recovery*. Deinstitutionalisation was first envisioned by the

Conservative Party's Minister for Health, Enoch Powell, in his famous 'water tower' speech (1961). Speaking of the Victorian mental hospitals, Powell said:

> *"There they stand, isolated, majestic, imperious, brooded over by the gigantic water-tower and chimney combined, rising unmistakable and daunting out of the countryside - the asylums which our forefathers built with such immense solidity to express the notions of their day. Do not for a moment underestimate their powers of resistance to our assault."* (Powell, 1961, as cited in Roberts, 2016).

As with Department of Health (2001), Powell's speech shows an *"assault"* on the past *"forefathers"* and their practices (*"notions of their day"*), and a championing of the new (Jones, 1972). Powell asserts the need to leave behind conservative tendencies to keep things as they are and to *"favour the unaccustomed."* A new conception of a post-asylum age is envisioned where there is a *"transformation of a whole branch of the profession".* This sets the scene for the emergence of a new culture and practice to develop within the care and treatment of the mentally ill; setting the scene for recovery.

This brings to mind Sedgwick's (1982) conceptualisation of a 'liberal, evolutionist history' of psychiatry where sympathies lie with present day modern medical discourse over and above its social past. Persecution and cruel treatment is left in the past and not considered a modern-day possibility. Similarly, Thomas Szasz writes about how *"horror stories of the past serve to make the present condition of the mentally ill somewhat more palatable"* (as cited in Sedgwick, 1982 p.130).

Budgetary and ideological understandings of deinstitutionalisation rock the taken-for-granted 'truths' of the water tower speech. Scull (1977) asserts the shift to 'community care' as relating to intensified fiscal pressures on the state during the 1960s and 1970s, and thus sees it as a cost cutting exercise. In relation to this, Sedgwick (1982) conceptualises deinstitutionalisation as ideological, acting as a *"'smoke screen', masking the bitter facts of* *social oppression"*. In this sense, the benign rhetoric of community care and all it encompasses as *saviour* and *liberatory* in this policy document is called into question.

The NHS and Community Care Act (1990), the first major reform of the NHS since its inception, attempted to address the problem of deinstitutionalisation through its bridging of health and social services and emphasis on community care. The government papers *Care in the Community* (1981) and *Caring for People* (1989) prior to the community care legislation conform to an ideology of market individualism and have a prominent independence agenda and empowerment discourse of choice and participation. This empowerment to make decisions might be critiqued as only offering choice within the limits of the cost and availability of particular services and treatments. The Conservative values of family and individual responsibility, under Thatcher's ministry, also perhaps helped to map a route away from collectivist welfare provision (Kim, 2008).

The 1980s had begun to see a rise in ideology that challenged the state's responsibility for social care provision. State care provision was criticised on ideological grounds by the authoritarian right for fostering dependence and undermining autonomy (Marsland, 1996). In this context, and in the aftermath of The NHS and Community Care Act (1990), there was an emergence of concepts such as 'social inclusion', 'self-management', 'choice' and 'personalisation'. These terms have been considered as convenient hooks which support an agenda of reducing welfare state dependency, in the name of good 'recovery' (O'Donnell & Shaw, 2016).

Consumerism. As stated in the introduction, the emergence of the internal market within the NHS under the Conservative government of the 1990's provided a landscape for the rise of consumerism, and it had started to introduce the notion of rights and standards for what it termed as 'customers' or 'clients'. However, a distinction remained between rights and standards, which showed an *intention* without the necessary commitment in some areas. For example, *"respect for privacy, dignity, and religious and cultural beliefs"* was a standard rather than a right; thus the patient voice still remained constrained (Department of Health, 1991).

The discourse of healthcare patients as consumers was enhanced under the Labour Government in The NHS Plan (2000) where the concept of 'patient choice' lay at its heart, and continues to feature throughout the New Labour policies starting with *Journey to Recovery.* The Coalition Government in 2010 again placed the consumer at its core whilst emphasising the marketisation of services in order to provide this. This strategy rested on the premise that competition would increase efficiency and standards and provide better choice for patients. Being able to choose one's treatment carried with it, on the face of it, an empowering sentiment.

This focus on listening to the voice of users of services continued to present itself in political correspondence and policies throughout the 1990s. For example, in 1995 the NHS Mental Health Task Force spoke of *"listen[ing] to service users, to discover from them what is good and what is not good about mental health services."* This emphasis on *listening* to users quite quickly changed to include also *involving* them a couple of years later, for example, *"patients, service users and carers will be involved in their own care and in planning services"* (Department of Health, 1998).

Recovery as model – the right way to recover. In 2004, the National Institute for Mental Health in England (NIMHE) released *Emerging Best Practices in Mental Health Recovery,* a year before their *Guiding Statement on Recovery* (NIMHE, 2005). The former document presented a new model, 'The Recovery Process Model', for understanding and providing guidance on how an individual might move through the recovery process and how clinicians, the community and the person in recovery can support this at each stage. The Recovery Process Model outlines a linear development from an unconscious to a conscious dependency, through to independence and finally *inter*dependence.

Through its explicit definition of recovery – *"a personal process of overcoming the negative impact of diagnosed mental illness/distress despite its continued presence"* – (p. 2) this model set a precedence for a 'right' way to recover. The 'right' way is summarised in the form of recovery goals which are defined as: realising one's personal potential, functioning at an optimal level, and being actively engaged with organisations outside of mental health services.

Rethink's "100 Ways to Support Recovery" (Slade, 2009b) differentiated recovery goals from 'treatment goals', outlining the importance of both. Recovery goals are described as *"dreams with deadlines"* (Slade, 2009b, p.17). A formal realisation of 'recovery goals' was introduced into the Care Programme Approach (CPA) document within some NHS trusts a year later in 2010, in an effort to validate improvements in patient experience (London Strategic Health Authority, 2010).

Although liberating by name, the introduction of recovery goals to the CPA can be seen as a way of exerting control and discipline over subjects. A goal may be a personal 'dream', but this dream has a state 'deadline' attached to it. Thus, the empowering quality of 'recovery goals' becomes something less liberating. Gould's (2012) study of people's experiences of recovery under CPA found that users felt that professionals did not take account of the diversity of views on recovery, rather reinterpreting patient views to fit their oft medical outlook. This was particularly the case for those from ethnic minority communities. In a Foucauldian disciplinary sense, service users are moulded into productive subjects through the use of recovery goals defined within the constraints of a CPA document. As a participant in Gould's study reports on the CPA experience: *"it's not for us, it's for the health professional, because they're going to do what they want to anyway."* (Gould, 2012, p.53).

Citizenship – responsibilities over rights. Underpinning New Labour's policy directives, and central to their agenda, was the discourse of citizenship. 6 and Peck (2004) discuss 'citizen's obligations' to have been a key feature of New Labour's 'modernising' reform regime in mental health. For example, in 1993, Tony Blair said:

> *"A modern notion of citizenship gives rights but demands obligations, shows respect but wants it back, grants opportunity but insists on responsibility."* (Blair, 1996, p. 218).

This indicates the growing emphasis on duty rather than rights, with people taking a greater level of responsibility, significantly for their welfare (Dwyer, 2008). This version of citizenship meant that social rights, such as welfare, depended to a greater extent upon hard work, accountability and personal responsibility (Dwyer, 1998). This citizenship discourse of responsibility and duty can be seen as a condition of possibility for the mainstreaming of recovery.

Work to recover. Between 1997 and 2010, New Labour's welfare reforms accentuated the rhetoric of 'no rights without responsibilities'. They aimed to get people back into employment and decrease their need for welfare benefit. The reforms drew on the ideology value of 'market participation' where an individual's 'good' citizenship is determined by their participation in the economic labour market (Owen & Harris, 2012).

Indeed, within *Emerging Best Practices* (NIMHE, 2004), there is an emphasis placed on the importance of "work/meaningful activity" to aid recovery throughout the document. The *"benefits of employment as related to wellbeing"* (p. 9) appears only to be celebrated, whilst de-emphasising other discourses around workplace stress and the negative impact of work. As individuals progress through their recovery they are expected to see the value in working and show that they *"seek[s] to contribute"* (p. 11).

Entering into the labour market is framed as a key part of recovery within this policy, but the nature and quality of such employment (e.g. inflexible hours, insensitive management), especially for people with long-term difficulties, is not considered (Harper & Speed, 2012). Individuals with disabilities face huge challenges to their employment rights and have limited appropriate employment opportunities (Owen & Harris, 2012). In this way, the discourse of working to recovery moves the 'responsibilities' away from the government to address wider structural obstacles to employment.

Recover from dependence. Within *Emerging Best Practices* (NIMHE, 2004), there is an ideal of recovery as striving towards a state of *inter*dependence. A focus on interdependence distances itself from neoliberal visions of personal responsibility, as it recognises how the self is rooted in community, and that, just as equally, the community is incomplete without individuals. This policy was written under the New Labour government after its implementation of the "community cohesion" agenda (previously known as 'social cohesion') which had been a response to riots and disturbances related to racial tensions between different groups. Community cohesion has been criticised for ignoring the contributing factor of socio-economic problems. The emphasis on the notion of 'community' within the New Labour ideology can also be associated with the concept of active citizenship with individuals taking responsibilities and duties within the community, and as bound up with market participation (Morrison, 2003).

The version of interdependence and community within *Emerging Best Practices* (NIMHE, 2004) seems to have faith in the assumption that communities are accepting of ‘mental illness’, or if they are not they will be once they have been psycho-educated by ‘anti-stigma’ programmes. It ignores the iatrogenic problems people can face from others in their community after receiving a psychiatric diagnosis (e.g. employers and disclosure, landlords not renting to welfare claimants).

Emerging Best Practices (NIMHE, 2004) also adopts a discourse of dependency as a worthless, passive and denigrated state. It is a state to be overcome through becoming self-sufficient. In the post industrial world, there was a growing stigma around dependency, namely of dependence on the welfare state. Dependence on welfare became the fault of the individual rather than difficult social and economic factors (Fraser & Gordon 1994). There was also a ‘psychologising’ of dependency where it became something located within a person, individualised. Indeed, in 1980 it was pathologized as a medical diagnosis within the Diagnostic Statistical Manual (DSM) as ‘dependent personality disorder.’ Much like a liberal narrative on dependency, the recovery process model does reference the influence of social and economic factors, but the overriding ‘problem’ is shown to be more to do with how the individual behaves *in spite of* difficult circumstances.

Self-management. The idea of self-management has developed as a significant part of recovery (Slade, 2009a). Alongside autonomy and self-efficacy, it became a key quality standard of improving user experience within mental health services (National Institute for Clinical Excellence, 2011). Manualised self-management tools, such as the Wellness and Recovery Action Plan (WRAP; Copeland, 1997), have been adopted into mental health services which users can *“use to get well, stay well and make their life the way they want it to be”* (Copeland, 1997). New Labour’s ‘modernisation’ of mental health services brought with it particular features that relate to the focus on self-management, including ‘citizens’ obligations’ (6 & Peck, 2004). The Mental Health Act (2007) had brought new powers which placed the *"duty upon patients for responsibility for compliance with treatment regime"* (6 & Peck, 2004, p.100).

This *duty* to self-manage relates to governing 'at a distance' where socio-political and economic objectives can be met through 'indirect' mechanisms without disrupting the concept of autonomous, self-managing citizens (Miller & Rose, 1990). Government can *"utilize and rely upon a complex net of technologies… for educating citizens in techniques for governing themselves"* (Miller & Rose, 1990, p.171). The use of self-management (in its various forms) as a recovery task supports this.

Recovery 'despite' illness. In *The Journey to Recovery* (Department of Health, 2001), it was envisioned that *"services of the future will talk as much about recovery as they do about symptoms and illness"* (p. 24). Indeed, this rhetoric of illness alongside recovery seems to have largely remained. McWade (2016) argues that madness and distress in policy has continued to be conceptualised as illnesses, thus 'recovery' is used as a justification for continuing with existing biomedical practice. In *Guiding Statement on Recovery – The Government's Vision for Mental Health Care* (Department of Health, 2005) where recovery from mental illness was discussed as a *"real possibility"* (p24) this is shown again. The view that patients were *"unable to take control of their lives and to recover"* was contested, and instead there was emphasis put on services needing to be optimistic, positive and *"driven by the right values and attitudes."* However, the biomedical discourses remained ("*services of the future will talk as much about recovery as they do about symptoms and illness"*) as did rhetoric around professional expertise of a medical nature. Support around access to social needs such as housing, education, work, and state benefits, were stated as basic needs of any recovery (p24). Although these basic social needs are briefly referenced, the paper ends by reducing mental illness to *"no more to be frowned at than breaking a leg"* thus arguably retracting the social and bringing forth a medicalised discourse of a thing to be fixed.

Likewise, the recovery process model in *Emerging Best Practices* (2004) continues to rest on the biomedical assumption of the concept of *"diagnosed mental illness".* Furthermore, it frames 'mental illness' as something that will have a *"continued presence"*, thus not really challenging the medical idea of chronicity. The thing to be overcome is instead framed as the 'negative impact' of the illness. Another way of viewing the 'negative impact' felt from such a diagnosis is iatrogenic – the harmful side effects of the care received by the psychiatric system – in which case recovery would involve an abandonment of such practices.

Ten years after its first mention in UK policy, the Royal College of Psychiatrists published a position statement entitled *Recovery is for All* (2010), which tried to tackle and dispose of the supposed contradiction of the notion of recovery and psychiatric treatment. It fully endorsed the use of recovery focused practice across psychiatry in order to make services *"fit for the twentieth century"* and proposed that recovery be the primary concern for the future of psychiatry. However, it was keen to point out that it would not be abandoning its medical training, and the new 'recovery' focused document is carefully balanced with biomedical rhetoric. For example, *"Recovery is about the person and their life, what happens to their 'illness' is a different question"* (p.18). It acknowledged this contradiction as a challenge to be faced, how they can work collaboratively with their patients toward recovery without abandoning their medical skills, or indeed bringing them into question. The document seems to subscribe to an Cartesian-esque dualism whereby there is a separation of personhood from 'illness'. This is in contrast to discourses around subjectivity and distress as inseparable and intricately linked (e.g. Laing, 1960).

Recovery is for All reads with an assumption that psychiatry and its tool of diagnosis is an unquestionable truth. This ‘professionalisation’ (Friedson, 2001) lends authority to the medical interpretation over others, particularly those of service users. Psychiatry is given a scientific status and autonomy as a body of knowledge. Even with an acknowledgement that labels can stigmatise and distress, there is an assertion by the Royal College that to withhold their expert scientific knowledge would impede recovery: *“Service users expect us as psychiatrists to provide information about their conditions, including the actual diagnosis. The failure to [diagnose]… may ultimately… minimise opportunities for their Recovery”* (p.20). This process is then referred to as *“breaking bad news”*, bringing to mind the image of the professional psychiatrist as a blameless messenger of some otherwise inaccessible but factual truth.

A failure to disrupt the medical model, noted in earlier policy discourse, is also apparent in the more recent *No Health Without Mental Health* (Department of Health, 2011), as discerned by Harper and Speed (2012). Harper and Speed (2012) noted how an assumed biomedical aetiology of mental health difficulties is maintained along with its inherent assumptions of deficits. They argue that these are then reframed as potential strengths to be gained, and as such does little to counter the deficit model; rather, it contributes to the original stigma and oppression against which the initial recovery movement aimed to protest.

Optimal functioning and positive outlooks. There is a focus within the recovery process model (Department of Health, 2004) to achieve ‘optimal functioning’. By introducing such a term, it indicates that there is a ‘less than’ quality about people who do not progress to their optimal functioning, that they are languishing rather than flourishing. Such people who languish remain ‘service dependent’ according to the model, and are then a fiscal burden for the state (Pilgrim & McCranie, 2013).

The recovery guidelines come with a warning:

> *"Failure… to behave consistently with the identified principles and best practices could result in people in recovery not functioning optimally, taking longer than necessary to reach their optimal level of functioning, or having unnecessary recurrence of their distressing experiences."* (Department of Health, 2004, p.3)

This introduces the possibility that there are 'failed' recoveries, as highlighted previously by McWade (2016). Within the model, the assumption is that failure will arise when individuals do not behave according to the principles to progress with their recovery. Recovery as an end goal is presented as a given truth. This relates to the process of 'normalisation', the institutionalisation of what counts as normal, where there is a construction of an idealised 'normal' version of recovery – that of 'optimal functioning' – and subjects are constituted in this way.

Optimal functioning is a term closely associated with positive psychology (e.g. Fredrickson & Losada 2005). In 2005, the *Guiding Statement on Recovery* (NIMHE, 2005) outlined a 'vision' of recovery which favours individual responsibility to restore a positive outlook:

> *"Recovery… involves a process of changing one's orientation and behaviour from a negative focus on a troubling event, condition or circumstance to the positive restoration, rebuilding, reclaiming or taking control of one's life."* (p. 1)

This vision has the potential to be used dangerously in practice, where the 'realities' of patients' lives, for example issues of abuse, oppression and poverty, are not given space in the name of aiding recovery, and a social level of denial can operate. Feminist and activist literature relating to the subject of recovery, from a decade earlier, is not represented within this vision. As opposed to looking the other way from the 'troubling event', Herman (1992) pays close attention to the necessity of 'speaking the unspeakable' in relation to trauma that often underpins mental health problems. It emphasises giving voice to troubling realities otherwise denied or silenced, and assisting patients to both remember and recover.

The value judgment inherent here between ‘positive’ and ‘negative’ personalities beckons yet another way that subjects are surveyed and ‘normalised’. The discourse of positive psychology, seen in this extract, privileges particular ways of living, those lives that claim a positive focus and ‘rebuild, reclaim and take control’. This ultimately supports the values of a neoliberal agenda through, for example, creating subjects who function optimally and independently and do not overly disrupt the social order (McDonald & O’Callaghan, 2008).

Coercive recovery. In 2007, with the growing rise of mental health service users being cared for in the community, the Mental Health Act (1983) was reformed.

> *“Patients who are detained under Mental Health Act powers, unless they are too ill to consider such matters at all, are very likely to view their new status with fear and perhaps anger… However, these fears are not always borne out; patients may be relieved to find that the law which takes away their liberty also contains some checks and balances that a patient can use to regain control throughout their recovery process, and which stand against any overenthusiastic exercise of powers granted to those who detain that patient.”* (Mental Health Act Commission, 2007, p.16)

The reform took place later than planned due to well-organised opposition from both professionals and service user groups (Glasby & Tew, 2015), which gives some indication of the controversy raised by the Act. Through its powers to treat people in the community without their consent, the newly reformed Mental Health Act (2007) solved the ‘problem’ of dealing with ‘problematic’ people in the community (McWade, 2016). It carried the implicit assumption that those with mental health problems could pose a risk to social order – public safety trumped the rights of people to make choices about their care (Glasby & Tew, 2015).

This seemed contradictory to the rise in policies endorsing recovery with their emphasis on patient choice and social inclusion (Pilgrim, 2008), although the rhetoric of 'promoting recovery' featured as a guiding principle in the Mental Health Act's revised code of practice.

The change brought with it new powers which placed a 'duty' on patients to be responsible for their 'treatment compliance' (6 & Peck, 2004). The paradox of a mental health service emphasising both compliance and recovery has been considered as leading to 'coerced recovery' (Morgan & Felton, 2013). Discourses around the risk from mental health service users, 'treatment pressures', as well as ethical arguments (e.g. coercion as 'enabling' recovery) can all be seen to contribute to the justification of coerced recovery (Morgan & Felton, 2013).

The new powers of the Mental Health Act (2007), combined with the paradoxical rhetoric of recovery focused practice, created an approach that could control and monitor those patients in the community, outside of the institutional walls. Its emphasis on the risk that people could pose to the public and themselves might be seen to have provided the discourse necessary to justify the reforms. The concept of risk itself can be considered a key component of governmentality, whereby risk is constructed to justify extension of compulsory powers over those deemed 'risky'. Lupton (1999) argues that those deemed risky are those who threaten the ideal of, and the security of, the 'civilised body' (e.g. characteristics such as white, able-bodied, masculine), therefore require control and surveillance.

The concept of clinical risk assessment (deemed necessary under the Mental Health Act) can be argued to have brought with it a 'de-personalisation' of clinical practice – patients do not need to *enact* risk but need to tick the box of certain risk factors which have been pre-determined by the legislation (Castel, 1996). The mental health professionals then become supervisors of normality (Foucault, 1975), fulfilling governmentality objectives. Once a patient is deemed a risk and placed under supervision, according to some this can enable the recovery process (Molodynski, Rugkåsa & Burns, 2010) – but, with this all in mind, it begs the question 'to whose script will they be following in their recovery?'

The Centre for Mental Health (Boardman & Roberts, 2014) published a briefing paper in response to the paradox between risk and recovery, questioning whether the two practices were *"uncomfortable bed fellows*" (p. 4). The briefing paper argues how 'at first sight' risk and recovery *seem* contradictory focuses, but actually *"in reality, there is much overlap"* (p.4). Solutions are offered in the form of 'person-centred safety planning' and 'positive risk taking' (e.g. Morgan, 2013). However, as humanistic as these techniques sound, the report states that *"adopting a recovery-supportive approach is not equivalent to relinquishing professional responsibility, nor does it renounce the need to intervene and take control in appropriate circumstances"* (p.10). This quote implies that, even within a 'recovery focused' legislation, ultimately powers rest with the state and institutions and *not* those in recovery.

Recovery as an organisational pursuit. In 2009, the Department of Health commissioned a new national project, 'Implementing Recovery through Organisational Change' (ImROC). It was felt that in order to support people in their recovery major changes needed to be made within services. ImROC sought to identify organisational challenges and change the culture, including staff attitudes and behaviour, to create an environment supportive of recovery. It involved pilot projects with NHS and independent sector sites, and produced a series of briefing papers with a focus on 'transforming' mental health services. ImROC set the motion for the formal introduction of recovery colleges, peer support workers and quality and outcome indicators. These have been defined as recovery ‘technologies’ (e.g. Smith-Merry, Freeman & Sturdy, 2011).

Measuring Recovery. The publication of *New Horizons* (Department of Health, 2009) placed recovery-oriented practices at the core of NHS mental health services. *New Horizons* introduced the use of new outcome measures, including the ‘recovery star’ to *“assess progress”* (p. 79) of individual recoveries as defined by ten ‘key dimensions’. This captures a growing need to quantify and measure recovery, which is connected to an increasing focus on outcome measurement in mental health services more generally.

The late 1980s and 1990s had seen a rise of the culture of audit and managerialism move from the financial sector to that of public services (Shore & Wright, 2000). Along with this came an introduction of new terms such as ‘value for money’ and ‘efficiency’ (Power, 1994). Government targets were first introduced by the Conservative government in the 1990s (e.g. proposing a maximum waiting time for surgery), but came to be one of the defining features of health policy under New Labour in the late 1990’s. Within such a culture, it seems that recovery’s use within the health sector could not remain a purely personal subjective journey defined by the individual. The original polyvalent and vague concept of personal recovery needed to evolve further and be defined as something which could be quantified and measured.

Recovery as something to be measured, as a performance indicator, points to its shift toward being something that can be audited within services. Recovery takes on a ‘bureaucratisation’ quality here. A well performing organisation which can be seen to ‘recover’ individuals through its auditing process is seen as one that is efficient and effective. Indeed, New Horizons (2009) asserts outcome measurement as *“vital for effective commissioning”* (p. 80). Thus suggesting that individual’s recoveries become something upon which NHS trusts and other organisations can be congratulated or penalised for financially. The introduction of the recovery star as part of CQUIN targets for many organisations has been a playout of this.

The introduction of such outcome tools, which are based on 'scientific' principles, set up a 'normalization' of recovery by which everyone's personal story can be judged and objectively measured as to its success or failure. In *Discipline and Punish* (1975), Foucault showed how discourses can produce such norms. This constructed norm is for all to strive towards, and from which all can be measured and compared. For the mental health service, this brings forth issues to do with self-surveillance and regulation of patients.

Indeed, in 2011's *No Health Without Mental Health,* there is a sense of urgency in the need to standardise recovery outcome measures and to routinely collect outcomes. This document states that outcomes are needed so as to *"provide the information that individuals need to make real choices between services and approaches, and will allow commissioners and providers to benchmark their services against one another"* (p. 22).

Furthermore, this raises ethical questions about defining how people should progress, as if there is a 'correct' way. Gadsby (2015) points out that *"fulfilment becomes functioning,"* (para. 3) where the ultimate pursuit becomes about self-management and meeting stated targets rather than gaining rich, inner lives. A wider discourse of instrumentalism might be being drawn upon here – recovery becomes an instrument to achieve a practical purpose, to solve a problem, as opposed to a phenomenological experience.

The Recovery Star, introduced in *New Horizons* (Department of Health, 2009) fails to embrace the impact of social factors on mental health, and the onus is placed on the individual to recover, seemingly regardless of social context. The UnRecovery Star parody, created by the Recovery in the Bin collective (Recovery in the Bin, 2017), highlights the basic human rights which the Recovery Star sweeps under the carpet (e.g. housing, security). Table 2 shows the multifarious social justice concerns of the UnRecovery movement which are omitted from the Recovery Star 'key areas' (also illustrated in Table 2). Gadbsy (2015) writes that for mental health clinicians to view the recovery star as *"synonymous with self-reliance [is] perhaps the perfect agent[s] of a state which would like its population to internalise and individualise their distress, to look to themselves for solutions"* (para. 4).

Table 2

Recovery Star and UnRecovery Star 'key areas'

Recovery Star Key Areas	UnRecovery Star Key Areas
Managing mental health	Unstable housing
Physical health and self care	Sexism
Living skills	Loss of welfare state
Social networks	Loss of rights
Work	Economic inequality
Relationships	Homophobia/transphobia
Addictive behaviour	Racism
Responsibilities	Discrimination
Identity & self-esteem	Trauma/iatrogenic trauma
Trust and hope	Poverty

A Foucauldian perspective might understand this measurement of recovery outcomes as a classical governmentality process, where power stems from normalisation. The

Recovery in the Bin Collective, in producing the UnRecovery Star, might be seen as subjects who have been able to discern their ‘subordination’ through archaeological critique (i.e. from what the Recovery Star arose), and create counter-strategies of resistance (Foucault, 1991, in Howarth 2000).

Payment by Recovery. Alongside the rise in measurement of recovery is the gradual introduction of a new NHS payment system for adult mental health services, entitled ‘payment by results’ (first introduced in 1991). People are ‘clustered’ into treatment pathways according to their ‘needs’ and these clusters form the basis of service funding. Furthermore, the clusters can be linked to ‘quality and outcomes’ to *“make it easier for commissioners of mental health services to hold providers to account”* (Department of Health, 2012, p.16).

Clustering is a subjective process carried out by mental health professionals. People can be clustered into distinct groups which determine their future care – ‘psychotic’, ‘non-psychotic’ or ‘organic’, before having their essential being redefined into further subgroups. It is easy to see how objectives of governmentality are facilitated here through the construction by professionals of distinct groups which imply an underpinning of a logical, scientific basis – the ‘mental health clustering tool’ is loaded with scientific rhetoric. For example, it states that *“clusters are statistically underpinned”* with *“definite patterns”* (p.3).

What does this all mean for people using services? The Department of Health (2014) states that the intention for clustering is:

> *“Those that deliver the most successful outcomes, such as highest recovery rates – get more funding.”* (p. 16).

Notwithstanding pressure on services and staff, the ultimate pressure to achieve the ‘highest recovery rates’ lands on those using services. Even though this pressure is not explicitly articulated to service users (although the documents are publicly available), there is undoubtedly an implicit message communicated in mental health systems through the use of the recovery technologies – service users must recover according to these standards, for the greater good of the service.

The rise of recovery outcome measures, alongside formal recovery goals and ‘payment by results’, has contributed to a new way of thinking about recovery. It has contributed to perpetuating and emphasising a discourse of people who do not recover within such parameters (of clustering, meeting prescribed goals, etc) as a ‘burden’ to public services. Mental health service users have long been described in such language in media discourse (this article, for example, *‘prescribe poetry to patients to reduce burden on NHS’*, The Telegraph, 2017).

Education not therapy. The ‘Recovery College’, also known as the Recovery Education Centre, started in the US before it first appeared in a London NHS trust in 2009 (Perkins, 2012). Following this, as part of the ImROC project, a briefing paper argued that recovery colleges were central to driving forward recovery-focused organisational change (Perkins, Repper, Rinaldi & Brown 2012) and there are now thirty-two colleges across the UK, each with approximately one thousand students at a given time (Research into Recovery and Wellbeing, 2017). The briefing paper states that prominent features of recovery colleges are their emphasis on co-production through recognising equal importance of both professional and lived expertise, and in providing an alternative to traditional, paternalistic psychiatric care. The briefing paper states that they adopt an educational approach over a treatment or therapeutic approach, for example users of services are referred to as ‘students’.

It appears to be a resistance to the dominant psychiatric discourse, but it also acquiesces through many of the courses on offer.

A national study exploring defining characteristics of recovery colleges and their perceived benefit to service users has recently been funded by the National Institute of Health Research (NIHR). The study team hypothesise that *"self-referral may promote empowerment, jointly-delivered training may role model partnership working, and hearing a trainer talk about their own mental health problems may make the service user less pessimistic about their own recovery"* (Research into Recovery and Wellbeing, 2017).

Recovery narratives. Writing and reading stories of recovery has been a central component of the recovery movement. As has been discussed, the recovery movement emerged in part from people telling their stories – courageous acts of resistance in the face of the dominating discourses of mental health, breakdown and recovery, and often calling for change. The literature is peppered with how stories of lived experience can enable others to gain insight into the healing process, can provide support and hope to others who are suffering, and how the process of telling one's story can be beneficial for the storyteller and their recovery (e.g. Repper & Perkins, 2003). Furthermore, there has been an explosion of interest in using stories of lived experience as part of academia, professional services, policy and research.

However, recent commentators have been noticing how personal stories of recovery are also being used in the interests of professionals, at the expense of those writing them (Costa *et al.*, 2012). In this way, their use by professionals and services has been likened to a form of voyeurism:

> *"While some people [through recovery stories] reveal their most intimate personal details, others achieve relief through passive watching, while still others profit from*

> *the collaboration of those on the front lines in compromised positions."* (Costa *et al*., 2012, p. 86).

Storytelling has been noted as a 'double-edged sword' which can enable 'sense-making' but also can be used within organisations to *"establish a 'regime of truth' that favours one story at the expense of others"* (Näslund & Pemer, 2012, p. 90). Stories of recovery have also been conceptualised as a 'recovery technology' (Smith-Merry, Freedman & Sturdy, 2011). As a recovery technology, they can work to provide evidence for services that recovery works whilst publicising particular versions of what recovery means.

Reprise of the genealogy. The genealogy has shown the way that recovery has been incorporated into, defined and refined within, UK government policy. It has explored the political and social processes at work behind the rise of recovery's adoption in policy, and its performative implications for services and service users. The subtle benefits to a neoliberal state are shown through, for example, care in the community, consumerism, outcomes culture, and optimal productive functioning of citizens. It has also teased out how various new recovery 'objects' (Poole, 2011) have emerged, such as recovery colleges, storytelling workshops, and recovery goals.

1.8. Summary and research aims

This chapter began by looking at the general underpinnings of the concept of recovery observed in the literature, before exploring some of the problems of, and challenges presented by it. It then explored the associated conditions which give rise to recovery's presence in contemporary services through use of a genealogy with a particular emphasis on UK Government policy documents. Recovery's increasing adoption into UK policy as a new ‘vision’ for mental health services brought with it evolving new connotations, at times showing a co-option of the notion of recovery from its activist and emancipatory roots.

Research into recovery over the years has predominantly focused on the experience of recovery (from user or professional perspectives), or outcomes related to recovery, and has been less concerned with discourse and wider networks of power. I became interested in how contemporary recovery narratives might uphold dominant discourses around recovery (as seen through the analysis of contemporary policy documents) held within policy, and whether the narratives might also offer a site for counter discourses to emerge. Policy plays its role in *“shaping both discourse, and within discourse, lived experience”* (Allan, Iverson & Rupers-Huilman, 2010, p.3). Thus, I explore how the discourses found within policy are upheld or not in ‘lived experience’ recovery stories.

Furthermore, Poole’s (2011) Foucauldian analysis of key recovery players in Canada concludes by stating that we need more critique of recovery *“fuelled by Foucauldian inquiry”* seeking to *“make noise”* (p. 109) to pull on the inertia of power and knowledge.

This research aims to look at how recovery is constructed through stories of recovery that have been published under charitable and public health sector organisations. Identifying available discursive constructions might support an understanding of how power relations can be enacted (usually unintentionally) by subjects and organisations. A greater awareness of dominant discourses and quieter sites of resistance might support practitioners, researchers and users of services in making informed decisions about their practice, research interests or care.

The following research questions are explored:

- How is the discursive object of recovery constructed?

- What are the implications of these constructions for possible ways of being (subject positions)?
- Which institutions and practices are strengthened or undermined by these discursive constructions?

2. Method

2.1. Overview

This chapter provides a discussion of the philosophical underpinnings, methodology and design of this research. I will clarify the epistemological assumptions that underlie the methods and how the research aims relate to this. In brief, I approach the data through the lens of a Foucauldian approach to discourse analysis, underpinned by a social constructionist epistemology.

2.2. Epistemological positioning

This section attempts to clarify the claims made in this research about what and how it is possible to know. Epistemology is concerned with asking questions of both the nature and acquisition of knowledge (Burr, 2003). True to all research, the epistemological positioning of the researcher informs the methodology and influences the way the researcher involves herself with the research topic, and therefore what kind of knowledge is produced (Willig, 2010).

Broadly speaking, this research is informed by a social constructionist epistemology. It concerns itself with how people generate versions of reality or ‘knowledge’ through social processes, such as language (Gergen, 1985).

This research is interested in investigating how recovery has been discursively constructed within organisationally promoted recovery stories. It therefore does not aim to discover a ‘truth’ or how people have subjectively experienced their recovery, for example through a phenomenological analysis. Rather, it draws attention to the way that recovery is constructed.

Burr (2003), in an effort to theorise social constructionism, outlines four ‘key assumptions’ that underlie a social constructionist approach. Firstly, social constructionist research demands a critical stance towards taken-for-granted knowledge. Assumptions about the nature of the world (e.g. mainstream psychological concepts such as ‘intelligence’ or ‘depression’) are suspended and space is made for different accounts of phenomena to be heard. Secondly, what we know about the world is historically and culturally specific. The genealogy section in this thesis shows how the taken-for-granted concept of ‘recovery’ has changed and evolved within various historical and political points in time. Thirdly, it is rooted in understandings of the world that are constructed through social processes, particularly the role that language has in generating knowledge. Fourthly, different constructions of knowledge bring about different types of social actions, and this has implications in terms of what people are permitted, or not, to do in the world.

Social constructionism can be viewed as relativist in its approach in the sense that it theorises how people’s experience of the world is mediated through language (or other culturally shared concepts) (Harper, 2012). However, within the large body of social constructionist research there is huge variety of epistemological positioning and debate about what, if anything, is ‘real’ outside of the discursive realm (Willig, 2012a). This goes beyond a debate between realists and relativists, with there being a variety of differing perspectives within these two ‘camps’ (Burr, 2003). Broadly speaking, there are ‘moderate’ and ‘strong’ versions of social constructionism, some which are more ‘realist’ and some which are more ‘radical relativist’. These differences in epistemology are intimately related to ethical and political debates, and thus have implications for what conclusions can be drawn, and the utility and impact of the research (Harper, 2012).

Relativism is often criticised for denying a reality outside of the discursive realm. Edwards, Ashmore and Potter (1995) discuss how concepts like ‘death and furniture’ are employed as ‘bottom-line’ arguments by realists to demonstrate that there exists an independent reality outside of discourse. In their argument, Edwards et al (1995) do not appear to refute the question of reality, but rather theorise that once something is spoken about or referred to (‘signified’) it becomes a discursive construction. In other words, it is the social world that forms something into what it is. They state: *“All the pointings to, demonstrations of, and descriptions of brute reality are inevitably semiotically mediated and communicated”* (Edwards et al, 1997, p. 27).

Following this, it can be argued that relativism makes an epistemological claim (that thinking and talking construct reality), which is different to making a claim about ontology (the existence of a world outside of discourse) (Edley, 2001). For critical realists, on the other hand, some material ‘things’ and practices are given ontological status, and are seen to also be in a complex relationship with discourse (Sims-Schouten, Riley & Willig, 2007). However, it seems that precisely which material ‘things’ or practices should be viewed independently from discourse is not clear.

In the same way, Foucauldian academics also vary as to how much they see Foucault as refuting or upholding the ‘non-discursive’ (Burr, 2003). Indeed, an ambivalence around this subject matter has been noted in Foucault’s analysis of discourse. Mills (1997) argues that Foucault is not denying there is something beyond discourse, but that he shows how certain aspects of our world are formed or legitimised through discourse, whereas other aspects are hidden. This research aligns with such a position, that when Foucault theorises the power and creative force of discourse he is not necessarily denying an ontological realism. As Burr (2003) writes:

> “[Foucault] does not deny the materiality of events, but says that our only way of apprehending reality is through discourse, which determines our perceptions of reality. In a sense, Foucault brackets off the question of reality.” (p. 90)

Multiple constructions of the world (discourses) exist and these have social, psychological and physical effects (Willig, 2010). This relates to Foucault's conceptualisation of power, which is said to be performed and exercised within discursive practices (e.g. in institutions, their practices, procedures and regulations). For Foucault, it is this discursive power that produces 'reality'. In line with this, this research seeks to move beyond the data text itself, and explore the intricate connection between discourse and power. This will be explored further under the data analysis section.

Social constructionist work has further been critiqued for its emphasis on plurality of 'truths', where all are equally 'valid', and therefore are seen as remaining silent in relation to arguing anything political or moral (Parker & Burman, 1993). However, Edwards et al (1997) indicate how relativism has an inherent *"moral and political strength"* (p.39) through its insistence on the *"liberating, dangerous, unsettling"* (p.39) process of inquiring, questioning and scrutinising all truth claims. This thesis, in exploring various truths about how recovery is employed and linked to discourse through a Foucauldian lens, should consequently support an understanding of the political and moral dimensions involved.

This research aspires to explore how versions of 'recovery' are constructed through language. Such an approach to research distances itself from quests to find out someone's experience (phenomenology) or an objective 'truth' (ontological realism), but rather seeks to understand constructed versions of the concept under study. An investigation of 'recovery' can be viewed as inseparable from the social and cultural context in which it is enacted, and in this sense analysis should seek to go beyond the text and make connections with the wider social, economic and cultural context (as begun in the genealogy). Knowledge about reality is seen as stated from various standpoints which are historically and socially contextualised, which is then transformed through the way we act on or practise this knowledge.

2.3. Methodology

Discourse Analysis. Discourse theory and analysis has the potential to offer a robust alternative to mainstream psychology, reconnecting the psychological subject with its social context. In the UK in the 1970s, in the throes of post-structuralism, and with the rise of 'anti-psychiatry', a shift was occurring within psychology towards a 'critical psychology'. This critical psychology was weary of the positivist and cognitivist assumptions and objectives of traditional mainstream psychology, challenging its scientific authority (Howarth 2000; Parker, 2006). As a result, mainstream psychology was confronted by issues of language, meaning, and truth (Hanna, 2014). In particular, attention was drawn to the role of language in the construction of our social and psychological reality (e.g. Gergen 1985; Potter & Wetherell, 1987; Shotter, 1993), as the epistemology section of this thesis has discussed. This historical shift has been referred to as the 'turn to language' (Parker, 1989), which then resulted in the 'turn to discourse' within the discipline.

Discourse analysis has been widely used within critical psychology research to enrich understanding of how language constructs and shapes our knowledge and realities (Willig, 2010). However, discourse analysis encompasses many different varieties of qualitative approaches to research. Discourse analytic approaches all share the general aim of analysing forms of discourse, such as textual data which is not seen as neutral, but as performing social action and as constructing or re-producing the world in different ways. Language is not seen as reflective of an objective reality, but for its role in creating meaning and structuring reality (Fairclough, 2003).

For this thesis, a discourse analytic framework would help to make apparent some of the ways in which current constructions of recovery are generated.

Rationale for research methodology. Within the varieties of discourse analysis available, I found insights from Foucauldian approaches to discourse analysis to be useful in relation to the object of study and in keeping with the epistemology. I was searching for a methodology which allows for a critical thinking about the influence of language on taken-for-granted knowledge and subjectivity. My position is that how one speaks of *one's own* recovery is likely to have been both shaped and constrained by wider contexts and issues of power, such as legislation and the practices of psy-disciplines. Alongside this, stories of recovery might also be individual and *embodied* and *resistance* discourses as well as being determined by them.

Foucauldian Discourse Analysis. Burr (2003) identifies two contrasting approaches to discourse analysis which are commonly used in psychology; discursive psychology (e.g. Edwards & Potter, 1992), and Foucauldian discourse analysis (e.g. Parker 1992). Discursive psychology, emerging from conversation analysis and ethnomethodology, is generally seen as a 'bottom-up' approach concerned with the practice of discourse, how meaning is constructed and negotiated by people. Foucauldian discourse analysis, arising out of the work of Michel Foucault, is more concerned with how discourses constitute social and psychological reality, and what discursive resources are available to people in constructing, for example, their subjectivity (Arribas-Aylllon & Walkerdine, 2008).

Foucauldian discourse analysis keeps its focus at more of a macro level. Its emphasis is on discourses, and the power and institutional practices that are bound up with these discourses. It is concerned with how discourse relates to subjectivity, practices and the wider socio-political conditions that envelope this (Willig, 2010).

A Foucauldian approach to discourse analysis asks, *"what discursive resources people draw on, how those resources came to be culturally available and what effects they* *have"* (Harper, 2004, p.55) for the object under study and its subjects. As such, it was felt to be appropriate for this study as recovery stories were analysed within a social context where discursive constructions are linked to different representations of social power (Harper, 2006).

There are various takes on executing Foucauldian discourse analysis but there is general consensus on the key Foucauldian principles that underlie it (Willig, 2010). These include concepts which interrelate and help form one another, but for the purpose of clarity they are outlined separately in this section.

Genealogy. A genealogy forms the first stage of Foucauldian discourse analysis (Arribas-Aylllon & Walkerdine, 2008) and has already been outlined in some depth within the first chapter of this thesis. As previously discussed, the concept of genealogy essentially refers to investigating the 'history of the present' through uncovering various relays of power. Genealogy can illuminate how particular discourses emerge and fade at particular points in history. The pragmatic separation between the genealogy and the second stage of analysis employed in this thesis may be considered a rather arbitrary one, but serves its purpose for both background clarity and practicality.

Discourse. The concept of discourse is central to Foucault's approach. In Foucault's Archaeology of Knowledge (1972), discourse is conceptualized as:

> *"Practices that systematically construct the subjects and the worlds of which they speak."* (p. 49).

Discourse is a set of statements which establish a way of talking about, and therefore knowing about, a particular topic at a particular time in history (Willig, 2010). Thus, language is seen as producing knowledge, which is tied up with discourse. It is through discourse that meaning is constituted in the world, and thus how we come to think about the world. Social practices, for example ‘recovery-oriented services’, can be understood by how they are constructed discursively. Discourses define and create the boundaries of possibilities for understanding that which it constructs. What can be said about the discursive object, by whom and when, is both limited and permitted by discourse. For example, a medical construction of 'schizophrenia' as a chronic illness at once positions people as 'sick' and ‘treatment-resistant’, thus limiting how they can subsequently behave and occupy such a position. The recovery movement had originally allowed people to resist this subject position and occupy a position of ‘wellness’.

Discourses are the process by which multifarious forces promote and protect their own interests, or block or mitigate the effect of other forces. Discourse comes in the form of contradicting texts, statements and events, forming objects and forcing individuals into subject positions. This is the march of history, and the task of discourse analysis is to discern both the clear and the more subtle but nevertheless significant constructions over time (Parker, 1992). The task is not to ask *why* discourse changes, but to discover *how* it changes. Inevitably discourse tracks the changing path of power, as discourse is the expression of power, while simultaneously modifying that power. And power and knowledge are mutually dependent.

Thus, Foucauldian analysis of discourse is interested in making clear the connection between discourse and power inherent in the practices of, say, institutions (Howarth, 2000). Parker (1992) states that a Foucauldian take on discourse emphasizes the *“material resources which make discourses possible”* (p.1).

Foucault had been concerned with how some discourses have constituted knowledge systems (e.g. medicine, psychology) which are then accepted as taken-for-granted truth, whilst others are not. This thesis is interested in the dominating and subjugated discourses around the concept of recovery within organizationally promoted stories of recovery.

Knowledge and power. Discourse is inextricably linked with power and knowledge in society. Foucault's work has largely focussed on exploring the nature of power and its relationship with knowledge, yet he does not explicitly theorise power (Cousins & Hussain, 1984). He is largely concerned with the ways in which power is exercised and the implications this has on how individuals live. Power is not viewed as a tangible concept, but rather as something exercised through multiple interrelated social practices and institutions (Foucault, 1980).

Foucault states that *"power and knowledge directly imply one another… there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations"* (Foucault 1977 p.27, cited in Howarth, 2000).

Power and knowledge are inextricably linked, constantly producing each other, and ultimately forming a discourse. In this way, discourses are both an effect of power and are an instrument of power, and can disrupt or enable new productions of knowledge. Through the Foucauldian lens, power has discursive properties that can be linked to knowledge formation.

Foucault (1977) rejects the idea that power is used *only* to constrain, repress or control people, but rather, in addition to this, he sees power as producing reality and enabling new ideas and truths to be constituted. Whether something is constrained or enabled occurs via the privileging of certain discursive formations and subject positions. Particular versions of social reality can become 'dominant' discourses which, at their most powerful, might feel like 'common sense'. They can become taken-for-granted truths which limit people from being able to see alternate understandings or ways of being. However, the march of history, or ‘genealogy’, shows that such dominant discourses do change.

Foucault viewed power as functioning in clusters of relations between different fields, social and political bodies of thought and institutions, rather than it being held by an individual or group (Danaher, Schirato & Webb, 2000). Discourses are tied up with the institutions in which they are embedded. These institutions will have their own set of practices and regulations which influence the discourse, and vice versa.

An important ingredient of Foucault’s concept of power is that it works best when hidden from its subjects. Danaher et al (2000) note how, for example, official sentiments such as ‘it is for our own good’ and ‘the system is working in our best interests’ serve to disguise surveilling and regulating systems. The compelling idea of empowerment behind the recovery rhetoric leaves service users feeling like they are making free choices about their treatment and lifestyle. However, choices about treatment, as an example, are constituted by the particular practices of the healthcare provider and therefore are restricted.

Subjectivity, subjectification and objectification. For Foucault, subjectivity, or the subjective self, emerges within the conceptual map of discourse. Self-reflection, thinking and behaviour all occur within the limits and possibilities of the discourse one is subjected to.

Subjectification and objectification are an important part of an analysis of power, referring to how an individual becomes a subject through particular modes of power. Subjectification is shown through the subject positions that individuals adopt within particular discourses (e.g. a patient within a medical setting) and where these discourses are then acted out (Kendall & Wickham, 1999).

Objectification refers to how people are made into subjects (Foucault, 1982). Howarth (2000) describes how Foucault's subject formation can involve 'subjectivization', where individuals transform themselves into subjects through 'practices of the self'. As subjects they are then observed and measured through technologies of power, and 'modified' if necessary (Hook, 2010). In mental health settings individuals can become visible and modifiable subjects through practitioners collecting detailed pictures of their history, psychological states, beliefs and attitudes, via the practice of psychiatric/psychological assessment.

Technologies of the self and of power. Foucault (1988) describes four 'technologies' or techniques used to organise knowledge about oneself. Foucauldian discourse analysis focuses on the two which Foucault concerns himself with most: technologies of power and technologies of the self.

> *"Perhaps I have insisted too much on the technology of domination and power. I am more and more interested in the interaction between oneself and others and in the technologies of individual domination, the history of how an individual acts upon himself, in the technology of the self."* (Foucault, 1988)

'Technologies of power' *"determine the conduct of individuals and submit them to certain ends or domination, an objectivising of the subject"* (Foucault, 1988). Foucault illustrates this technology of power through a description of Bentham's 'Panopticon' prison. The Panopticon had been proposed as the 'ideal' prison, and its principles structured 19th Century prisons in the UK and elsewhere. The design, Foucault asserts, allowed for very interesting aims to be realised. The design introduced a feeling of 'invisible omnipotence' amongst the prisoners. They could be observed at any time by the guards, but would not know when this was happening, and thus prisoners needed to self-govern according to a state of constant surveillance (Cousins & Hussain, 1984). Foucault shows how political institutions embody the principles of the Panopticon. The topic under study in this thesis might be concerned with the extent to which people ‘in recovery’ are observed and surveyed as opposed to acting as ‘free-agents’.

‘Technologies of the self’ are a series of techniques referring to the ways in which people actively work on themselves through a process of self-governing. These ‘technologies of the self’ are presented to people as ways to perfect their lives. Foucault identifies ‘self-knowledge’ as key in this process, whereby people are obliged to know themselves for both individual happiness and wisdom, as well as for the greater good of their society (Foucault, 1988). Foucault shows how this had been an ethical stance in ancient communities, but has become much more problematic in modern times where ethics are more varied in the absence of ‘stable truths’ (Danaher, Schirato & Webb, 2000).

Technologies of the self can be seen as self-examination techniques that enable people to become ‘subjects’. Foucault identifies that these techniques have involved people examining themselves through verbalising their inner worlds (Danaher, Schirato & Webb, 2000). This can be seen in the practice of the psy-disciplines, particularly psychology and psychoanalysis, which promote self-disclosure to achieve good mental health. The way in which people are able to use, or to not use, such techniques depends on those discourses available to them. Recovery discourses might demonstrate the process of ‘technology of the self’ as they provide the means for people to examine themselves according to a set of principles of what recovery looks like.

Governmentality. The technologies of power and of self do not operate in isolation, and it is the way in which they relate to each other which Foucault terms ‘governmentality’ (Foucault, 1988). Governmentality is a concept that refers to how individuals self-govern in socio-political contexts where power is decentred.

Foucault’s notion of governmentality appears to bring together much of his work. It functions for the service of disciplinary power and biopower. Biopower is concerned with forms of modern power and how these are directed towards individuals and social groups. For example, it describes how psychology has created norms which define when someone is ‘normal’ or ‘abnormal’ in various ways (Taylor, 2011). Such norms are created through governmentality techniques to provide healthy and disciplined subjects who do not deviate from social order and can contribute to the capitalist market (Danaher, Schirato & Webb, 2000).

It seems that Foucault is also providing a hopeful message with governmentality. By gaining insight into what is ‘done to’ individuals through the ‘art of governing’ opportunity is provided for resistance and negotiation, whereby individuals can more fully be free (Danaher, Schirato & Webb, 2000).

Normalisation. Foucault (1975/1991) shows how methods of disciplinary power move away from punitive and outward disciplinary measures to being more subtle but persistent. He traces the increasing concern by the state with the health of its citizens, so that citizens become less deviant and more able to contribute to society. As seen in this genealogy, policy is one method of carrying this out to ensure that particular subjects are formed (Danaher, Schirato & Webb, 2000).

Foucault is concerned with how subjects are divided categorised and subject to surveillance. The DSM is an obvious example of how people come to be categorised against a set of norms and are thereby seen as fulfilling their citizenship duty or not (Danaher et al, 2000). If discovered to be deviant and fulfilling of a DSM category then people can become subject to surveillance through a number of institutional avenues – psychological assessments, legal detention, staff observations, etc. This starts the process of ‘normalisation’ – with ‘normality’ being a standard imposed by the State (Feder, 2011). This surveillance can become internalised to achieve ‘self-governing’, normalised citizens.

2.4. Procedure

Data selection. Decisions related to the procedure have been guided by steps in selecting data for a discourse analysis (Titscher, Meyer, Wodak & Vetter, 2000). This process has included: choosing the population of material, selection of data, and selecting from this data the units of analysis.

Discourse analytic research can make use of many types of material, including ‘naturally occurring’ data from articles or advertisements, as well as material gained from the researcher’s own interactions with participants (Parker, 1992). This research has made use of naturally occurring data selected from online websites available in the public domain. The benefit of using such data is that the data set is already part of the social fabric, and thus limits the possible distorting effects of an interaction with an interviewer (Potter & Wetherell, 1987). Being part of the social fabric also means that it can really give insight into dominant discourses.

The internet is a huge resource for social and psychological research (Evans, Elford and Wiggins, 2008). It has become essential within the contemporary world for so many aspects of life, including: communicating ideas, seeking information, promoting or advertising work, and campaigning and activism. There is a wealth of information available about mental health and recovery on the internet, including on charity and government websites, personal ‘blogs’, online newspaper websites, health-related internet forums/communities, and social media.

This research concerned itself with how recovery was discursively constructed within a dataset of narratives detailing people's relationship to recovery ('recovery stories') which had been made available on the internet by the charitable and public sectors. It was felt that such organisations (the charitable and public sectors) would be reaching a wide audience, especially those conducting searches related to their own, or a loved one's, mental health or recovery. It was felt that these organisations collectively, both represent power (and in this way influence others), as well as being themselves influenced by other powers (through governmental policy, for example). The stories, authored by people who have had a personal relationship to recovery, but promoted by centres of power, were therefore felt to be a strong data source to explore dominant discursive constructions.

In order to satisfy the research questions, and due to the expanse of recovery literature on the internet, data for this research was purposively sampled according to the inclusion and exclusion criteria, as outlined in this section.

The inclusion criteria:

- Data which included a 'recovery story' or that related to a central theme of adult mental health recovery. The research was concerned with how the discursive object of 'recovery' was constructed within people's narratives about their relationship to recovery.
- Data that was published via a third sector or public sector organisation. It was thought that these organisations would have generally been influenced by healthcare policies which informed the genealogy, as discussed above under 'data selection'.
- Data could include text or video format. Internet viewers absorb information through reading and watching videos, and thus it was felt that to expand the

format to both text and video would allow for a greater representation of publicly accessible discourse.

- ‘Contemporary’ mental health recovery stories were included, so that it was decided that only stories published from the year 2010 would be included in the dataset. This cut-off date overlaps the time that recovery began to become ‘normalised’ within policy and to take a greater hold within services in the ways outlined within the genealogy.

The exclusion criteria:

- Data published in non-organisational, ‘personal’ forums, for example through personal blogs, were excluded. The research was interested only in ‘organisational promoted’ narratives to reflect available discourses within these centres of power.
- Data that primarily related to stories of recovery from alcohol or drug addiction, or other adverse or traumatic life events, and not explicitly a mental health theme, were excluded.
- Data that was written or published outside of the UK were excluded. The research was concerned with the genealogy of recovery and its construction within the UK.

Forty-one sets of data were selected for analysis (see Appendix A). There is thought to be no natural point of saturation (Potter & Wetherell, 1987), and this was considered an adequate amount of data due to the depth of analysis involved. Furthermore, in discourse analytic research, small data sets are likely to give rise to large numbers of linguistic patterns (Potter & Wetherell, 1987).

The data that were collected ranged in their word counts, but generally the data tended to be fairly short (ranging between 133 to 1500 words in length per story) and so were analysed as a whole, rather than as extracted sections.

Data collection. Data was collected through two phases. The first involved conducting a search using the online search engine Google (www.google.co.uk) and the online video search engine YouTube (www.youtube.com). Searches were made using the search terms “recovery story mental health UK” and “recovery story mental illness UK”. It is impossible to use a search term without discursively constructing an ‘object’ within the search (Frith & Gleeson, 2012) and therefore, by using the terms “mental health” and “mental illness” there are certain narratives that could have been excluded. This is discussed further under ‘reflection on methodology’.

The second phase of selection involved purposefully ‘cleaning’ the data to include only those which met the selection criteria as defined above.

Video narratives were transcribed into text by the researcher.

Reflection on methodology. The data inclusion criteria by definition made it possible that only particular data would be found. The research was concerned with how recovery is constructed within organisationally promoted mental health literature that was readily available using key word searches. It was interested in ‘dominant’ discourses, and sites of resistance, that exist within such data. By restricting the data collection in this way, discourses constructed within minority or marginalised groups, for example black and minority ethnic communities and gender minority groups, were likely not well represented in the data. Thus the inclusion criteria may not have revealed the broad range of stories that exist that are not named as ‘recovery’ or ‘mental health/illness’ but are perhaps analogous to it. For example, it could have missed different cultural or spiritual perspectives. Using such data might have led to findings that resist mainstream versions of recovery. However, given the stated research aims the data collection method chosen was considered appropriate.

2.5. Ethics

Ethical approval. The dataset under study consisted of material collected ‘unobtrusively’ (BPS; British Psychological Society, 2013), from online internet organisational websites in the public domain. Ethical clearance from the University of Essex was granted (see Appendix B). Although this research did not require a consideration of issues such as participant recruitment, consent, and well-being, the moral and ethical considerations inherent in doing this research are explored below under ‘ethical considerations.’

Legislative aspects were explored in relation to using data from the public domain and copyright laws were adhered to (BPS, 2013).

Ethical considerations. The nature of analysing online narratives of recovery demands ethical consideration from perspectives other than those considered in institutional ethical applications. I have used this section to outline the ethical dilemmas I have come across during the process of this research.

Publicly private. I have aimed to be sensitive to different ethical issues within the context of re-reading ‘publicly private’ texts. This is partly because I wish to remain respectful to those people who have shared their personal stories, applying what must have been a lot of courage to say the least. Furthermore, interpreting anyone’s words involves a consideration of ethics and morality (Parker & Burman, 1993).

To help make sense of my concerns I am very grateful to have had a lengthy conversation with an extremely helpful and insightful woman who was employed as a ‘service user liaison lead’. She had had experience of being hospitalised, was feeling herself to be recovered and was presently working in an employed role at a recovery college. This conversation ‘re-grounded’ me in some sense. It left me with a renewed sense of what ‘recovery’ means for some people, but also what it can not offer. Our honest discussions about the trials and tribulations of mental health services and personal wellbeing gave me some experiential confidence that to critique did not have to mean to criticise or disparage. And that critique was necessary. For example, our conversation highlighted the huge benefits that working within mental health can provide for users of services but also that it risks becoming the only definition of that person.

I found that Willig (2012b) had discussed some of these concerns about critiquing through a discursive lens when personal accounts have been provided to the public in ‘good faith’ that their subjective experiences will be heard. Willig (2012b) discusses this in relation to data from interviews and mis-leading participants as to the nature of how their accounts will be analysed, but I think it rings true for this data set. People have likely consented to posting online their stories of recovery with the belief that they will be recognised by others and will be useful to others who are suffering. With this in mind I hoped to keep hold of a sensitivity to the subjectivity of the speaker, whilst still remaining critical and discursive. This position underpins the epistemology of this research. Furthermore, this type of discourse research which attends to available socio-cultural resources, rather than purely the individual, is perhaps less ethically problematic because of its attention to ‘non-blaming’ external influences.

With this in mind, I have paid attention to staying within a Foucauldian point of view throughout my analysis which does not ascribe ‘intentionality’ to the writer/speaker. Rather, the Foucauldian lens is interested in how discursive constructions occur, and not with their conscious production. In other words, I was not paying attention to personal experience or narrative, as in other qualitative methodology, but in how particular discourses are re-produced through the stories and how these function to position subjects.

Furthermore, although the data is available to the public, it seemed important to preserve a level of anonymity by omitting mention of those specific services which reference a geographical location, and names of people and places.

Reflection on language. It has been noted how in discourse analytic research it is impossible to avoid engaging in a process of construction before the analysis has even begun (Craven & Coyle, 2007). I have used terms such as mental illness, mental health difficulties, service user, patient, etc. interchangeably throughout so as to reflect the nature of the discourse presented. Although these are all ‘commonly accepted’ terms, the deconstructive nature of this research naturally disputes that, and it has been difficult to settle on language that feels comfortable throughout this project. I have been often left feeling uncomfortable, which I found has both hindered and re-awakened my engagement with the writing. At times when I have written such terms I feel assured by their use as a label to identify a distinct category to which I refer, but at most other times I am uneasy by such arbitrary differences between layers of the human condition. I think this, albeit rather crudely, indicates the power in language of both creating and repressing thoughts, ideas, actions. The necessity of a reflexive stance is again indicated here.

Furthermore, I came to a decision to, at times, write in the first person so as to take responsibility for that which I researched and wrote about (Parker, 2005). The detachment born from writing in the third person, most commonly associated with empirical academic papers, did not seem appropriate for particular sections of this thesis. For this reason, there are alternating sections between the first and the third person.

2.6. Method of Analysis

Analytical method. The research employs a Foucauldian approach to discourse analysis, using a set of methodological steps (Parker 1992, 2002). In addition to these steps, an engagement with reflexivity and subjectivity will be central to the analysis.

Potter & Wetherell (1987) compare the analytic process to riding a bicycle, in that it is not easy to convey in separate ‘steps’ but rather requires experience and dynamism. Parker (1992) is also wary of formalising the analysis into a technique which then risks becoming similar to positivist research methods. However, it is noted that outlining techniques or ‘steps’ does provide some framework for the novel researcher, so long as they are not followed too rigidly, for example, in the precise order outlined.

The analytical ‘steps’ that this analysis followed are taken from Parker (1992, 2002), and are outlined below and grouped under ten criteria of discourse. The *first fourteen steps* systematically explore how certain realities are constructed and how we, as researchers, are taken up by these realities (reflexivity). This interpretation of the text taken from the first fourteen steps is then used to analyse the text with a *further six steps* which engage in broader socio-political reading. The steps are outlined here under each related criterion of discourse analysis:

<u>Criteria one: a discourse is realised in texts</u>

1. The data, or object of study, should be turned into a textual form of words (if not already).

2. Explore possible connotations or symbolic connections that the text evokes. This can be done by means of a creative free association to cultural material.

Criteria two: a discourse is about objects

3. Identify and itemise the objects in the text (simple nouns, and also more implicit objects such as word combinations or adjectives) which are referred to.
4. Treat the text as the object of study, rather than stepping outside to evaluate, for now.

Criteria three: a discourse contains subjects

5. Identify and itemise the subjects, the types of people who are talked about (e.g. those objects which speak or listen).
6. Explore the ways in which the subjects have been employed to speak in the text, and speculate about what else they can say within this system of discourse.

Criteria four: a discourse is a coherent system of meanings

7. Identify networks of relationships and images of a particular social world that the discourse represents.
8. Understand different competing discourses and representations of this world.

Criteria five: a discourse refers to other discourses

9. Identify contradictions within the text, or contrasting ways of speaking about the objects they constitute.
10. Notice the points of overlap between different ways of talking about the ‘same’ object.

Criteria six: a discourse reflects on its own way of speaking

11. Consider other texts which elaborate an understanding of a discourse (e.g. views not voiced within the text but part of the discourse).
12. Choose labels for the identified discourses, and reflect hermeneutically on terms adopted (e.g. moral/political choices of the researcher).

Criteria seven: a discourse is historically located

13. Trace the historical underpinnings of discourses (e.g. how and why they emerged).
14. Unravel how the discourses have changed, perhaps through hiding their history or conjuring up a different story of origin.

Criteria eight: discourses support institutions

15. Identify institutions which are strengthened by the identified discourses.
16. Identify institutions which are confronted or subverted by the identified discourses.

Criteria nine: discourses reproduce power relations

17. Understand if there are types of people who serve to lose or to gain from the identified discourses.
18. Understand if there are there certain people or groups who would either promote or erode these discourses.

Criteria ten: discourses have ideological effects

19. See if the discourses engage with other oppressive discourses
20. Look at how the discourses justify present practices, allow certain stories to be heard and others to be hidden.

Process of analysis. The dataset was printed as one document with numbered lines for clarity. It was then initially repeatedly read and re-read in order to gain familiarity with the data and to begin to ‘free associate’ (Parker, 1992), marking down annotations as things came to mind. Potter and Wetherell (1987) note how disarming the dataset can feel before the process of analysis has begun, and thus following their recommendations I engaged in a process of coding the data as part of the familiarisation phase. Parker’s (1992) analytical ‘steps’ were subsequently engaged in the way he described, as a guiding set of questions to aid the analysis (see Appendix C for an example of an annotated data extract).

2.7. Reflexivity

For research to remain critical it should be a reflexive endeavour. An engagement with reflexivity within critical research should encompass both critique and spaces for change. Parker (2002) shows how there are ‘blind spots’ within psychological practice which inhibits both reflection and action. Thus, it is critical reflection within research which has the potential to unearth these unseen areas, and to foster action and socio-political engagement.

Foucault’s conception of the power-knowledge relationship might also be read as a call for reflexivity in research. The knowledge produced in discourse analytic research is *authored* by the researcher, and is itself a discursive construction (Willig, 2010). As such the truth claims that research produces must be continuously reflected on, for example, by continuously being aware of the theories and discourses the researcher is drawn to or avoidant of. Harper (2003) discusses the importance of reflecting on analytic choices and decisions made during the discourse analytic process. For example, the researcher is required to choose particular themes and discourses over others, and to interpret how these relate to the aims. This requires an interaction with their own subjectivity.

As part of this process a research journal was kept to enable personal and critical reflections regarding aspects of the research and to support a working through of obstacles and dilemmas (Willig, 2010). Alongside this, the journal was also used to play with ideas, to scribble, to make a mess, and sometimes it began to form what felt a bit like my own performative writing for recovery.

Parker (1987) has stated, *“discourse analysis surely does need some account of how it is that a speaker or writer, or a listener or reader, is moved by language”* (p.484). Discourse analytic work attempts to understand how discourse constitutes subjective experience, but is critiqued for failing to theorise subjectivity (Willig, 2010). The ‘turn to language' brought with it a focus on how language constructs subjectivity, and together with its rejection of cognitive accounts of mental life, fails to sufficiently answer questions about the inner workings of people. Parker (1992) introduces the idea of 'complex subjectivity' – a subject is theorised as having an internal life which has been forged through cultural elements and the internalisation of wider ideas about individuality. Critical research in psychology can *"arrive at something suitably complex"* (Parker 2002, p.187) which does justice to the complexity of the human condition.

Subjectivity is complicated by context and culture. This is true for both the object of study and the researcher. Dominant cultures or constructed forms of experience in which the research is taking place, are likely to be shared to some extent by the researcher and object of study. In this study, these shared dominant 'contexts' might include that of psychology and related psy-disciplines, mental health services and treatments, and public mental health policy and campaigns. This necessitates the researcher finding a 'third position' from which this process can be observed.

2.8. Research Quality

There are several different assessments available for evaluating the quality of discourse analytic research (e.g. Antaki, Billig, Edwards & Potter, 2004; Burman, 2004; and Potter & Wetherell, 1987; Georgaca & Avdi, 2012). This research selects the five criteria identified by Georgaca & Avdi (2012), whilst holding the other assessments in mind during the research process. The criteria are as follows:

- *Internal coherence.* For an analysis to be trustworthy there should be a coherent and consistent reading of the data, which does not ignore nuances in data.
- *Rigour.* The whole dataset is given full attention, including diverse and deviant data.

- *Transparent and situated.* Stages of the research process should be carefully detailed and grounded in substantial data extracts.
- *Reflexivity.* The research must engage with the role that the researcher plays throughout the process. Reflexivity is particularly important to discourse research (Parker, 1992) and has therefore a major section elsewhere devoted to it.
- *Usefulness.* For research to be useful it must provide new insights, enhance existing research and be applicable for the real world.

3. Results

3.1. Overview

In this chapter I explore how people talk about recovery and invest meaning in the concept within contemporary online recovery stories held on organisational websites. The data has been examined using Foucauldian discourse analysis in order to focus on how the discursive object of recovery, as expressed through these stories, is constructed and affected by various sources of power (Willig, 2010). I consider various constructions of recovery as used within the data, the subject positions these entail and the wider meanings and discourses they are invested in.

Multiple discursive formations are available within the recovery stories which make up this dataset. Some of these are located in wider discourses and permit particular subject positions, others strengthen or subvert particular institutions or disciplines. Points of overlap, as well as contradictions, between ways of speaking about the discursive object of recovery are discussed (Parker, 1992). Extracts from the data are provided throughout this chapter to show the formation of these constructions.

Broadly, discursive formations can be seen as representing either an internal or external process, or in some cases an overlap. Internal processes of recovery involved constructions of personal responsibility, personal interpretation, and acceptance of illness. External processes involve socioeconomic opportunity and acceptance by others. Constructions of self-management, ongoing journeys and the professional embodiment of recovery involve both internal and external processes.

Personal interpretation or not? Within the data there are competing constructions of recovery as either a personal interpretation or as something imposed by others.

"But one thing I can say for certain, I would not
Have been these places, done these things
Nor made these contributions, such as they are,
If my recovery, such as it is, had danced
To someone else's definition." (29:1333-1337)

This extract (29) draws from two competing discourses of recovery, acknowledging that recovery can be something imposed by others, as seen in the 'recovery as model' in the genealogy, or something more personal (e.g. early stories such as Deegan's). These competing constructions are explored within this section 'personal interpretation or not?'. Within the poetic extract above (29) recovery is constructed as occurring precisely *because* it did *not* 'dance to someone else's definition.'

The construction of recovery as one of personal interpretation is a dominant discursive formation throughout the dataset. It is something to be uniquely defined by individuals, and often employs the rhetoric of the personal journey. Personal endeavour is commonly observed in mainstream literature, and is also predominant within the dataset. Constructions of personal interpretation, on the face of it, challenge a dominant discourse of there being authoritative knowledge about recovery, through a rejection of 'someone else's definition'. The following extract (25) constructs this personal interpretation as defying 'one definition'.

> *"To me recovery is a bumpy and winding road, that isn't to say that it is a bad thing as I have found many of my experiences both positive and negative have added to my collection of tools I use to try to stay well. There is no one definition that fits everybody's experience."* (25: 1113-1115).

Within this construction of personal interpretation, metaphor is often employed perhaps because an individual's description of it is by its nature difficult to convey. Thus individual interpretations of, for example, 'a bumpy and winding road', has to be personally interpreted again by other individuals.

Such personal interpretation is constructed as liberating:

> *"I think what is inspiring is saying that we all have our own journey to make and our own interpretation to make about what illness is. I think that's really, really good. That's liberating and allows us, especially with unconventional thoughts to feel secure in our thoughts and have them seen as valid."* (12)

However, a counter formation of the risk of it having the opposite effect is also indicated within a continuation of this extract (12). The extract continues as follows, constructing recovery as something imposed on people:

> *"It [recovery] sometimes substitutes itself as being the voice for all users. Which is wrong. I don't think it is and sometimes I think it becomes almost, almost a religion. If you don't believe in recovery then you're misguided. You can't have a valid disagreement with recovery. Everyone in mental health has to believe in recovery."* (12: 584-588).

The sarcasm in 'everyone in mental health has to believe in recovery' speaks to what is constructed as *"a dogma"* (12: 609) of recovery by 'everyone in mental health', presumably speaking of mental health services. In the following extract (21) recovery is constructed as an imposed *model*, which is in opposition to the construction of recovery as personally defined.

> *"I don't get involved in that much in recovery because I think it's wrong why are we telling people how to recover?... man has got a capacity to recover what he needs is love and compassion and guidance, we don't need tools for recovery, we don't need*

> *models for recovery, if somebody had a model for recovery, oh my God what a waste of time, or you don't fit this model so it's your fault you're not recovering... we're turning recovery into a science it has been hijacked by the services."* (21: 929-941)

Furthermore a humanistic discourse ('love and compassion') is drawn upon of a personal endeavour which competes with a scientific discourse of 'psy' 'tools' and 'models'.

Recovery as a personal responsibility. Within the data set, linked to the personal journey discourse, is the construction of recovery as a personal responsibility. Within this discourse the subject position is adopted of determining one's own recovery through taking responsibility of their life and staying in control through making 'good' choices. This is in line with the dominant rhetoric of current UK policy as outlined in the introduction. It is illustrated in the following extract:

> *"I said to myself, 'I can change my life'. There was a lot of temptation around me, but I knew the consequences... I look out for my kids, I've learnt to enjoy my own company and find ways of relaxing that don't involve drugs, I take responsibility for myself and I know I can help other people."* (1: 29-58)

In this extract, recovery becomes something of a personal choice or a moral decision. This construction creates subjects who are at liberty to make decisions which directly impact their recovery or otherwise. The recovered subject is thus constructed as someone who comes to understand their responsibility for recovery. A certain strength of will, commitment or determination from within the individual is constructed as central to this responsibility.

Other potentially influential external factors, such as 'the hospital' in the following extract, are given reduced influence within a personal responsibility discourse. The emphasis becomes not so much about external factors but on one's overall spirited self will. Responsibility is placed more in the individual and less in institutions.

> *“The ultimate shift, after the last time I had been in hospital, my cousin said ‘[name], you don’t need to do this to yourself anymore’ – and something kind of clicked with me. I realised I had a choice, I could make positive choices about my own health and wellbeing.”* (2: 96-99)

Furthermore, responsibility gets equated with a duty to make ‘positive choices.’

Within this discursive construction, recovered subjects are positioned as strong, self-sufficient and empowered. The ‘victim’ subject position is recognised but rejected, as is a need for help from others. This is shown in the following extract:

> *“The social model makes me feel like a victim, when I am not. I can cope with far more than people assume, and flourish – and in fact I don’t want anything given to me on a plate – I prefer to work for it. Look at the list of social stressors – well I have been through most of them several times. They didn’t cause my ‘mental health problems’… So, Recovery. Let’s get rid of models, and concentrate on individuals. Who is this person? Where has she been before this? Where would she like to go? And instead of worrying about the help she needs to get there, give her the hope that she can do it herself.”* (33: 1547-1555)

The construction draws from a neoliberal rhetoric that victimisation arises from the self, thus erasing a sense of social vulnerability seen in inequality, discrimination or violence. A ‘victim personality’ of weakness and bad choices is evoked and distanced from (Stringer, 2014). Furthermore, this extract uses a rhetoric of ‘hope not help’. The abstract notion of hope is offered as a solution over the tangible and complex area of help. Thus, recovery as a personal responsibility becomes about having a strong mindset and *hope*, rather than a victim mentality needing *help*. Read in another way it speaks to institutions offering an imagined positive future rather than actually providing or creating this future. The mind and imagined futures become more powerful and important than the tangible material conditions of the here and now.

The idea of ‘doing it yourself’ evoked in the extract allows for subjects to be positioned as responsible, empowered and in control of their lives via the choices they make. Empowerment becomes the taking of responsibility for oneself, which is further shown in the following extract, a recovery story written in the third person:

> *“After learning about assertiveness, [name] felt he had greater control over how people treated him. He believes that his own passivity may have contributed to his work colleagues turning on him – it drew out their negative behaviour. By asserting himself he believes he can stop naturally aggressive and domineering people from trying to control him. Using assertiveness techniques has enabled [name] to take ‘a more even place in society.’”* (5: 229-233)

Within the extract, the personal quality of assertiveness becomes the turning point in this person’s recovery, through which he overcomes a victim role. Within this construction, the ultimate decision to recover rests within the individual. Thus, a barrier to recovery becomes idleness or passivity as traits within a person, which ambition and a strong will can then counter. Furthermore, it seems that the requirement to achieve ‘a more even place in society’ is seen as a personal responsibility, which has repercussions for the way that social exclusion is tackled within society and in national policy. Recovery becomes about ‘fitting in’ to society, regardless of the ‘naturally aggressive’ environment. It links to a construct of recovery as about recovering from social exclusion, perhaps adapting to social norms rather than oppressive structures being tackled.

Consider the following extract from an individual’s testimony whose time in prison formed much of their narrative of recovery from mental health difficulties:

> *“There’s a better life out there, and even in the prison. There’s a lot of opportunity to do things in prison and you can actually structure your life. If you just sit back, then you won’t make it – but you can make it if you want to.”* (1: 64-66).

The ‘opportunity’ *and* the reality of the wider environment – in this case the constraints and the prospects of prison – is constructed as less vital than the individual’s will to negotiate such environments. In this way, the story of recovery seems to be written as one of actively choosing a ‘better life’ despite contextual constraints. The construction of working hard at recovery is bound up with this, which is discussed further in this paper under the ‘self-management’ section. The emphasis is on ‘you’ and ‘your’ determination: *“you’ve got to keep at it, and you’ve got to keep positive and have hope otherwise you’re not going to get there.”* (10: 57)

Within this construction recovery reads as an individual endeavour. Other support contributes (e.g. being taught about assertiveness, use of a hospital) but the predominant message points towards recovery being a personal responsibility and choice (*“I realised I had a choice”).* As will be explored in the discussion chapter, a society with a focus on individuals becoming responsible for themselves is described by Rose (1999) as a technology of ‘responsibilisation’, whereby the self is governed but from a distance, which creates an illusion of freedom.

Recovery is meaningless without socioeconomic opportunity. In resistance to the responsibilisation of recovery was a less dominant construction of recovery from mental health difficulties as contingent upon safe, secure and adequate living environments. In the following extract the narrator uses the analogy of a tree to offer a construction of the social ‘roots’ of mental health problems, which is stated as being safe housing but goes on also to mention issues of prejudice and oppression.

> *“The roots [of the ‘recovery tree’] are safe housing, if someone is not safe you will not recover, it is an impossibility seventy percent of the homeless are mentally ill and we have to look at why that is, because we have dumping grounds for the mentally ill, we discharge them from acute services, maybe blunted in expression acting bizarre,*

> *like a bit unkempt and we put them on crap housing estates and people think it's funny to take the piss, they call them names, they throw things at them, they draw on them, draw on the windows, put dog shite through the letterbox, I know because I was that person I don't care how good a therapist is, you can work with a person, you send them back to that environment you're wasting your time, it's the government issue that has got to be addressed, it's an international crisis what is happening with the mentally ill."* (21: 946-955)

Drawing on a discourse of a social model of disability, the extract offers a picture of recovery that is not reliant on personal willpower, but rather the will of the wider community and society, or the state, to overcome prejudice and invest in adequate social resources. Mental health services are constructed within the extract as discharging people before they are ready and 'dumping' them in inadequate living arrangements where they are then exposed to victimisation and prejudice. Safety in living arrangements are emphasised within this construction as imperative for recovery from mental health problems. Furthermore, the psy-discipline practice of therapy is noted as a 'waste of time' in the face of bigger social problems, regardless of how 'good' it might be.

In another extract, it is the absence of social and financial obstacles, and the presence of 'privilege' that is constructed as playing its part in the author's recovery.

> *"Having not lived uncomfortably, I realise I am lucky. There has always been food on the table and I have had money to live and enjoy recreational things. I am very aware that my recovery is in a large part due to my privilege. Having worked in mental health and seen the damage that injustice through benefits, poverty and inequality can do to those labelled mentally ill, I like to remind myself of how much I have done sometimes. Despite how lucky I am, I try to not feel guilty for playing the hand I have been dealt."* (22: 1000-1003)

'Privileges' such as food security and adequate financial resources are constructed as enabling this recovery from mental health problems. Recovery is pictured as 'largely' contingent upon such practical obstacles being addressed. This also constructs one's ability to be responsible and make 'choices' as embedded within a context of 'opportunity.'

In a further example, although a responsibilisation discourse is predominantly drawn upon, it is alongside a construction of 'opportunities' which have allowed for personal responsibility to be possible. Opportunities here are connected to the *availability of state resources* for mental health care:

> *"I knew I needed to turn my life around. I was already clean because time on the medical wing had stabilised me. I thought "this is an opportunity to get my life straight"... When I had the opportunity to choose, I chose freedom. While I was in prison I heard about [project offering emotional and practical help]. I thought to myself this might be a place that could help me get my life together."* (1: 27-38)

This extract shows how the construction of responsibility to choose recovery contests with, but also is compatible with, the necessity for state provision of adequate resources and opportunity.

Recovery as self-managing. Another prominent discursive construction of recovery within the dataset, intimately related to personal responsibility and personal interpretation, is that of the dominant policy discourse of 'self-management'. There are several different ways in which self-management is constructed within the dataset – as either keeping 'healthy' or managing an 'illness' by taking medication, through the use of psychological techniques and 'coping skills', or through 'personal medication' (Deegan, 2005).

Some constructions of self-management are steeped in a biomedical discourse of mental health, linked to gaining 'insight' into an 'illness' requiring management – either through taking medication *"every single night like a good boy"* (7: 337) or through learning and practising psychological 'coping' techniques. Equating recovery with 'managing' an ‘illness’ can close down alternatives to a biomedical discourse of mental health and treatment. The idea of taking medication ‘like a good boy’ has hints of coercion – could the patient have been coerced to take medication as part of, for example, a community treatment order?

The following extract (26) shows how recovery is constructed as a continuous individual effort of staying ‘well’ and not becoming ‘unwell’. It suggests a somewhat precarious balancing act, where ‘un-wellness’ is continuously balanced by self-management strategies, keeping an imminent ‘crisis’ at bay.

> *“Another part of recovery is ensuring I take my medication every day as when I was unwell it was one of the first things I lost track of. Sometimes I thought I was “cured” and didn’t need any medication anymore which I soon learned was a disastrous conclusion to come to. Taking my medication properly has given me the stability to engage in self-management things with various groups to help me increase my self-awareness so that I can recognise if I’m getting unwell and seek help before I reach crisis point.”* (26: 1128-1133)

This extract also closely relates to ‘taking responsibility’ whereby individuals are responsibilised through the technique of self-management to prevent reaching ‘crisis point’. This type of responsibilisation has succeeded in helping people to move away from being stigmatised subjects who pose ‘a risk’, and therefore require constant professional management and assessment, towards the position of a responsible citizen who knows they are ‘*at* risk’ of a crisis, but work hard to self-assess and manage this (Cook and Wilson, 2011). This also serves to move people back into an ‘even place in society’ as discussed earlier. Potentially, however, this does have repercussions for those who do find themselves ‘a risk’, at ‘crisis point’ and needing support. They could be positioned by mental health professionals to have failed as a responsible citizen in their self-management capabilities.

Another strategy of self-management seen constructed within the data set is that of the use of learned, psychological self-help strategies to be able to feel in control, to cope and to self-manage symptoms. Psychological techniques are constructed here as liberating and as empowering the self toward a state of recovery. Differing techniques are referred to, largely drawing from discourses of positive psychology, cognitive-behaviourism and acceptance-based therapies.

> *"When I was using mental health services I often felt disempowered and that things were being done to me rather than with me so having more control and being able to make my own decisions using the skills or mindfulness or the distress tolerance, doing something that, making myself do something that I enjoy doing until I feel better has helped."* (7: 321-325)

The construction of self-management positions people as empowered, autonomous agents responsible and accountable for managing and acting upon themselves.

In the following extract the discourse of cognitive-behaviourism is drawn from to indicate the necessity of 'alternative ways of thinking', such as maintaining a positive attitude. It can be seen that recovery becomes a personal effort of using psychological 'tools' to control negative thoughts. However, the extract also shows how external professional support (seemingly from a CBT therapist or psychologist) has been necessary in order to be able to set the motion for 'self-managing' – positive thinking was taught through a course of CBT therapy. Even though people are 'self-managing', the professional legitimacy of psychology is upheld.

> *"What I've had previously is CBT and that kind of really, that is one amazing tool to have, in regards to recovery, because it kinda gives you alternative ways of thinking, of dealing with, kind of you know painful situations, another thing that helps with regards to recovery is positive thinking you know. If you've been negative for like thirty odd years and you say to someone be positive it's you know it's like telling the*

> *person to swim in, you know throwing them in the water and telling them to swim, you have to teach them how to do it and that's what CBT did it kind of taught me how to think positively."* (9: 409-415)

The therapy is constructed as a teaching exercise. In this way, it can be seen as an example of normalisation (Foucault, 1973), where specific techniques are taught and employed to support a modification of atypical behaviour. With the UK Government having implemented widespread CBT programmes over recent years, and with it being a key intervention in most National clinical guidelines for mental health difficulties, it can be seen as a form of disciplinary social control (Brown, 2002).

The dataset draws on recovery 'tools', including "WRAP" (Wellness Recovery Action Plan). WRAP was developed as a self-management approach by ex-patient/consumer Mary Ellen Copeland (2007). Copeland's recovery vision is one of people *"stepping out of the limitations of a passive 'patient' role, and becoming active and autonomous authors of a self-actualised life"* (Scott and Wilson, 2011, p.3) and the WRAP 'tool' is a way in which this vision can be acted out.

> *"Recovery to me means, continually using and having faith in the tools which help in clearing that dark storm cloud, tools like WRAP, Grounding, Mindfulness."* (32: 1437-1438)

Recovery is constructed in this extract as a continuous process of using such tools and believing in their effectiveness, drawing from the discourse of formal self management. The tools clear the storm cloud, but perhaps not the storm, with an indication that the tools are ever-necessary. Scott and Wilson (2011) argue that although WRAP is defined as empowering in the way that it is a continuous project of staying in control, this also has the effect of positioning subjects as always 'at risk' of losing control.

Prominent within the dataset is a construction of recovery as ‘doing things’ and keeping busy:

> *“He [my dad] asks me to leave the house, he doesn’t let me lounge around the sofa. I have to get out the house, I have to do things, which is sensible of course.”* (9: 422-424)

In this extract, keeping busy is described as a ‘sensible’, common-sense way to live. Other activities, like ‘lounging’ on the sofa, are thus implicitly constructed as not a sensible way to spend one’s day. It leads one to ponder on how organised ways of relaxing, such as attending a relaxation session, might have become acceptable for mental health service users over more informal activities such as ‘lounging’. An emphasis on ‘doing things’ could also contribute to forming subjects in a Foucauldian sense who are socialised to contribute to society in some way.

Furthermore, ‘doing things’ is constructed as keeping one well through negating ‘feeling’:

> *“For me, recovery is when I am no longer focusing upon how I am feeling and instead begin thinking about doing things in my life.”* (2:77-78)

How a person is ‘feeling’ becomes unimportant, a hindrance even, and a construction is made where one can make a decision to explicitly ignore feelings and funnel energy instead into thinking about ‘doing things’. It connects to the wider discourse of cognitive-behaviourism which constructs people as cognitive beings who have the potential for rational and irrational thinking. Thoughts, feelings and behaviours are viewed as interrelated and amenable to change. In cognitive behavioural therapy (CBT), successful outcomes rest on people positively challenging ‘faulty’ thoughts (‘cognitive restructuring’) or adapting their behaviour (‘behaviour activation’) through various exercises. From a Foucauldian perspective, CBT socialises individuals to take responsibility for themselves through a necessity of ongoing self-observation – for example, through challenging negative emotions and ‘thinking about doing things’ as in the extract above.

This construction of recovery as a state of surveilling and rectifying not only one’s behaviours, but also thoughts and feelings, can be viewed as a disciplinary practice which creates subjects who are implicitly compliant and self-regulating.

Self-managing was also described as a trying and arduous process which only took affect with support from friends and services:

> *“I also had to get through the long nights alone with awful anxiety and panic attacks, I tried to read about anxiety, and learn coping strategies for my debilitating panic… she [colleague] encouraged me to seek support from secondary services and to continue to develop my coping skills and self management skills.”* (3: 150-160)

An interesting, less dominant, counter formation within the data comes from the following extract in describing what recovery means to the narrator:

> *“There’s no such thing. There’s no such thing. People, doctors, GP’s, nurses, whatever all try and say like you can recover from this. My psychiatrist, and this is why I respect him so much he says, you’re not going to recover. You’re going to have to spend your life… but what I can do is help you manage it better.”*

Recovery is here constructed as non-existent, and ‘managing better’ replaces it. A psychiatric discourse of clinical recovery is promoted, yet is seen as not attainable. Managing is constructed as something to almost be put up with *instead of* gaining recovery.

Recovery as an ongoing process. Intimately linked to continuous self-management is a dominant construction of recovery as an ongoing process, where one is always *in* recovery.

> *"Recovery… it is a long and continuous journey. I don't think I'll ever be totally free from my disabilities as I have to take medication three times a day so I'm never really allowed to 'forget' that I have illnesses that effect myself and my loved ones. I know that doesn't mean I can't recover fully however and that gives me a lot of hope and strength."* (25: 1106-1110)

Here, the process of taking medication at three daily time points serves as a constant reminder of a 'disabling illness' which has consequences. The recovery process as an ongoing journey requires the subject to be continuously ill. Recovery and illness go hand-in-hand. The subject enacts a state of *having* illnesses. Illness is constructed as a permanent, chronic state with which recovery continuously competes. Again:

> *"You never get rid of it, it's like you have a scar there even if it's, you sort of control it, you always have some sort of, how should I say something that's, if you take away the medication or take away certain things it's going to come back, you know, so, that's something you have to live with."* (18:844-846)

The construction of recovery as an ongoing process, alongside self-management, implies one has to 'work hard' at recovery. It becomes something rather laborious and just-about-manageable. This long process is referred to as a *"struggle"* (20:923) and a *"constant battle"* (28: 1193). In a related way, mental health difficulties are constructed as something to be accepted and *endured* in the following extract:

> *"I have come to accept that the fog can appear at any time and especially when I have been busy. So, it's a case of putting up my metaphorical umbrella and weathering the storm in whatever way works best for me at that point in time."* (24:1053)

However, the metaphor of weather employed here can be seen as resisting the psychiatric discourse of 'illness', in favour of something more common.

Preceding the following extract (2), what the narrator refers to as the 'standard dictionary definition of recovery' of 'returning to a state of normal health' is rejected in favour of a construction of moving forward and leaving something behind. Rather than being in a state of constant management, the ongoing recovery journey is defined as a sense of renewal and moving forward through a sporting metaphor:

> *"The action of returning the paddle, leg or arm or back to initial position to make a new stroke. Once I have moved forward from a period of disruption I don't want to return the place I was in before."* (2:73-75)

Deviating from the descriptions of recovery as a strenuous task of working at, or coming to manage, are competing constructions of the ongoing journey being akin to the ordinary human task of living. For example:

> *"Although I still have my moments, you know, like everybody where I go through and I, struggle with how I'm feeling about things and, you know, but that's not illness that's living."* (20:914-915)
>
> *"It's a very kind of slow process of lots of things. Actually what I think it is, it's just a slow process of learning how to be human."* (15:749-750)

A continuum model of mental health is drawn on here, where mental ill health is constructed as part of the spectrum of human experience, which is in contrast to the dominant rhetoric of illness being separate from oneself.

Linked to this is the construction of the journey as being one of having *"survived the rich tapestry of mental health issues."* (3: 173). This survival, at times, is talked about as a personal endeavour, and resisting a clinical discourse of psy-treatment: *"I have never had any formal therapy or treatment but I have survived."* (36: 1686-1687).

However, there are also constructions of the journey which draw directly from therapeutic discourse, thus legitimising such practices:

> *"I had already come along way on my road to recovery by this time and I spent the next few years delving into issues from my childhood that were the probable route of the anxiety."* (3: 163-165).

Counter to the construction of recovery as ongoing process is the less prominent presentation of recovery and illness as either-or states. Once an individual is no longer 'badly ill' they are constructed as having recovered. Any other states are not considered incompatible with recovery.

> *"It's just the, you know, if there's black and white and then say, recovery is white and being ill is black. So it's a ying and yang, it's rather than rather a linear thing, more of a ying and a yang, you know, recovery is what you are when you're not you're not when you're not very, you know, when you're not floridly or badly ill."* (17: 818)

Recovery expertise and sharing stories. The dataset involved the discursive construction of 'recovery expertise and sharing stories' Recovery is equated with *"becoming expert in my own mental health"* (33: 1515). Individuals who have lived through mental health difficulties, treatments and services are positioned as implicitly having knowledge and expertise in this area, gaining what has been referred to as 'experiential authority' (Noorani, 2013). Within this construction lived experience is valued as a particular form of knowledge and expertise, presenting a challenge to the dominant discourse of the 'professional as expert', and playing a key part in recovery. The construction of the 'expert by experience' within the dataset reproduces a wider counter discourse, arising from the broader service user movement (Wallcraft, 2003). This is seen in the following extract:

> *"Those people [NHS mental health professionals] were getting paid to do a job. That job, as far as I'm concerned, is to aid my recovery. In the two examples given, they failed to do this. They failed because all they saw was another patient in front of them. They didn't see me as someone equal to them, with hopes and dreams and thoughts and fears who was enduring a phase of an illness that was cyclical in nature. I had to practically teach them about Bi-polar disorder – and I was in hospital!"* (33: 1507-1511).

A subject position becomes available here for service users as experienced and authoritative. The service user is required to almost take up a role that is able to challenge and 'teach' the professionals, and to notice when they are 'failing' at their jobs. Although undoubtedly this is a powerful subject position to adopt in resistance to a dominant psychiatric authority, it perhaps also has the effect of again constructing recovery as an individual responsibility (the service user needs to do the learning and the teaching).

Furthermore, connected to 'expertise' is that of sharing one's lived experience with others. Sharing stories of lived experience often occurs through writing or speaking stories or ideas about recovery as in, for example, *"I wanted to share my feelings of recovery in the hope that it might help you"* (11: 535-536).

Within the following extract (39), the act of sharing stories constructs recovery as connecting with people who have 'told their stories' before going on to tell one's own story. Alongside this text is an image of a butterfly amongst flowers, accompanied by the text 'telling your story'. This picture can be seen as constructing the act of sharing as a transformative, liberating and natural process, and also that the story is a personal one – the butterfly develops the strength and resource to emerge from its own cocoon.

> *"The Telling Your Story course gave me a different perspective on what I was feeling. I realised I still had some work to do, but was helped to see how to do it. Meeting other people who told their stories in different ways helped too. Meeting the*

> *trainers, and seeing the peer trainer do her thing, encouraged me to go after what I wanted to do: help people with mental health problems."* (39: 1849-1853)

The 'Telling Your Story course' referred to is an eight-part workshop which is reported to encompass finding ways to 'accept, express, celebrate and move on' through writing one's story. Notwithstanding how commendable this practice is in supporting people to do this, the organisational guidelines of storytelling are arguably constraining – to tell a story that accepts, celebrates and moves forward. Telling stories draws from the roots of recovery (e.g. Deegan), but is now bound up within an organisational framework which offers guidelines on how to tell it. Who else is benefitting from the telling? The extract above does function in one way as an advertisement for telling one's story (Poole, 2011).

The professional embodiment of recovery. This leads us on to noticing a further dominant subject position available within the dataset whereby the 'expert by experience' eventually becomes a professional employed within mental health services to support other patients or facilitate training for staff: *"I live life to the full. I have a fantastic job as a Peer Employment Project Manager"* (3:174). The peer support worker role is a progressive and understandably celebrated progression within the field of mental health. It emerged out of the national programme for organisational change as seen in the genealogy (*Implementing Recovery for Organisational Change,* 2009). In several places the dataset constructs peer workers as 'co-workers' to other professionals, re-instating a sense of value and skill lost in the patient role. Employment in peer roles is talked about within the dataset as bringing gains of an 'ideal' content and satisfying life where one *"can engage in all the activities and delights of a rich and fulfilling life"* (3: 176).

Consider the following extract.

> *"I have had wonderful people who have worked with me to try to keep me well for longer periods and I have enjoyed many therapeutic treatments. These interactions taught me to see that there are patterns to the ways that I experience mental health illness, and that by understanding these patterns better, I can act upon them as warning signs quicker… I am now in two paid jobs working as a Peer Support Worker (after training two years ago through the X Recovery College) and a Recovery Trainer at the X Recovery College. Co-designing the 'Understanding a diagnosis of psychosis' course and co-running it with a great psychiatrist has given me a new way of seeing mental health services, and a far more empowering way to be part of it. I can honestly say I now find my present life fulfilling and stimulating."* (38: 1796-1804)

At first sight the extract shows a validation of the expert by experience peer role. However, alongside this it also seems to amplify the power of the psy-disciplines. It shows how the narrator has embraced and learned from her therapeutic treatments, and thus her new role in co-producing an 'understanding psychosis' group likely includes much of the therapeutic treatments she has embraced herself. Whilst this is a seemingly obvious point that her lived experience role would naturally include her lived experience of treatment, its significance here is in the way that the dominant discourse of psychiatry and psychology are perpetuated despite the introduction of the peer worker. It begs the question of how many of those who have not embraced their treatments go on to fulfil peer support roles. Furthermore, sharing lived experience occurs within the parameters of the framework of the 'great psychiatrist'.

The narrator's description of 'co-running' and 'co-designing' serves to construct the peer role as on par with the role of the 'great' psychiatrist. This language of co-production has begun to be used more frequently in health and social care settings and adopted as a term in policy (e.g. Department of Health, 2010). Needham and Carr (2009) note that *"if co-production is to improve outcomes in social care, it will be at the 'transformative' level,* *avoiding versions of co-production that simply cut costs, demand compliance or reproduce existing power relations"* (p. 17).

A romanticised discourse invoking fate is drawn on here to construct psychiatric hospitalisation as a necessary 'experience' which can lead to the transformation and fulfilment of a working life. This is illustrated in the following extract:

> *"I have now got a job as a personalisation peer support worker… I believe things happen for a reason. It might not have made sense at the time, but If I hadn't been on the other side of the experience before and ended up in hospital, I wouldn't be doing what I am now."* (39: 1853-1856)

Work within mental health services is constructed as fulfilling and beneficial. However, there is an example of a counter-discourse within the dataset that spoke to the possible financial implications of peer work for the individual. In the following extract, the speaker is afraid about withdrawing from state benefits in order to accept payment for peer work she has carried out. There is recognition that pursuit of a 'fulfilling' employed life would take away basic rights to welfare, presenting her with a dilemma. However, this is ultimately coloured by the dominant discourse of participation in the labour market as the ultimate fulfilment.

> *"I have found that over the last two years I have been more and more involved in volunteering and ended up doing five days in some weeks. I was offered payment for a lot of what I was doing, but declined as it would have meant coming off benefits and that was too frightening for me. I finally took the plunge and when the [name of trust] Recovery College opened I applied for a post as a peer trainer and was successful. I have never felt so excited about my future. I feel in control of my destiny to a greater extent than I ever thought possible."* (37: 1734-1740)

It is also notable within the extract that coming off welfare benefits is predominantly constructed as an empowering and liberating transition, and significantly as an *inevitable* part of recovery – dependency on welfare is ‘overcome’ through a commitment to participation in the labour market. The fear of withdrawing from benefits is spoken about but quickly replaced with a confidence and excitement about a future within employment. Being in receipt of benefits is constructed as a restricted life where opportunities have to be turned down, whereas working is equated with being ‘in control of my destiny’. Withdrawing from state welfare is also constructed within the ‘fulfilment through work’ discursive formation discussed below.

Peer work and expertise by experience was also legitimised as a way of ‘giving back’ to society, implicitly inferring that recovered subjects had ‘taken’ something during ‘unwell’ years. This was apparent later in the narrative of the previous extract after talking about transitioning from benefits to employment as a peer worker:

> *“I feel proud of what I have been through and that this is recognised as my expertise. At the College I have helped to produce courses and material like the Health and Wellbeing Plan. Giving something back and trying to fight for a better future has given me so much to look forward to.”* (37:1740-1743)

Another person’s peer work with people experiencing mental health difficulties shows a similar construction: *“I feel I owe something to the community”* (1:43). This talk of giving back and owing something positions those who have recovered as subjects indebted to society, and that fulfilment arises from returning this debt. This fulfilment sits well with the neoliberal utilitarian discourse (Knight, 2016) of achieving happiness through helping.

Fulfilment through work. Related to many of the features of ‘professional embodiment of recovery’ is the construction of employment in a more general sense.

Spending one’s time at work, in any kind of employment, not necessarily peer-work, is also predominantly constructed within the dataset as a productive and sensible way to spend time:

> *“The fourth thing that comes to mind is work, be that charity work, voluntary or paid. Sadly to me my options have become limited due to my multiple disabilities, however recovery is finding a way around these limitations. The happiness and pride I get from using my time wisely and effectively is something I always see as a big part of recovery.”* (25: 1102-1104).

McWade (2015) argues that there is a *“peculiar management of time”* within current neoliberal society and mental health recovery which dictates how one should or should not spend time. Spending time sensibly (e.g. through working) can be contrasted with the construction of *un*wise ways to pass time, for example through ‘lounging on the sofa’, as noted earlier.

Worthwhile employment (‘serious’) is constructed as involving bureaucratic processes such as payroll and Human Resources. Other types of work, such as the childcare job of the ‘nanny’, are constructed here as less worthwhile in the pursuit of a recovered, fulfilling life. Withdrawing from benefits is again constructed as ‘difficult’ but ultimately exciting and ‘better’ in this next extract.

> *“I realised that work was something that had been missing from my life and I thoroughly enjoy it. Although I had worked as a nanny, this was the first time that I was working for an organisation with HR departments, payslips and all the other things that make you feel like you’re in a serious job. It was actually really exciting. I came off benefits when I started work, and this was a difficult time financially but once it was all sorted out I was better off in many ways. Stepping into the working world really enhanced my recovery. In 2012 I completed the Peer Support Worker course and got a job working in the [name of NHS Trust] Recovery College which I really enjoy too.”* (41: 1981-1987)

However, this is in contrast to another less dominant construction where work is fulfilling when it is free of the constraints of a ‘serious’ job with the associated bureaucratic processes: *“develop[ing] my own avenues of becoming self-employed, independent and working.”* (10: 515). This particular work entailed *“being an artist, being a painter, selling my prints… to anyone who's interested in having a look and maybe buying some”* (10:515).

Recovery as living well without work. Resisting the ‘fulfilment through work’ and ‘professional embodiment of recovery’ constructions is a quieter voice present within the data constructing recovery as living well in spite of not working. It challenges the dominant construction that a person’s worth and value are contingent upon paid employment. The following extract enacts this resistance:

> *“I mean I can’t work but it doesn’t mean I don’t have a fulfilled or useful life”* (14: 663-665).

Although this draws on a construction of recovery as living a fulfilling and meaningful life, paid work and money are resisted as a necessary condition for such a status.

> Furthermore, gaining employment in particular is rejected as a necessary standard for recovery:
>
> *“There are too many people have a value base around recovery that says the only way to recovery is certain models like getting into employment.”* (12: 591-592).

This draws upon the construction of recovery as a personal interpretation, rather than being something imposed.

Recovery as acceptance of illness. A dominant construction of recovery within the data involves the use of the object of acceptance. Acceptance is used in different ways to construct different versions of recovery.

In the following extract recovery is constructed within a biomedical, psychiatric discourse, making use of the objects of acceptance and insight. The subject is positioned as initially 'lacking insight' through wilfully denying, rebelling and fighting against a 'very painful truth' of an 'illness'. This is then contrasted with her allowing for an opportunity to be helped via the notion of acceptance of psychiatric knowledge.

> *"When someone confronts you with the line 'you're ill' it's easy to reject it out of hand and dismiss it totally. But denial can be extremely damaging… Acceptance of my illness was a turning point – the start of my path to wellness. It is important to understand that denial of the illness can be a natural reaction and a normal defence mechanism to a very painful truth… For me, denial was my way of coping, of staying normal… The trouble with not accepting is that you also reject treatment. You refuse medication, fight confinement and rebel, or worse – turn on those trying to help you. This behaviour gets you nowhere, and just makes things worse. By accepting treatment I could actively seek the right medication, access support, and turn my life around. Without acceptance you remain trapped in the delusion that nothing's wrong."* (4: 188-197)

Within this extract is the implicit message that to resist psychiatric treatment 'just makes things worse'. Acceptance of experiences as biomedical in nature is constructed as a pre-requisite for being able to make use of 'treatment'. Therefore, recovery here is inextricably bound up with a biomedical discourse of understanding one's experiences as an illness and making use of medication to counter this. Gaining 'insight' often means that someone has accepted a professional's explanation over their own (Trivedi and Wykes, 2002), which is contrary to the 'personal interpretation' construction of recovery, and the humanistic discourse.

Furthermore, it introduces an interesting problem to the construction of recovery as empowering through gaining responsibility and choice. 'Refusing' treatment is a choice, but is constructed here as the 'wrong' choice – one of rebellion and 'turning on those trying to help'. Thus, people who express agency and an ability to choose are constructed here as problematic subjects. There is also a silence around the legitimate reasons people might 'refuse' psychiatric medication or confinement, for example further incapacity through iatrogenic harm of both practices. The dominant discourse remains unchallenged.

In the following extract, in a similar vein, recovery is constructed within a biomedical discourse, where recovery requires becoming aware of one's mental illness.

> *"The challenge is to try to have an awareness of that you are mentally ill. That is the major challenge that anyone has. To recognise that you are, to recognise that you are mentally ill and to confront it. That is the biggest challenge. That leaves you, in my opinion, on the road to recovery."* (9: 384-387)

These extracts show how subjects can reproduce the rhetoric of biomedical psychiatry in their recovery talk, which has the effect of unwittingly doing little to challenge the status quo of institutional psychiatry. Grant and Short (2015) note how stories of recovery can take on 'implicit organizational narratives' (e.g. Richardson, 1997) where unspoken rules and assumptions of an organisation begin to inform members' assumptions and actions. This can be seen through the adoption of psychiatric language throughout the extracts.

Acceptance of illness is at times resisted and talk of self-awareness is not always constrained by a biomedical discourse. At times it takes on a more spiritual discourse, for example, through 'depth of understanding.'

> *"Recovery means life to me. It means growth, and it means strength; but it also means depth of understanding and sensitivity to change. Recovery means that my awareness of who I am becomes more complete but, at the same time, less definite. I am a part of the world I experience, not an observer and, as a participant, I have the ability to change myself and my surroundings. When I am unwell my life is limited in*

> *a million little ways; my understanding of self is constrained by pain and confusion and self-judgement, my horizon narrows to the hole I inhabit but, when I am well, I inhabit the horizon itself. When I am well I accept my frailty, and I see that the recovery process is a journey, not a destination."* (27:1164)

Different to the more concrete process of gaining insight into mental illness, this construction of recovery becomes 'more complete but, at the same time, less definite.'

Recovery as acceptance by others. In contrast to the individual endeavour of recovery, but also at times working alongside, is the construction of recovery as being accepted by others. The discourse of other people overcoming their stigmatic attitudes is a recurring dominant construction within the dataset. For example:

> *"Recovery to me means, a better understanding of labelling and stigma attached to people's problems, by others, uneducated in mental health."* (33: 1433-1434)

This extract (33) describes overcoming stigma as necessitating other people to be 'educated in mental health'. Whether this education is from public health campaigns, media or in early education is not the point, rather it is the removal of stigma that constitutes recovery. Anti-stigma campaigns have emerged in recent years, a discourse from which the above extract clearly draws.

In the following extract (8), acceptance by others is constructed as being involved in social circles, but this is precarious in light of another construction of the naivety the public (in this case, 'friends') have with regard to 'what psychosis, depression, anxiety actually are'. Again, 'education' is constructed as pivotal:

> *"I'm really glad that my friends and family did come to visit me, uh, it played a big part in my recovery. The biggest barrier for me kind of came out of nowhere, wh- and that barrier was getting back into social circles. I was worrying, probably*

> *without any need to, but I was worrying what would my friends be thinking, how are they gonna react when they see me cos they all know that I was in hospital being treated for a mental health illness. I don't think some of them were too sure about how to approach me and how to speak to me to begin with erm maybe because it's just something that's not talked about a lot, just mental health in general. No one's really open about it erm maybe for me and my friends if we had sometimes just mentioned at all that this could happen, this could go wrong, a bit of education on what psychosis, depression, anxiety actually are could have really helped with my friends and my family."* (8: 357-367)

Acceptance by others is intimately connected with a construction of people being well educated about mental health. Less present within the dataset was that sometimes it is mental health professionals who needed to be 'educated'. This construction resisted the professional authoritative discourse, and the service user takes on the subject position as 'educator', an enactment that is inextricably linked with the 'expertise' construction. In the following extract the individual is seen to resist a psychiatric discourse, but at the same time perpetuate it through a separation of 'personality' and 'symptoms'.

> *"The difference was, not in how we dealt with things, but in how others dealt with us. People often confused my personality with my 'symptoms.' One example is… I said to [the nurse], "No, you were the rude one, talking about me as if I wasn't there. And I wasn't being aggressive; I was being assertive, because actually that is how I am in real life."* (33: 1473-185)

Competing with this, present within the dataset, was a construction of acceptance by others as unrelated to any kind of 'mental health' discourse and rather as a necessary part of being human. Acceptance is constructed as a profound sense of just being with others and feeling secure in their company:

> *"I do have some wonderful people around me. You know, when we came in, you know, I was holding a friend's baby. You know, what can replace that. You know,*

> *having a wee child, so trusting that they want to use their wee fingers to touch your nose and your, your chin and feel your mouth, is, you can't replace that. It's those are the important things. And they are what keeping me going"* (12: 568-571)

Related to this, acceptance by others was constructed as having aspects of oneself that are not necessarily related to 'mental health' being accepted by others. For example, one's sexuality:

> *"My sexuality started to frighten and confuse me as I was told by a consultant psychiatrist (and he should know, shouldn't he?) that it was an aspect of my mental illness... I met a nurse who proved, literally, to be my life-saver. She was an open lesbian feminist who told me to trust my own feelings and to not necessarily believe everything the doctors were telling me... With her support I started to learn about myself, and she talked with me about feminist ideas and explanations about the position of women in society."* (38: 1755-1764)

This construction explicitly acknowledges the authority of biomedical psychiatry but rejects its attempt to impose an 'acceptance of illness' discourse. The subject is positioned as one who is liberated through an understanding of *identity* and the powers that can form this: *"I now felt strong in myself as a lesbian woman"* (38: 1780). The frightening and confusing sexuality becomes something welcome. This constructs a notion of illness and identity as less binary, and allows for subjects to gain 'self-awareness' in new ways. Finding a community who was accepting of identity in this way – the nurse (and also a women's community peace group is referred to later in this story) enabled recovery to begin.

4. Discussion

Listen up and I'll tell a story about an artist growing old. Some would try for fame and glory, others aren't so bold. Everyone and friends and family, saying, 'Hey! Get a job! Why do you only do that only? Why are you so odd? We don't really like what you do. We don't think anyone ever will. It's a problem that you have. And this problem's made you ill'.

– Daniel Johnston, The Story of an Artist

4.1. Introduction to discussion

This project was novel in its application of a Foucauldian discourse analysis to stories of recovery in the context of a genealogy of its emergence. It aimed to understand how recovery was constructed within narratives that had been made available for public viewing on charitable and public health forums. It has provided insights about how recovery is constructed within this context and how people are further positioned as subjects.

4.2. Appraisal of research questions

The research was interested in how recovery was enacted through 'recovery stories' published on organisational websites. This section will explore the three research questions considering the results of the analysis in the context of the genealogy: First, *how is the discursive object of recovery constructed?* Second, *what are the implications of these constructions for possible ways of being?* And third, *which institutions and practices are strengthened or undermined by these discursive constructions?* To explore these questions in a coherent manner, discursive constructions will be discussed alongside subject positioning and the wider power relations these imply.

The analysis led to the identification of eleven discursive constructions underpinning the dataset of recovery stories. These include recovery as: personal interpretation, personal responsibility, socioeconomic opportunity, self-management, an ongoing process, expertise and sharing stories, professional embodiment, fulfilment through work, living well without work, acceptance of illness and acceptance by others.

Responsibilisation and governmentality. A predominant discursive construction of recovery within the dataset was that of 'personal responsibility.' It linked closely with several others, most significantly with 'self-management', 'personal interpretation' and 'acceptance of illness'. Having responsibility, managing on one's own and making choices over one's recovery is, on the face of it, empowering, especially in light of the oppressed history of psychiatric patients. Service users, survivors and activists have fought hard to achieve autonomy within what has predominantly been a paternalistic system. Notwithstanding this, it is important to note the implicit message that this 'truth' can also bring forth. Smail (2005) argues that within constructions of responsibility for people to recover, a message of blame is projected which implies *"that somehow the individual lacks the moral fibre to face up to his or her difficulties and mobilise the necessary internal resources to deal with them"* (p.73).

Personal responsibility can be seen to draw upon a wider citizenship discourse of 'responsibilities over rights' noted in the genealogy, thus drawing attention away from the social determinants of mental health problems. The discourse of responsibility was found to often involve a moral imperative or an obligation to make good, virtuous choices which required a strength of will and determination. Along with this, personal responsibility was seen to rest on hope and aspiration, side-lining 'help'. There were two possible subject positions implied here: *"to act responsibly is to choose to act with consideration and constraint; to act irresponsibly is to take the easier path of selfishness, disobedience,* *disloyalty"* (Smail, 2005, p.73). The findings in the section 'recovery as a personal responsibility' demonstrated this invidious 'choice'.

Where individuals feel empowered in taking responsibility for themselves is described as a technology of 'responsibilisation' (Rose, 1999). Responsible and autonomous individuals are 'free' to govern themselves without state interference. Rose (1999) argues this is a form of 'advanced liberalism' whereby the state can govern and regulate citizens with minimal involvement whilst seen to be upholding the liberal and liberating values of independence and choice. The subject becomes a moral, self-governing agent. With subjects responsible for solving their own health or social problems these duties become less of a burden on the state.

The discourse of self-management upholds the discourse of personal responsibility. People become 'responsibilised' (Rose, 1999) through the use of self-management techniques. This is a finding in line with Harper and Speed (2012). As seen in the genealogy this is encouraged within what is dominant government policy. Self-management would appear to be a move away from dependence on services, but ironically dependence is often maintained, for example, through long-term medication regimes. Responsibilised individuals are continuously in a state of maintaining their health, which in turn reduces the burden on public health services. Discourses from psychology, particularly cognitive-behaviourism, were drawn upon within the stories, thus benefiting the legitimacy of the profession and simultaneously passing the responsibility on to the individual.

CBT techniques and recovery tools, such as WRAP, empower and liberate but also facilitate the creation of subjects who are under constant self-surveillance – people who are trained to constantly monitor their 'symptoms' and 'triggers'. Such a state of self-surveillance was predominant within the stories, and was present in the construction of recovery as an ‘ongoing process’. It has the effect of producing subjects who are always ‘at risk’ of becoming unwell (Scott & Wilson, 2011), thus maintaining the legitimacy of the psy professions and their techniques for management.

Rose (1999) can be drawn on here to interpret the practice of self-management as a ‘project of autonomy’. He argues such projects of autonomy are bound up with the growth of professional ‘expertise’. ‘Experts’, such as clinical psychologists and other mental health professionals, mediate between the State and the individual, producing subjects who fit the social norms through a constant regulation of their own actions. Experts provide ‘objective’ answers to how one should live a normal, contented life through the establishment of psychological ‘facts.’ Such ‘facts’ induce a combination of anxiety about being not-normal and hope for a better, happier future, resulting in self-regulating individuals. This carries an implicit acknowledgment of a deficit-based model (Harper & Speed, 2012).

A focus on people self-managing is significant in the context of what has been referred to as a ‘crisis’ in UK mental health crisis care (Mental Health Network, 2016). Diminishing government funding for frontline mental health services has been linked to a lack of assessment beds for those presenting in ‘crisis’ and a tragic increase in suicide by people under community crisis teams (Mental Health Network, 2016). An over-emphasis on the empowering effects of self-management within public discourse may be acting as a smoke screen for the reduction in adequate professional services, decreasing investment in NHS mental health services and the increasing re-organisation of NHS mental health services within the current wave of austerity. Indeed, such recovery-focused interventions have been reported as generally cost-effective (Knapp, McDaid and Park, 2015).

Governmentality speaks to how dominant techniques of self-management (e.g. medication, CBT) are effected. Individuals manage themselves to conform to a dominant standard set by society at large, and more specifically by the “psy” world, which is expressed in their construction of employing techniques to ‘keep stable’.

Resistance to responsibilisation. Within the stories were also sites of resistance to the discourses underpinning responsibilisation. There were constructions of recovery as something not possible without basic levels of social security and safety, drawing upon a social disability discourse (Pilgrim & McCranie, 2013).

Austerity measures introduced by the coalition government since 2010 have had a huge impact on the decline in funding of the UK’s NHS, social services and welfare benefits, with major psychological costs (Barr, Kinderman & Whitehead, 2016). Feeling safe and secure in one’s environment is a fundamental human need (Maslow, 1943), and therefore one might presume important to any recovery. Social insecurity, with regard to housing, finance or physical safety, can have a direct impact on one’s psychic sense of security, and thus one’s potential for mental health breakdown and recovery (McGrath, Griffin & Mundy, 2015).

Citizenship. Within the stories analysed, self-management is predominantly constructed as directed activities, activities with purpose, which take effort and commitment. This echoes the discourse of citizenship embedded within UK policy, as discussed by McWade (2016). Self-management is constructed throughout the dataset as a beneficial endeavour, maintaining dominant discourses of pro-active recovery, a version of recovery promoted by leading recovery proponents (Slade, 2009a). Although this might be the case, the construction socialises individuals into subjects who are good, contributing citizens.

From patient to professional. This pro-active and contributing subject position is also available within the construction of the professional embodiment of recovery, identified in the analysis. To recall, this involves recovery as a process of being employed as a professional within mental health services as a 'peer' or 'recovery' worker. Through roles as peer support workers, subjects become *"credible embodied evidence of recovery"* (Austin, Ramakrishnan & Hopper, 2014, p.884). The promotion from 'patient' to 'professional' is seen to reinstate purpose and the empowerment from the 'patient', or even 'service user', subject position.

This cycle of progression from patient to professional, who is then able to support other patients in turn, is constructed as vindicating this process. However, this can be at the expense of being co-opted as part of the clinical establishment (Brown & Stastny, 2016). Peer support emerged from the survivor movement, which at its core critiqued services as part of a 'power struggle' with the psychiatric system (Pilgrim & McCranie, 2013). Interestingly, this process has effectively neutralised this struggle within the construction of 'professional embodiment'. However, there are competing constructions within the dataset where this power struggle between 'patient' and 'professional' clearly still remains.

The 'expert by experience' peer worker also fits into a wider discourse of user involvement. As discussed, the user roles that are taken up are within the existing power structures of the mental health system and psy-world, and therefore they are regulated and restricted by a dominant ideology. Indeed, Beresford (2005) has previously noted how *"much user involvement has only been able to operate within existing frameworks… thus restricting opportunities service users have had to generate their own ideas on equal terms"* (p.37).

The rhetoric of the 'fulfilling' life of the peer worker obscures a more hidden point that peer support roles can act as *"cheap labour"* (Rose, 2014, p.218) within a climate of financial cuts to health and social care. Indeed, a recent briefing paper concluded that *"the* *financial benefits of employing peer support workers do indeed exceed the costs, in some cases by a substantial margin"* (Trachternberg, Parsonage, Shepherd & Boardman, 2013, p. 2).

Normalisation and governmentality. The use of work as a form of recovery was clearly apparent within the stories. The 'fulfilment through work' discourse was not featured as prominently as 'professional embodiment' within the analysis. This is most likely because these stories were published largely on websites of organisations which arguably benefit from the promotion of the patient to mental health professional cycle identified earlier.

The idea of working for recovery is closely connected with the policy initiative of 'social inclusion'. Spandler (2007) argues that, although social inclusion should be about promoting inclusion and contribution in all areas of life, it is one's involvement in the labour market which is the predominant concern when measuring inclusion 'outcomes.' Indeed, within the stories analysed, coming off state welfare is at times constructed as an inevitable and beneficial part of (and sometimes consequence of) recovery. This draws upon what Peacock, Bissell and Owen (2014) refer to as a prominent discourse within neoliberal society of there being 'no legitimate dependency'.

Constructions of giving back to society through work (of either of the identified categories) draws on a discourse of citizenship. Foucault's (1988) concept of governmentality supports an understanding of work as a 'technology of the self', a way in which the subject position of a passive and dependent patient can transform into that of an active and contributing citizen of the community. People are 'normalised' in this way. Citizenship involves taking responsibility for actively participating in and contributing to one's community, economy and one's own wellbeing (Odih and Knights, 1999).

Resisting normalisation. Not all constructions of work within the dataset were consistent with the fulfilment through work construction of recovery. There was some resistance to the dominant discourse that one must be a productive and useful citizen (through work) to recover. The 'model' of recovery through working was explicitly rejected by some, thus resisting the construction of a 'right way to recover' as discussed in the genealogy section. This is arguably not in the interest of the state which thrives on full market participation (Owen & Harris, 2012).

Legitimisation of biomedical psychiatry. The construction of 'acceptance of illness' draws upon the dominant biomedical psychiatric discourse which is seen as evident within government policy documents, but resisted by many early recovery advocates (as seen in the introduction of this thesis). A notion of 'clinical recovery' (Slade, 2009a) or 'therapeutic optimism' (Pilgrim & McCranie, 2013) is drawn on here where 'treatment', often involving medication, is constructed as a necessary part of recovery. The implicit rules and assumptions of a biomedical discourse are employed and used to make sense of one's identity and ability to recover.

This presents a problem to those employing a 'personal interpretation' discourse, whereby asserting autonomy to *not* accept 'illness' is deemed problematic and can work to create a subject position of a 'failed' citizen (McWade, 2016). However, there are other constructions of 'acceptance' that work alongside that of personal interpretation in supporting a resistance to the dominant biomedical rhetoric and thus promoting service user testimonies of a 'personal journey' discourse (Pilgrim & McCranie, 2013).

In a similar way, the use of a personal interpretation discourse is, at times, able to de-legitimise the idea of 'recovery as model' as seen within the dominant policy discourse. Recovery as model is acknowledged at times within the dataset, but ultimately resisted in favour of self-interpretation. However, it is precisely the open, non-rigorous and ambiguous nature of personal interpretation which has arguably enabled competing discourses to so malleably become unwittingly adopted into one's own interpretations.

Othering. Employed within the recovery stories was a construction of being accepted by others through educating the public about mental health, often drawing upon an acceptance of illness discourse. One of the ways this has been attempted most recently is through anti-stigma campaigns (e.g. the 'Time to Change' campaign), usually carried out by the third sector. As commendable as their intentions are, these have been criticised as unintentionally actually contributing to stigmatisation through perpetuating a biomedical discourse rather than a social understanding of distress (Bellamy, 2014). A focus on a discourse of 'anti-stigma' paradoxically can then reinforce the discrimination and oppression that these groups face through the concept of 'othering' via 'labelling' (Bellamy, 2014). Othering serves to cast the stigmatised identity onto another, thus protecting the self (Peacock, Bissell & Owen, 2014).

Competing with this was an equally prominent version of acceptance by others which was not explicitly related to having one's 'mental health' accepted, but rather having one's self or identity validated and consequently feeling accepted in this way. This incorporated a construction of relationships which fostered safety and connection. Being part of an accepting community of one's choice can provide the necessary energy to resist dominant ideologies (Timander & Möller, 2016).

Stories as confession. A notable discursive formation interpreted within the recovery stories was that of 'storytelling' itself. Sharing stories is clearly relevant to the dataset as a whole, where stories are written or told with the knowledge that they will be shared with others on public health websites.

Drawing on Foucault’s notion of the confession, Poole (2011) argues that this act of sharing can be empowering, supportive and a site of political change, but can also work as a disciplinary practice: *“for revealing the state of one’s soul may open one up to exclusion or ‘correction’ not only from psychiatrists but also from peers”* (Poole, 2011, p. 31).

Foucault draws his notion of confession from Christian practice, whereby during the Rennaisance confession was expected and served the purpose of admission of sins and penance (Raffnsøe, Gudmand-Høyer, & Thaning, 2016). This has been replaced in contemporary times, Foucault argues, by a need to speak the ‘truth’ about oneself, with the help of a ‘listener’, for example in the act of psychotherapy. Recovery stories, particularly those published by organisations like those generating the data analysed here, might be understood further as a type of confession, where there is a relief in disclosure.

For Foucault, *“the obligation to confess is now relayed through so many different points… that we no longer perceive it as the effect of a power that constrains us”* (Foucault, 1978, p.60). Foucault maintained that as a society we have become used to an idea that power constrains us, which is particularly true for the psychiatric service user community who have a long history of being confined and constrained, and that sharing what is inside, or confessing, can become a liberating act of ‘breaking free’.

To summarise, although the act of confession can be liberating to the storyteller through an attempt to establish a truth about themselves, it simultaneously has the effect of surrendering power to the organisation by supporting its vision (Raffnsøe, Gudmand-Høyer, & Thaning, 2016). Third sector and public health organisations assert their power through knowledge, much of which is available through their websites from where these stories are sourced. This knowledge is peppered with smaller sites of resistance within the recovery stories, as interpreted.

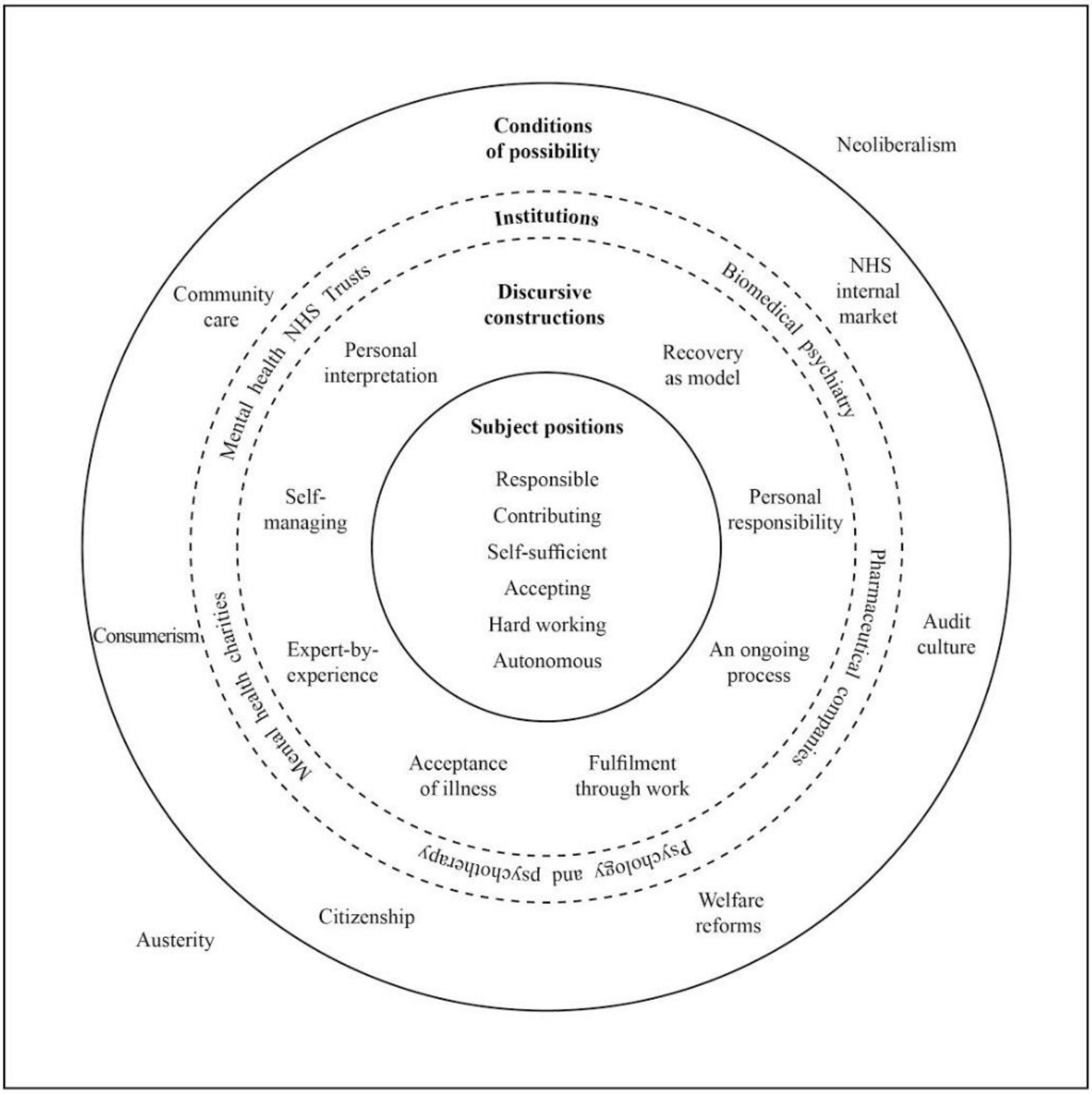
Furthermore, individuals who share their stories of recovery are able to take up a subject position of being accepted by those in more powerful positions, with the production of a story constructed as almost a necessary part of this acceptance (Poole, 2011). Having a published or ‘shareable’ recovery story is itself constructed as a significant part of recovery.

Within personal stories of recovery, as promoted through organisational contexts, the dominant constructions of recovery can be seen to draw from a neoliberal political ideology. Power (through socio-political institutions) shapes and regulates the subjectivities at play within the stories of recovery. Foucault’s notions of discourse and governmentality have helped in the understanding of this process. This supports and builds on previous research that has shown how neoliberalism has perpetuated, or re-formed, recovery’s success as a policy driver (McWade, 2016).

The dominant discursive constructions legitimise powerful disciplinary interests, particularly psychology and psychiatry, as well as serving wider political rhetoric of neoliberalism and recent austerity. Recovery is constructed, on the whole, as something individual, which can be captured in the form of personal stories. It is said to be ‘for all’ and yet, within the dominant discourse, it is for only those who can prove their autonomy and productivity. Figure 1 shows a schematic representation of the relationships between the conditions of possibility for recovery (the genealogy), its dominant discursive constructions and consequent subject positioning, as well as the centres of power involved (institutions and practices). This encapsulates the complexities behind the usage of recovery today.

Figure 1

Schematic representation of the dominant recovery discourse



The dominant ways that recovery has been shown to be constructed indicates available subject positions that are in line with a neoliberal vision of what makes a good citizen. This has been shown in how the discourses position recovery subjects as responsible, self-managing, autonomous and contributing. The concern here is how other versions of recovery are side-lined, particularly those that pose a challenge to the myth of the autonomous individual. Nevertheless, the research yielded significant sites of resistance. For example, counter discourses placed recovery as a responsibility beyond the individual, contingent upon resource, opportunity and welfare security. This has profound implications for people using services and the professionals that form part of their ‘recovery journey’, which will be discussed under the “implications” section below.

This research also draws attention to the commodification of experience (Phipps, 2016). It shows that personal recovery testimonies within organisational material follow the proposition that such use of lived experience *“perpetuates the neoliberal invisibilisation of structural dynamics”* (Phipps, 2016, p. 303). This serves as a reminder that recovery, and all the ‘personal’ it encompasses, brings with it a host of structural context. It also legitimises the knowledge/power of the publishing organisations.

4.3. Evaluation of the research

Methodology. The employment of Foucauldian thought to recovery stories has been novel and useful in providing a critical analysis of recovery throughout this research. Application of key Foucauldian principles, including those of genealogy, discourse, power/knowledge and governmentality, have allowed for a disruption of the ‘truth’ inherent in dominant discourses of recovery in the UK within these recovery stories. In this way it has complemented previous research which has employed Foucauldian analysis to the concept of recovery ‘talk’ (in Canada) rather than published stories (Poole, 2011), and it has enriched other policy critiques of recovery rhetoric in the UK (McWade, 2016; Harper & Speed, 2012).

Through a consideration of subject positions, this analysis has also shown the more ‘performative’ aspect of language – how different discourses work to produce different social relations. The Foucauldian discourse lens has allowed for the research to pay attention to socio-political and moral factors (Parker & Burman, 1993).

However, a shortcoming of using a Foucauldian discourse analysis has meant that it has necessarily implied that individuals generally adopt a ‘passive’ position – their subjectivities (as formed through subject positions) are shaped by discourse (Budds, Locke & Burr, 2014). It does not consider agency, intentionality, and exactly *how* it is that people are able to take up the discursive resources on offer. Combining a discursive psychology approach and a Foucauldian approach to analysis has been argued as providing some possibility of an answer to this (e.g. Wetherell, 1998; Budds, Locke & Burr, 2014). This suggests an arena of possible future research.

Quality Criteria. As discussed earlier in the methodology, this research employs the criteria identified by Georgaca and Avdi (2012) to evaluate the research in terms of its strengths and limitations.

Internal coherence. For an analysis to be trustworthy there should be a coherent and consistent reading of the data (Potter & Wetherell, 1987). Willig (2010) states that internal coherence describes how well the analysis ‘hangs together’ (p. 154). Although Foucauldian discourse analysis actively seeks out competing discourses, these contradictions are part of the nature of the analysis and actually provide together a coherent whole. Indeed, a strength of the analysis is the identification of competing discursive constructions and an attention to the ways that these constructions interplay and interact (or not) with each other (Burman, 2004). The constructions work together to produce an integral story of the research topic, whilst also demonstrating their own individual integrity, as deemed important by Burman (2004).

Rigour. For rigour to be achieved the whole dataset should be granted full attention, including diverse and deviant data. This analysis was carried out in full cognisance of the potential to miss many different discursive formations (as the dataset was made large enough to be useful). This involved thorough readings of the dataset, gaining familiarity with the text, and employing the analytical steps described in the methodology. Harper (2003) describes the difficulty in 'choosing' what gets included in the final write up, and how choices are still inevitably merely choices, rather than analytical 'truths'. A continuous engagement with reflexivity was a strength of this research and aided a working through of these dilemmas. Again, deviant cases are acceptable and even necessary within a rigorous discourse analysis. The variety of 'truths' reported in the analysis illustrates this point.

Transparent and situated. In this paper the reader is given the perspective to judge the quality of the research by a careful description of the research process and an analysis grounded in the careful use of quoted data extracts. This research contextualises its findings using selected extracts (Burman, 2004), seeking not to 'under-analyse' through either summarising without evidence or over-quoting, and thus diluting, the data (Antaki, Billig, Edwards & Potter, 2004).

Usefulness. For research to be useful it must provide new insights and enhance existing research. Foucauldian analysis has shown at a broader level the wider issues that are represented in recovery stories. It has facilitated the exploration of hidden influences and relations of power which are implicit in people's talk about recovery, and has strengthened previous findings (McWade, 2016; Harper & Speed, 2012). Recovery research has usually tended to focus on personal experience and feelings, and as important as this is, it is useful to gain a more complete picture in the context of genealogy.

4.4. Implications

This section will outline the implications of the research findings for the discipline of clinical psychology, particularly through a consideration of its ‘core competencies’ as they are currently constituted (British Psychological Society, 2010).

Clinical implications. Clinical psychologists who are predominantly employed within NHS and independent sector mental health services, will no doubt be working within recovery-oriented services, or with recovery teams, and with people in distress who have come to know about something called ‘recovery’. Indeed, a ‘recovery approach’ is advocated in best practice guidelines. This research calls for clinical psychologists (and other practitioners) to consider their position in relation to dominant contemporary discourses of recovery, and with this in mind, how they can support service users who take up recovery in the varying ways highlighted here.

A core competence of clinical psychologists is ‘transferable skills’ which describes the expectation that they are able to adapt to novel situations though a flexibility of approach, drawing from a wide range of theoretical models and knowledge (BPS, 2010). On the one hand this can be seen to fit neatly with the variety of recovery discourses that have been spoken about. However, this multi-tooled, flexible approach could be at risk of being misused, by ‘going with the flow’ and ‘fitting in’ with the dominant discourse of a particular group, service or organisation. This research calls for clinical psychologists to use their knowledge and transferable skills not to simply ‘fit in’, but rather to be able to step back and understand how they might be pulled into certain practices, and to reflexively be aware of this danger.

There are treatment implications for clinical psychologists. As a discipline, psychology generally maintains the dominant discourses of individualism and responsibilisation (Smail, 2005) that also dominates the current recovery approach, and the profession would do well to seek ways to resist this. One such site of resistance might be carried out in the practice of assessment, therapy and formulation, where clients bring their ‘stories’ and psychologists’ are placed in a powerful position of theorising, influencing or leading those stories in particular directions. Bringing subject positions into awareness (Holloway & Jefferson, 2005), and knowing about different interpretations of recovery (including critical and less dominant versions) might allow for practitioners and service users to make more ‘conscious’ decisions about their recovery, or for people to feel ‘empowered’ to speak about differing ideas to those they may have come across in publicised recovery stories.

Furthermore, post-structural therapies such as narrative therapy (White, 1995) which consider dominant and subjugated discourses (or ‘thick and thin’ narratives) could also play their part in this. Psychologists are in a strong position to offer this space, and to listen out for resistance and quieter voices (counter discourses) in their consultations – and also for what is not, or cannot, be spoken. I believe it is an ethical responsibility for psychologists to facilitate this, and to be able to ‘step outside’ (as much as possible) of the dominant discourse (Sugarman, 2015).

The use of ‘power-mapping’ (Hagan & Smail, 1997) could be employed by psychologists’ (and services) to resist discourses of individualisation and normalisation centred around traditional recovery outcomes. Power-mapping involves an exploration of how different sites of power (distal and proximal) influence mental health development and deterioration, as well as offering possibilities for change (Smail, 2005). Such considerations should be incorporated into assessment, formulation or intervention to offer opportunities for counter discourses to emerge. Furthermore, power-mapping would support clinicians and users of services to be able to think realistically about what kind of ‘recovery’ is possible given the available resources in their wider context. Similarly, the UnRecovery Star (Recovery in the Bin, 2017) can also usefully be employed within traditional recovery services to provoke engagement and thoughtful consideration with the macro-level influences on people’s lives.

Apparent in the constructions was a side-lining of ordinary human dependence, with a privileging of autonomy. To resist this, clinical psychologists might seek to foster *interdependence* through supporting the creation of protected spaces for this to happen. Community psychology (e.g. Orford, 1992) offers insight into how psychology can be carried out as a communal project. As an example, the *Psychology in the Real World* type of groups (Holmes, 2013) provide opportunities for people to come together in groups over a shared interest and to explore, for example, differing theories about mental health development/deterioration. These groups support the aims of facilitating *thinking about things* within collective groups so that people can make informed and empowered choices or create change within the world they live in. In this way, people might have some scope to influence their subjugation to dominant discourses. The following quote illustrates the point:

> *“He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously upon himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection”* (Foucault, 1975/1991, p. 203).

I am convinced that organising groups informed by principles of community psychology is a really important project in terms of loosening the hold of dominant power/knowledge structures. Such groups offer ways for people to share knowledge, critique, and thus facilitate counter discourses to operate.

Governmentality works through targeting subjectivity. Clinical psychologists are in positions of trust whereby they have access to peoples' subjectivities on a daily basis (a powerful position). They might, perhaps unwittingly, preserve and perpetuate the neoliberal values of producing autonomous and self-managing subjects through practices of, for example, positive psychology (Sugarman, 2015). It would seem imperative that any theoretical model employed is used in a fully reflexive manner, embracing an appreciation of the subject positions it may promote or silence.

Alongside this, it is imperative that psychologists work in ways that promote an intrinsic awareness of the social, political and economic obstacles that make 'recovery' possible, or, as it might stand, impossible. Indeed, good practice guidelines advocate an awareness of the wider societal factors when undertaking psychological formulation (BPS, 2011). I would advocate for this, but also suggest for such factors to be explicitly included in every formulation.

In light of this, a critically discursive reflexive stance seems vital to undertake clinical practice in a socio-politically aware and ethical manner. Practitioners are encouraged to pose questions to the taken-for-granted dominant 'truths' of recovery and pay attention to the ways in which it becomes a politically-loaded term which can hinder rather than help, or disempower rather than empower, those it seeks to support. Psychologists working within the NHS might consider producing discursive research of service initiatives, alongside the traditional audit cycle. This is ever-necessary in the current climate of neoliberalism and cuts to welfare and health services. A naivety about the history of mental health practice by clinical psychologists' has been noted by Pilgrim (2010). Training which incorporates a genealogical perspective alongside 'truths' could be very important in fostering critical reflexivity, and an awareness of ways to resist rather than perpetuate oppressive powers.

Sugarman (2015), in his essay on ‘neoliberalism and psychology ethics’, questions whether psychologists *“are acting ethically in preserving the neoliberal status quo”* (p. 115). He calls upon their ‘social responsibility’ and for a need to carefully examine their relationship to neoliberalism and the consequences on the population they serve. For psychologists to comprehend different versions of recovery means facing some discomfort at the part the profession has played in upholding a responsibilised discourse that has allowed dominant versions of recovery to take hold. Clinicians should look beyond the dominant discourses of hope and responsibility, and listen for the counter-discourses in their patients’ stories and in the power structures of the society in which they are living, so as to support meaningful change.

NHS recovery workshops which foster the writing and sharing of recovery stories are called upon to consider the findings of this research. Their commendable work should also consider incorporating shared or collective storytelling workshops which actively encourage reflection of wider influences on individual recovery endeavours, as Costa *et al.* (2012) promote. This would help to resist the responsibilisation of recovery promoted through stories, as well as encouraging a level of activism for socio-political change (Costa *et al.,* 2012).

Wider implications. Austerity measures have had a significant and deleterious effect on the recovery environment. Clinical psychologists, who are working within the universally acknowledged mental health crisis are in a very influential position to press for change in mental health funding and a general improved welfare environment. An example is of the campaigning group *Psychologists Against Austerity* who have produced a briefing paper making use of psychological theory to this affect (McGrath, Griffin & Mundy, 2015). Pressure can be placed on professional bodies to take action too. An example of this having an effect is the recent position statement published by the British Psychological Society which outlines its opposition to benefit sanctions (BPS, 2018). It states the negative effect that welfare sanctions have on mental health.

The research calls into question the helpfulness and reliability of dominant discourses available within policy and its direction, well-meaning though they may be. Clinical psychologists', or their professional bodies, might effect change by involving themselves and in the third sector more directly.

Furthermore, the research indicates how dominant discourse can work to take hold of all aspects of an organisation, even that which is promoted as 'personal'. McWade, Milton and Beresford (2015) eloquently argue for a future of 'Mad Studies' in academia and research which seeks a collective activism with marginalised groups of people, to effect social change. They conclude with the following, which holds great relevance for implications here.

> *"It is 'time to talk', and not in the way the establishment wants us to, with individualised and neatly packaged tales of recovery. Instead, let us build upon the rich histories of activism and bring our shared experiences of oppression and marginalisation together."* (McWade, Milton & Beresford, 2015, p. 398).

Research implications. This thesis has contributed towards a growing body of research and literature which is questioning the way in which recovery is being used. The thesis was novel in its approach to analysing pre-existing data which is in the public domain.

Future research might be interested in understanding how these discursive constructions are constituted or resisted by people using services through conducting research interviews, rather than collecting data already available. Interviewing people in research outside of the theorised 'constraints' of the organisational context might generate slightly different dominating discourses, and support an understanding of how people can become constrained by organisational power and ‘truths’.

Qualitative research which interviews people about their recovery journeys might do well to supplement a Foucauldian approach with ‘realist’ data – for example, collecting information on the individual socio-economic contexts of those employing the discourses (housing status, for example). This might allow for a more thorough analysis of how discourses of recovery work within their socio-economic environment.

Furthermore, interviewing people who actively resist ‘recovery’ seems important. However, one would want to remain sensitive to not re-producing power dynamics in the research process through using research ‘subjects’ in this way. Finding a way forward that is truly participatory or user led seems imperative. There are research paradigms available which seek to address this aspect of power relations in research, such as participatory action research (e.g. Baum, MacDougall & Smith, 2006).

4.5. Conclusions

The research provides a new angle on understanding recovery through recovery stories. Through a Foucauldian lens this research was able to discern how recovery is constructed by people given voice within third sector and public health organisations. The analysis indicated multiple, overlapping and competing discursive formations with differing prominence. The dominating discourse of government policy provides the backdrop for these constructions, being largely supported yet with small but defiant challenges emerging. The research shows the powerful interests at play under the discourse of recovery, and the promotion of particular ‘truths’ that this brings with it. Counter to this, are smaller voices trying to swim against this, though at times paradoxically working to support these powerful interests.

Foucault (1980) shows how, through the obscurity of mechanisms of power, forms of knowledge are given a ‘truth’ status. I think this research helps to understand that simply disposing of the term ‘recovery’ would probably not result in the loss of the dominant discourses that construct it. Rather, this might be modified through informed knowledge, critique and exposure of its ‘counter memory’, to which this research hopes to have contributed. Furthermore, it calls into question the assumption that recovery can be an attainable goal (or process) within a climate of welfare cuts and shrinking public services.

Critical professionals and their organisations have a role to play in the evolution of power and knowledge regarding recovery. Ultimately both service users and professionals benefit from an ‘informed’ engagement with this evolution. Knowledge and power can be steered in this way, thus constituting legitimate hope. Poole (2011) refers to this as developing and working toward a ‘critical recovery’, which accords well with the findings here.

4.6. Reflexivity

Reflexivity within critical discursive psychological research must pay attention to where knowledge is coming from, keep a theoretical critical distance and hold in mind complex subjectivity (Parker, 2002). I agree with Harper (2003) that it is problematic to claim to wholly *know* oneself and where one’s knowledge comes from, and that reflexivity needs to be much more than simply about ‘confessing’ and being ‘open’ (Parker, 1999). Rather, I think it is about an *engaged* continuous process between research, self and wider structural conditions. This maps onto the tensions I felt at times during the writing between my own differing subjectivities as psychologist, as student, as psychoanalytic patient, as white and middle class, and as single, to name a few examples of my subjectivity profile.

Reflexivity gives rise to the researcher’s personal engagement with the research, where there is scope to feel *“immersed, overwhelmed and sometimes of being transformed by the subject matter”* (Parker, 2002, p. 18). This made me think that critical researchers are perhaps always attempting to look *beyond* what is given or true, and perhaps always just a little *beyond* what feels safe. It speaks to the sheer excitement of research but also the self-struggle, and even danger, inherent in reflexive critical research. Albeit not discussing research per se, and rather more dramatically (but perhaps necessarily so), Hélène Cixous’s well known verse captures this struggle well:

> *“The only book that is worth writing is the one we don’t have the courage or strength to write. The book that hurts us (we who are writing), that makes us tremble, redden, bleed.”* (1993, p.3).

Furthermore, the feminist argument ‘the personal is political’ speaks to how the researcher needs to hold both an inward and outward stance simultaneously throughout the research – one needs to consider personal involvement in the process of ‘discovering’ discourses (Harper, 2003). To appreciate the personal as political is to explore how issues of subjectivity and identity function within objective ‘truths’ such as socio-political contexts (Parker, as cited in Papadopoulos & Shrabe, 2004). ‘Personal’ matters need to be determined and understood in the context of political analysis.

I do not seek to ‘confess’ here but rather to trace how my research interest emerged, and thus provide insight into the worlds I inhabit as researcher. Early in my career, working within various adult mental health services, I had become absorbed in, and enamoured of, the concept of recovery after my attendance at a Mind conference around the time of the launch of *New Horizons* (Department of Health, 2009). I worked as a ‘recovery champion’, I ran recovery groups and I completed recovery stars with those with whom I worked. I lived and breathed it. However, as time went on I felt a growing dis-ease and had more and more questions about what recovery actually was and *how* it was being used by professionals for their own interest or desires.

This discomfort and confusion about recovery hardened after working in a secure service which had started to introduce the concept at an organisational level – they had a new recovery ‘lead’ but I could see little realistic change for service users, especially those who were deemed ‘uncompliant’ with the ‘new’ recovery spin. Furthermore, I had become slightly uncomfortable with the ways in which the service user voice and their experience was at times ‘used’. Alongside this I became interested in the politics of the NHS, as I too often witnessed the sad and tragic effects on service users and staff of the ‘cost-effective’ NHS, as well as the consequences in my personal life. Coming across Foucault and discourse spoke to something of the questions and problems that had been troubling me.

Using Foucault’s methods in my research has been a novel idea for me, as his concepts were unfamiliar, but I had really hoped to be taken slightly *beyond* my comfort zone and to broaden my horizons regarding the nature of the realities we inhabit. There is a certain ‘mystification’ of Foucauldian discourse analysis (Harper, O’Connor, Self & Stevens, 2008), without a sure ‘recipe’, which thus requires a level of authority, and confidence in, myself as researcher.

Reflexivity involves an interaction with ethics. During the analysis I was sometimes preoccupied with the ethics of interpreting the words of others, the power I held as researcher (Parker & Burman, 1993) and, as Harper (2003) draws attention to, of harming people’s original utterances (Stainton-Rogers, 1991). It has been noted how an overemphasis on reflexivity can produce a ‘research paralysis’ in this way (Parker & Burman, 1993). There were periods during the analysis where I felt a level of identification with the stories, particularly during times of parallel processes of the writing of this thesis, which had contributed to a type of ‘self-struggle’. However, throughout the analysis this seemed to naturally progress to a thoughtfulness which supported a sensitivity to keeping analysis at a discursive level and not letting *intentionality* slip into my analysis, as Harper (2003) eloquently describes. The discursive researcher is concerned with *“not the person who uses the discourse, but [rather] the discourses that are available to be used that set the parameters of talk”* (Speed, 2011, p. 125).

The subject positions that I myself inhabited within this discourse of recovery no doubt affected my analysis, a pertinent reason for reflexivity. I attempted to preserve neutrality through being aware of how I, for example, as trainee psychologist, might often read language *through* particular psychological theory, and by casting a ‘third eye’ over my analysis. This need to be resistant to ‘certain’ ‘truths’ reminded me of Keats’ notion of ‘negative capability’:

> *“When a man is capable of being in uncertainties, mysteries, doubts, without any irritable reaching after fact and reason.”* (Keats, as cited in Rycroft, 1995, p.108)

Reflexivity necessitated, at times, a level of confusion and uncertainty to avoid falling into ‘fact and reason.’ Immersing myself in literature related to the genealogy, as well as connected fields and disciplines, supported this critical position on my own knowledge claims as I read through the dataset. Related to this, I took effort to increase my awareness around political history, cultural trends and social developments (Parker & Burman, 1993).

5. **References**

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6. Appendix A: Web Sources

Table illustrating web-sources from which the data were extracted.

N	*Web-link*	*Organisation details*	*Type*	*Format*	*Year of pub.*	*Words*
1	https://www.centreformentalhealth.org.uk/nashs-story	Centre for Mental Health	First person testimony	Written	2016	1,018
2	https://www.centreformentalhealth.org.uk/pennys-story	Centre for Mental Health	First person testimony	Written	2016	678
3	https://www.centreformentalhealth.org.uk/sharons-story	Centre for Mental Health	First person testimony	Written	2016	633
4	https://rethink.org/living-with-mental-illness/recovery/recovery-challenges/acceptance	Rethink Mental Illness	First person testimony (+ psycho-ed)	Written	n.d.	306 (+ 106)
5	https://rethink.org/living-with-mental-illness/recovery/recovery-challenges/gaining-control	Rethink Mental Illness	First person testimony (+ psycho-ed)	Written	n.d.	230 (+162)
6	https://rethink.org/living-with-mental-illness/recovery/recovery-challenges/interdependence	Rethink Mental Illness	First person testimony (+ psycho-ed)	Written	n.d.	133 (+123)
7	https://www.youtube.com/watch?v=2E54NTi6Xow	Rethink Mental Illness	Three people being interviewed	Video	2016	772
8	https://www.youtube.com/watch?v=7BHKV2_wiik	Time to Change	First person testimony	Video	2013	493

9	https://www.youtube.com/watch?v=purscrXmygc&feature=youtu.be	South London and Maudsley NHS	Four people being interviewed (part 1)	Video	2010	1,249
10	https://www.youtube.com/watch?v=G6I7Ud2zZfc	South London and Maudsley NHS	Four people being interviewed (part 2)	Video	2010	1,076
11	https://www.youtube.com/watch?v=dVgI1AatSEg	Mind	First person – 'vlog'	Video	2016	553
12	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	902
13	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	570
14	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	669
15	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	805
16	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	615
17	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	296

18	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	483
19	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	198
20	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	368
21	http://www.healthtalk.org/peoples-experiences/mental-health/experiences-psychosis/recovery	Health Talks	First person	Video	2014	837
22	https://www.scottishrecovery.net/resource/gareth-jones-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2017	489
23	https://www.scottishrecovery.net/resource/laura-mcglinn-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2017	442
24	https://www.scottishrecovery.net/resource/emma-goodlad-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2017	493
25	https://www.scottishrecovery.net/resource/gabby-quinn-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2017	450
26	https://www.scottishrecovery.net/resource/an	Scottish Recovery Network	First person	Written	2017	530

	gela-mccrimmon-what-recovery-means-to-me/					
27	https://www.scottishrecovery.net/resource/len-northfield-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2016	379
28	https://www.scottishrecovery.net/resource/lorna-stewart-what-recovery-means-to-me/	Scottish Recovery Network	Poem	Written	2016	428
29	https://www.scottishrecovery.net/resource/chik-j-duncan-what-recovery-means-to-me/	Scottish Recovery Network	Poem	Written	2016	568
30	https://www.scottishrecovery.net/resource/pete-white-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2016	488
31	https://www.scottishrecovery.net/resource/ron-coleman-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2016	514
32	https://www.scottishrecovery.net/resource/tommy-addison-what-recovery-means-to-me/	Scottish Recovery Network	First person	Written	2016	276
33	https://recoverydevon.co.uk/creative_work/what-recovery-means-to-me/	Recovery Devon	First person	Written	2014	1,500
34	https://recoverydevon.co.uk/creative_work/elsie-s-story/	Recovery Devon	First person	Written	2013	229

35	https://recoverydevon.co.uk/creative_work/richie-s-story/	Recovery Devon	First person	Written	2013	430
36	https://recoverydevon.co.uk/creative_work/john-seeker-after-truth-2/	Recovery Devon	First person	Written	2013	1142
37	http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf	Camden and North West London NHS	First person	Written	2014	962
38	http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf	Camden and North West London NHS	First person	Written	2014	1,110
39	http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf	Camden and North West London NHS	First person	Written	2014	859
40	http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf	Camden and North West London NHS	First person	Written	2014	1,282
41	http://www.cnwl.nhs.uk/wp-content/uploads/CNWL-Recovery-and-hope_-RC-Stories-Booklet_.pdf	Camden and North West London NHS	First person	Written	2014	911

7. Appendix B: Ethics Approval Form

University Ethics application approval form.

University of Essex

10 August 2017

MISS SARAH MADDERS
FLAT 3
KENSINGTON COURT
47 ROMAN ROAD
COLCHESTER
ESSEX
CO1 1UR

Dear Sarah,

Re: Ethical Approval Application (Ref 16093)

Further to your application for ethical approval, please find enclosed a copy of your application which has now been approved by the School Ethics Representative on behalf of the Faculty Ethics Committee.

Yours sincerely,

Lisa McKee
Ethics Administrator
School of Health and Human Sciences

cc. Research Governance and Planning Manager, REO
Supervisor

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University of Essex

Application for Ethical Approval of Research Involving Human Participants

This application form must be completed for any research involving human participants conducted in or by the University. 'Human participants' are defined as including living human beings, human beings who have recently died (cadavers, human remains and body parts), embryos and foetuses, human tissue and bodily fluids, and human data and records (such as, but not restricted to medical, genetic, financial, personnel, criminal or administrative records and test results including scholastic achievements). Research must not commence until written approval has been received (from departmental Director of Research/Ethics Officer, Faculty Ethics Sub-Committee (ESC) or the University's Ethics Committee). This should be borne in mind when setting a start date for the project. Ethical approval cannot be granted retrospectively and failure to obtain ethical approval prior to data collection will mean that these data cannot be used.

Applications must be made on this form, and submitted electronically, to your departmental Director of Research/Ethics Officer. A signed copy of the form should also be submitted. Applications will be assessed by the Director of Research/Ethics Officer in the first instance, and may then passed to the ESC, and then to the University's Ethics Committee. A copy of your research proposal and any necessary supporting documentation (e.g. consent form, recruiting materials, etc) should also be attached to this form.

A full copy of the signed application will be retained by the department/school for 6 years following completion of the project. The signed application form cover sheet (two pages) will be sent to the Research Governance and Planning Manager in the REO as Secretary of the University's Ethics Committee.

1. Title of project:
   A discourse analysis of recovery stories.

2. The title of your project will be published in the minutes of the University Ethics Committee. If you object, then a reference number will be used in place of the title.
   Do you object to the title of your project being published? Yes ☐ / No ☒

3. This Project is: ☐ Staff Research Project ☒ Student Project

4. Principal Investigator(s) (students should also include the name of their supervisor):

Name:	Department:
Sarah Madders	Clinical Psychology, School of Health and Social Care
Danny Taggart	Clinical Psychology, School of Health and Social Care

5. **Proposed start date**: ~~July~~ 10th August 2017
6. **Probable duration**: three months

7. Will this project be externally funded? Yes ☐ / No ☒
   If Yes,

8. What is the source of the funding?
   Funded by Health Education East of England as part of a doctoral degree.

9. If external approval for this research has been given, then only this cover sheet needs to be submitted

External ethics approval obtained (attach evidence of approval) Yes ☐/ No ☒

Declaration of Principal Investigator:

The information contained in this application, including any accompanying information, is, to the best of my knowledge, complete and correct. I/we have read the University's *Guidelines for Ethical Approval of Research Involving Human Participants* and accept responsibility for the conduct of the procedures set out in this application in accordance with the guidelines, the University's *Statement on Safeguarding Good Scientific Practice* and any other conditions laid down by the University's Ethics Committee. I/we have attempted to identify all risks related to the research that may arise in conducting this research and acknowledge my/our obligations and the rights of the participants.

Signature(s): SMadders

Name(s) in block capitals: SARAH MADDERS

Date: 31st July 2017.

Supervisor's recommendation (Student Projects only):

I have read and approved the quality of both the research proposal and this application.

Supervisor's signature:

Outcome:

The departmental Director of Research (DoR) / Ethics Officer (EO) has reviewed this project and considers the methodological/technical aspects of the proposal to be appropriate to the tasks proposed. The DoR / EO considers that the investigator(s) has/have the necessary qualifications, experience and facilities to conduct the research set out in this application, and to deal with any emergencies and contingencies that may arise.

This application falls under Annex B and is approved on behalf of the ESC ☑

This application is referred to the ESC because it does not fall under Annex B ☐

This application is referred to the ESC because it requires independent scrutiny ☐

Signature(s):

Name(s) in block capitals: WAYNE Wilson

Department: S.H.S.C.

Date: 9/8/2017

The application has been approved by the ESC ☐

The application has not been approved by the ESC ☐

The application is referred to the University Ethics Committee ☐

Signature(s):

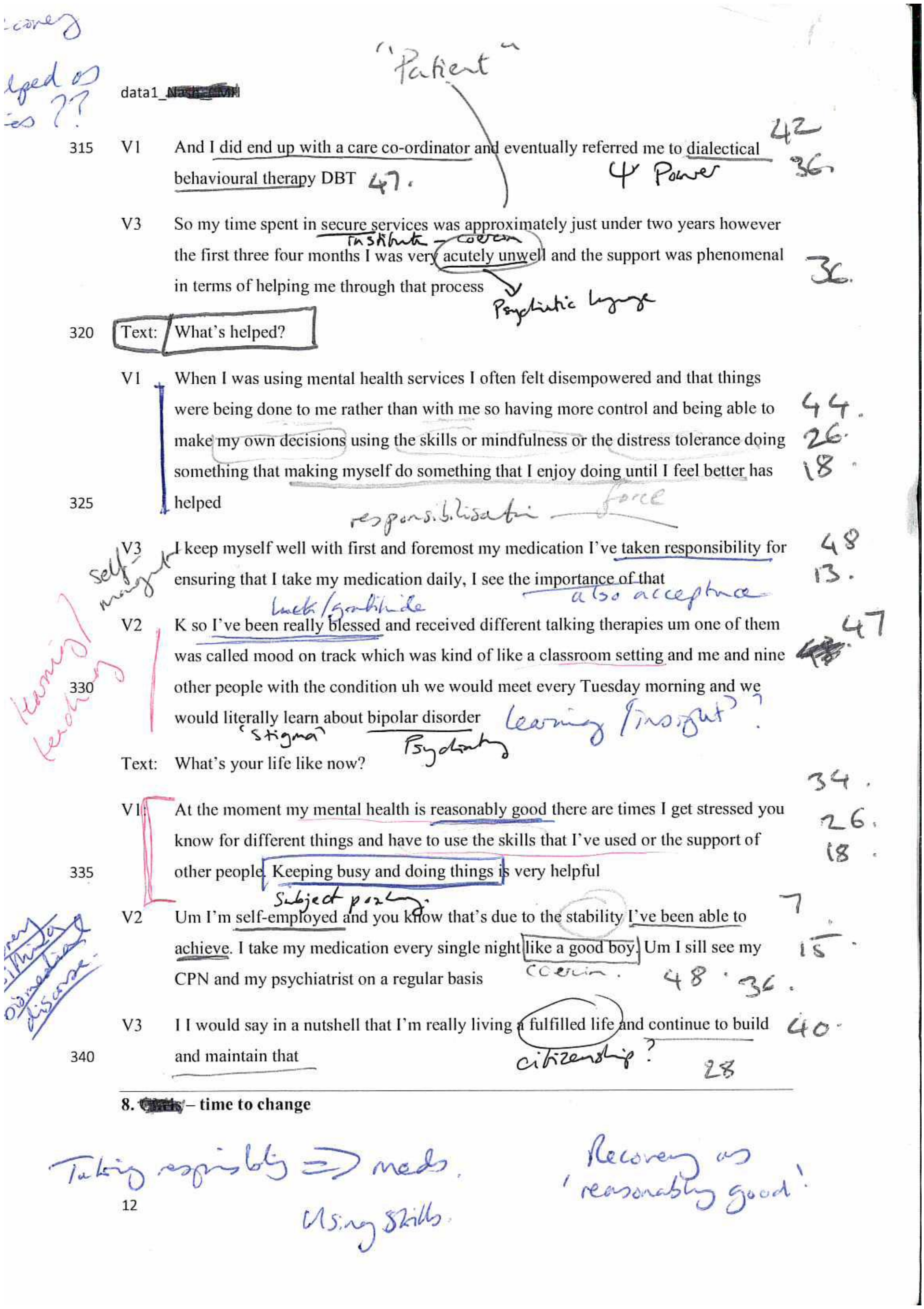
Name(s) in block capitals:

Faculty:

Date:

8. Appendix C: Example Data Extract

Example data extract illustrating hand annotations.



covery

lped as
es ??

data1_[redacted]

"Patient"

V1 And I did end up with a care co-ordinator and eventually referred me to dialectical behavioural therapy DBT 47.

42
36.
4 Power

V3 So my time spent in secure services was approximately just under two years however the first three four months I was very acutely unwell and the support was phenomenal in terms of helping me through that process

Institute – coercion
Psychiatric language
36.

Text: What's helped?

V1 When I was using mental health services I often felt disempowered and that things were being done to me rather than with me so having more control and being able to make my own decisions using the skills or mindfulness or the distress tolerance doing something that making myself do something that I enjoy doing until I feel better has helped

44.
26.
18.
responsibilisation — force

V3 I keep myself well with first and foremost my medication I've taken responsibility for ensuring that I take my medication daily, I see the importance of that

self-management
48
13.
also acceptance

luck/gratitude

V2 K so I've been really blessed and received different talking therapies um one of them was called mood on track which was kind of like a classroom setting and me and nine other people with the condition uh we would meet every Tuesday morning and we would literally learn about bipolar disorder

47
learning/teaching
learning/insight??
'stigma'
Psychiatry

Text: What's your life like now?

34.

V1 At the moment my mental health is reasonably good there are times I get stressed you know for different things and have to use the skills that I've used or the support of other people. Keeping busy and doing things is very helpful

26.
18.
Subject position.

V2 Um I'm self-employed and you know that's due to the stability I've been able to achieve. I take my medication every single night like a good boy. Um I sill see my CPN and my psychiatrist on a regular basis

7
15.
coercion.
48. 36.

V3 I I would say in a nutshell that I'm really living a fulfilled life and continue to build and maintain that

40.
citizenship?
28

[illegible] within biomedical discourse

8. [redacted] – time to change

Taking responsibility => meds.

Using skills.

Recovery as 'reasonably good'!

12