A FOUCAULDIAN DISCOURSE ANALYSIS OF 'MENTAL HEALTH RECOVERY' TALK

HARRIET KEZIA WALKER

1820415

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ABSTRACT

Constructions of ‘mental health recovery’ derive from varying discourses and differing philosophical assumptions. ‘Biomedical’ and ‘rehabilitative’ constructs appear to dominate the current literature, practice, and policy. Nonetheless, a critical discourse has emerged which challenges these constructions, their use in policy and their wider implications for understanding psychological distress. This research aimed to explore how ‘mental health recovery’ is being constructed in mental health services by those with a significant responsibility concerning the development and provision of care. The purpose was to gain an understanding of how these different ways of talking about ‘recovery’ are indicative of wider social and political struggles and to enable the exploration of possible ideological ramifications on service provision.

Seven mental health practitioners, holding Band 7 positions and above, were interviewed. A Foucauldian discourse analysis, aligned with a critical realist social constructionist position, was used to analyse the transcripts. Analysis identified four main discursive constructions of ‘mental health recovery’: (1) recovery as being well (2) recovery as an ongoing process (3) recovery as being achieved through pluralism (4) recovery as taking place in the interaction with others. The first two constructions were considered to uphold and privilege dominant understandings of psychological distress and ‘recovery’, with the second two interpreted as a resistance to prevailing power structures. Overall, ‘recovery’s’ use in neoliberal policy and practice is argued as problematic considering participant’s constructions of a subjective, relational, and pluralistic process.

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ABBREVIATIONS

BPS: British Psychological Society

CBT: Cognitive Behavioural Therapy

DSM: Diagnostic and Statistical Manual of Mental Disorders

FDA: Foucauldian Discourse Analysis

HCPC: The Health and Care Professions Council

IAPT: Improving Access to Psychological Therapy

ImROC: Implementing Recovery through Organisational Change

MS Teams: Microsoft Teams

NHS: National Health Service

NICE: National Institute of Clinical Excellence

RITB: Recovery in the Bin

UEL: University of East London

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1 CHAPTER 1: INTRODUCTION

1.1 Setting the scene

Improving Access to Psychological Therapies (IAPT) was an ideological vision based on minimising the welfare benefit-cost burden of 'common' mental health difficulties to public spending (Wakefield et al., 2021). Whilst the principal objective of the 2008 rollout was one of economic productivity (Scanlon & Adlam, 2010), the programme commendably publicised the scarcity of mental health provision across the United Kingdom (UK) and presented a non-pharmacological 'treatment' alternative to anxiety and depression (Lewis, 2012). IAPT provides evidence-based, standardised, and protocol-driven psychological therapies, applying routine outcome monitoring to measure its efficacy. Endorsed by mental health policy (such as The Journey to Recovery- The Government's Vision of Mental Health Care*,* Department of Health, 2001), the promotion and enactment of 'mental health recovery' became integral to the economic and social imperatives of the time (Howell & Voronka, 2012). It is within this context that 'recovery' was presented as a new vision and key target for mental health services with the potential to alleviate pressure on the welfare state. The ensuing consequences of this approach, however, appear to have inadvertently changed the provision of psychological therapies throughout the UK, with many citing it as the demise of other therapies being available on the National Health Service (NHS) (Jackson & Rizq, 2019; Lewis, 2012; Mollon, 2009; Nuttall, 2016; Stephenson & Hale, 2020).

As a counselling psychologist in training, I have become accustomed to managing the tensions between mainstream Western understandings of psychological distress and the phenomenological foundation of my chosen profession. This research does not aim to contribute to the 'modality wars' and acknowledges from the outset that there

are many meaningful NHS mental health services and practitioners. Rather it critiques the real-world challenge that the healthcare system is becoming increasingly limited in its approach to the human experience, often underpinned by “problematic political and professional assumptions” (Scanlon & Adlam, 2010, p.10). From a counselling psychology perspective, there are many ways to engage with the human condition and this research hopes to contribute to a relational way of thinking that embraces a range of therapeutic approaches and perspectives (Cooper & McLeod, 2010). Influenced by post-modernist theory, counselling psychology was, after all, founded upon the diversity of therapeutic approaches. The pluralistic approach in counselling psychology “advocates the employment of various known methods of therapeutic enquiry and practice, in order to meet the clients’ needs” (Athanasiadou, 2012, p. 18). This includes a consideration of a psychosocial understanding of psychological distress and the possibility of moving beyond a focus on the individual (Kinderman, 2019; D. Rose, 2014; Tribe, 2019).

1.2 Background to the research

It was a trainee placement at an IAPT service that first piqued my interest in ‘mental health recovery’. Readers who have worked in an IAPT service may be acquainted with the little figure on screen that announces whether the client has “reliably improved”, “moved to recovery”, or “reliably recovered” (with corresponding celebratory arm movements). This ‘recovery’ relates to a reduction in the client’s routine outcome measure scores, i.e., symptom relief, throughout the therapeutic intervention, specifically where post ‘treatment’ scores move below the clinical cut-off (Clark & Oates, 2014). I wondered how someone’s multifaceted reality could be quantified like this; whether being “reliably recovered” was representative of experience; if it was an applicable concept to those affected by socio-cultural

inequalities; how it has been embedded into NHS policy, whether this is different to how mental health practitioners construct ‘recovery’, and so on. Of course, I could not follow each of these threads within the remit of this study, and, with an already sizeable body of literature on ‘mental health recovery’, I was able to satisfy some of my curiosity.

Within the literature, there is a multitude of discourses derived from differing philosophical assumptions. A literature search informed by genealogical inquiry allowed for the different epistemological antecedents of ‘mental health recovery’ to be reviewed, and how these subsequently justified different mental health interventions (Arribas-Ayllon & Walkerdine, 2017). A critical perspective emerged from the debate that not only challenges the biomedical paradigm but further queries the usefulness of the construct of recovery and its endorsement by mental health policy (McWade, 2016; M. Morrow & Weisser, 2012). Inspired by teaching from a postmodernist perspective and my first encounters with Foucault, I set out to explore how ‘mental health recovery’ is being constructed in our mental health services by those with a significant responsibility concerning the development and provision of care. My purpose is to enable the exploration of the ideological ramifications on service provision with a view to these implications being conveyed to those for whom it has significance, with particular relevance to counselling psychology’s social justice agenda (Cutts, 2013; Tribe, 2019).

1.3 Positioning the self

I am originally a languages graduate, living first in Madrid and then in Rio de Janeiro as part of my year studying and working abroad. It was during this time that I first considered how we categorise and understand the world can be culturally specific (Burr, 2006). My time with the Brazilian community, in particular, brought new meaning

to this when my deep longing for the city was understood by my companions as *saudade,* something that does not have a comparable meaning in English. It is perhaps my passion for these language intricacies and my many struggles with translation assignments that have been influential in drawing me to the social constructionist paradigm and particularly to the methodology adopted for this doctoral thesis: discourse analysis.

I hold a realist ontological position and a relativist epistemological position as a researcher. The critical realist, social constructionist approach acknowledges that although discourses are constructed and dependent upon social, historical, and cultural contexts, their wider implications are real. I recognise that this thesis is itself a construction and requires a critical focus on my knowledge-making practices. These are attended to using reflexivity that is embedded throughout the thesis. The thesis is written in the first person to highlight its construction and to represent that I, as the researcher, am inseparable from the work. I do not seek an objective truth as a result of the research, and it should be understood as one narrative amongst many others. As a counselling psychologist in training, I have tried to remain alert to my socialisation into “discourses and dispositions” shaped by the socio-political order I seek to challenge but acknowledge that this is a socio-political order that I may reproduce unconsciously (Alejandro, 2021, p. 154).

1.4 A note on language

Language, such as ‘mental illness’, is used and repeated in the field of counselling psychology research and beyond. I believe that these terms are loaded with assumptions, connotations, and have far-reaching consequences for how the human experience is pathologised and positioned in Western society (Parker et al., 1995). While I choose not to use these terms as a practitioner, I sometimes use them within

the research to accentuate their charged nature and use quotation marks to depict their social construction. The use of the word madness is in keeping with its grounding in resistance and provocation (Scull, 2015), and avoids the common association with 'illness' and 'disease' (Cromby et al., 2013). Reference to the human condition and/or experience, psychological needs, and distress are attempts to use language more aligned with my ontological and epistemological position, located within a counselling psychology framework. However, it is acknowledged that these terms also have their limitations. For example, 'mental health' is used with scepticism, recognising its use as a "euphemism for mental illness" (Edge & West, 2011, p.17); 'distress' is acknowledged as not capturing the full complexity or degree of suffering involved; similarly, I recognise that "not everyone who is psychiatrically labelled is in a state of distress" (Johnstone & Boyle, 2018, p.15).

1.4.1 Defining discourse

Discourse, and therefore discourse analysis, may have different meanings dependent upon the researcher's approach which is often shaped by specific "intellectual desires, problems, and institutional demands" (Arribas-Ayllon & Walkerdine, 2008, p. 91). My use of the term 'discourse' throughout the research is informed by a Foucauldian perspective and by post-structuralist ideas that are aligned with Arribas-Ayllon and Walkerdine's (2017) conceptualisation of discourse as "institutionalised patterns of knowledge that govern the formation of subjectivity" (p. 110). Within this understanding, discourse is considered as a set of ideas, attitudes, beliefs, and/or practices that construct representations of our common ways of understanding the world (Parker, 2015). Language, therefore, becomes a way in which we come to understand both ourselves and the cultural world we inhabit. This perspective also

offers ways of discussing how some means of talking about reality are privileged over others (Foucault, 1971).

From a post-structuralist position ‘mental health recovery’ can be understood as a discursively constructed object that carries social meaning and is historically and culturally variable. An ‘object’ like ‘mental health recovery’ is therefore constructed by multifaceted power relations and socially produced discourses. By problematising the discursive object and practice of ‘recovery’, the research allows me, as the analyst, to take up a critical position in tracing the historical emergence of ‘mental health recovery’ and how it is presently constituted and governed (Arribas-Ayllon & Walkerdine, 2017).

1.5 Literature review

1.5.1 Literature search

Various databases were used to review the existing literature concerning ‘mental health recovery’: The University of East London’s (UEL) generic search engine, EBSCO host, APA PsycArticles, APA PsycInfo, and Academic Search Complete.

Searches were conducted from May 2019 to January 2021 using a combination of the following terms: mental health recovery, mental illness recovery, recovery from mental illness, mental health AND recovery, mental illness AND recovery, recovery from AND mental illness, mental health OR mental illness OR mental disorder AND recovery, mental health AND recovery AND United Kingdom OR England OR Britain.

The review is predominantly concerned with the British literature for its relevance to the research aims but acknowledges that studies further afield have made significant contributions to the development of the concept. These studies are drawn upon to attend to the genealogical perspective of the literature review and where there is a paucity in the British literature concerning the current review.

1.5.1.1 Constructs of mental health recovery in the literature

'Mental health recovery' is considered a 'real', objective 'thing' within much of the existing literature. Within this critical literature review, however, it is suggested that 'recovery' is constructed. From this perspective, the concept of recovery is constituted by historical, social, cultural, and political factors. Although the present research is not a genealogical inquiry in itself, this chapter is informed by Foucault's questioning of the historical conditions of emergence. In Madness and Civilisation, Foucault (1988) appeals to the reader to make links between the language used by dominant social institutions and the implications for those who behave outside of the 'social norms'. Turner et al., (2015) further highlight that there is an absence of historical context in new focal points of service provision, such as 'mental health recovery'. I will therefore make use of historical narrative as a means of critically engaging with present 'truth claims' (Garland, 2014). This allows for the different epistemological antecedents of 'mental health recovery' to be explored and to examine how these have consequently justified different mental health practices and policies (Arribas-Ayllon & Walkerdine, 2017; Foucault, 1988). As mainstream ideas of 'recovery' appear based upon the aetiology of 'mental illness', this concept is traced as a starting point.

The following review details a complex assembly of professional and public ideologies, changing economic landscapes, Government policy, and resistance to all the above (Prior, 1993). It is organised to support readability and does not indicate a rigid chronology or linear emergence of the constructs of 'mental illness' or 'recovery'. I also acknowledge ancient Greek approaches to madness, the religious worldview of the Middle Ages, and the significant medical, scientific, and philosophical developments that took place in the Islamic world during this time (Cromby et al., 2012). However, to remain within the remit of this study the review explores how psychological distress

and ‘recovery’ from this experience came to be seen from approximately the 17th century onwards.

The nature of what is commonly known as ‘mental illness’ and what constitutes ‘recovery’ from this phenomenon are complex and contested issues, about which there is considerable current debate. There is a multitude of discourses of ‘mental health recovery’ emerging from the existing literature, deriving from differing ideological and philosophical antecedents. Two prominent constructs of ‘recovery’ emerged: a biomedical construct and a rehabilitative construct, with a further body of literature that is critical of the concept.

1.5.1.1.1 The biomedical construct

It was during the Enlightenment of 17th-century Europe, that an empirical view of knowledge superseded previous discourse, such as that of religious or royal decree (Plante, 2013). The turn to ‘reason’ and the construction of the autonomous mind saw a move away from humoral medicine and “served as the major rationalising device” for the foundations of a “systematic psychology” (Gergen, 2001, p. 805). René Descartes’s distinction between the mind and body had a momentous impact on medical thought and madness was progressively understood as an organic, rather than spiritual, entity. Scientific discourse was paramount in influencing new theories and ideas, and the widespread acceptance of Cartesian dualism justified medicine’s jurisdiction over the mad (Scull, 2011). This generalisation of disciplinary power from the confines of religious communities to the juridical and psychiatric institutions meant the “objectification of individuals became the means for their subjection and the subjection of individuals became the means for their objectification” (Hoffman, 2011, p.34). Soon, a loss of ‘reason’ was the cause for insanity and ‘recovery’ lay in the restoration of reason through torture, punishment, and torment (Whitaker, 2010). This

was a defining moment in history for Foucault (1971) whereby unreason “became the defining feature of madness” with psychiatry positioned as the “monologue of reason about madness” (Cromby et al., 2013, p. 27). In Foucault's (1988) subsequent exploration of madness, he argues that judicial and moral discourses were at the forefront of the ‘Great Confinement’, legitimising the exclusion of the mad to asylums as they deviated from the ‘norm’.

Counter discourse to the chronicity paradigm could be found in the idea of ‘moral management’ practiced by some 18th-century institutions such as the York Retreat. Cromby et al., (2013) highlight the emergence of a psychogenic model of madness whereby a more humanistic approach was seen to facilitate the development of ‘self-control’ within the mad. This made substantial contributions to the construct of ‘moral insanity’, based on the notion that other forms of insanity existed that were not solely caused by a loss of reason and that any number of people could be affected. Goldstein (1998) highlights that this was used by psychiatry to establish the profession’s public legitimacy.

> Here were ‘hidden’ disorders whose existence had implications for public safety. They were not available to the scrutiny of naive observation by lay witnesses, jurors or courts; but they could be detected by newly established experts in insanity (Jones, 2017, p. 266).

This not only bolstered the medicalisation of the mind but further implied the need for psychiatric expertise to identify these subtle yet threatening manifestations. In Britain, ‘moral insanity’ was further determined as a lack of ‘goodness’ within an individual and was said to be at the bottom of an “uneasy marriage” between the medical and legal systems (Hanganu-Bresch, 2019, p. 805). Unacceptable traits outside of the post-Enlightenment social norms were deemed a defect in character and the consequent

threat to social order called for condemnation (Jones, 2017; Millon et al., 2003). In the ensuing essentialist climate of psychiatry, degeneracy constructs became further linked with the individual brain and defended the need to regulate those who were unable to 'control' themselves. Rimke & Hunt (2002) neatly sum up the century's discursive transition from the Church to the institutions in the title of their paper: From Sinners to Degenerates.

The turn of the 20th century saw Emil Kraepelin's impactful ideas on classification and categorisation support the validation of psychiatry as a science, strengthen its union with medicine, and encourage additional degeneracy constructs of psychological difficulties (Allott et al., 2002). 'Diagnosis' advanced as a leading 'tool' that legitimised the authority of psychiatry, and the publication of the third Diagnostic and Statistical Manual (DSM) in 1980 reinforced the biomedical discourse around madness. The DSM-III differed from its predecessors in its presentation of diagnostic labels as the definitive truth, despite ambiguous empirical evidence that continues to be contested by many (Bentall, 2004; Johnstone & Boyle, 2018). Alongside advancing medical treatments, psychological therapies, and the growing cost of asylums, the 'management' of the 'mad' contributed to the move from care in psychiatric hospitals to care in the community.

Psychiatric labelling and the DSM (now in its fifth edition) still dominate amongst the contemporary practice of mental health care and the implications of locating these difficulties in individual minds can be seen in the market-driven rollout of manualised care (Rizq, 2012). It is no surprise then that the literature attempting to quantify 'recovery', considers an individual can be effectively 'diagnosed' with a biologically determined 'illness' (Pilgrim, 2008). Persisting from the Enlightenment, this literature often presents individuals as clinical cases in need of 'treatment', positioning them

within an illness framework that continues to facilitate objectification and the opportunity for social control (Hoffman, 2011). ‘Recovery’ is considered as an outcome and therefore understood as no longer meeting the ‘symptomatic criteria’ of an ‘illness’ or as returning to relatively ‘normal’ social and occupational functioning (Silverstein & Bellack, 2008). This ‘recovery’ is observable, binary, can be measured and investigated, and often does not vary between individuals (Slade et al., 2014; Weeks et al., 2011). This may also be synonymous with unsubstantiated claims about a restoration of the brain’s ‘chemical imbalances’ through the use of psychiatric medicine (Pilgrim, 2015).

Grounded within a biomedical paradigm, psychoanalysis and behaviourism were amongst the early psychological therapies that were used to ‘treat’ these newly diagnosable ‘illnesses’. Freud’s theory of the ‘psyche’ has been postulated as “the fullest elaboration of a psychogenic model” (Cromby et al., 2013, p. 37) during this time and ‘recovery’ was (and perhaps still is) accomplished by methods of free association and the interpretation of dreams. ‘Recovery’ from a behavioural therapy perspective, on the other hand, focussed solely on the changing of an individual’s behaviour before its synthesis with cognitive therapy. Despite their differences, both approaches consider that something is ‘faulty’ within the individual, propose causality when it comes to psychological distress, and suggest that this can only be treated through professional intervention.

As a fundamental part of modern practice, IAPT services enact the biomedical construct of ‘recovery’ in recording client-reported outcome measures of depression and anxiety during triage, assessment, and at each subsequent therapy session the client attends (C. Knight et al., 2020). If a client scores above the clinical cut-off for these measures prior to psychological input and below the cut-off afterwards, they are

deemed and recorded as “reliably recovered”. As of July 2017, 51% of clients that attended IAPT services nationally were considered to have ‘recovered’ (Clark, 2018). When reporting on “reliable recovery” rates, Gyani et al., (2013) suggest that service compliance with National Institute of Health and Care Excellence (NICE) treatment guidelines is associated with improved clinical outcomes and therefore with higher rates of ‘recovery’. However, as the principal ‘treatment’ option provided through IAPT, Cognitive Behavioural Therapy (CBT) has been repeatedly criticised for expecting the individual to take responsibility and help themselves with little power to change what may need changing, such as their socio-economic conditions (Loewenthal, 2018; Smail, 2005).

When concerned with recovery-orientated agendas, studies from a biomedical perspective have focussed on evaluating ‘recovery’ rates of ‘common mental disorders’ that include ‘psychotic’ experiences defined by service-level outcome measures (C. Knight et al., 2020). Studies have investigated the efficacy of interventions such as CBT on symptom reduction and wellbeing (Widnall et al., 2020) and examined the impact of early intervention models on functional outcomes of ‘recovery’, namely a return to paid employment (Fowler et al., 2009). Studies have also provided insight into mental health interventions that may reduce the severity of symptoms associated with experiences most commonly known as ‘schizophrenia’ and ‘psychosis’ (Harrison et al., 2001), which were once considered intractable ‘illnesses’. Whilst these studies challenge the chronicity paradigm of severe psychological distress (Ramon et al., 2007), the biomedical construct has often been criticised for being medicalised, reductive, and based upon a weak evidence base (Johnstone & Boyle, 2018).

1.5.1.1.2 The rehabilitative construct

It has been argued that the anti-psychiatry movement of the 1960s was one of the first conditions of possibility leading to the emergence of 'mental health recovery' from a rehabilitative perspective (Crossley, 2002). The movement, navigated predominantly by psychiatrists, criticised the prevailing construct of madness, psychiatry's power over an oppressed group of people, and called for a consideration of psychosocial causes of psychological distress. Pilgrim (2008) delineates between this movement, which still focussed on improving symptoms, and the psychiatric survivor movement of the 1970s and 1980s which focused beyond looking for a 'cure', to the liberation of those experiencing psychological distress (Harper & Speed, 2014). Activist groups, such as the Mental Patients Union and Survivors Speak Out, positioned themselves against psychiatry's theories and practices (Chassot & Mendes, 2015), and service user discourse highlighted the stigmatising impact of objectification, demanding an alternative framework for conceptualising the experience of madness. Other activists sought improvements in existing services rather than the creation of alternatives (S. Rose, 2001). From this perspective, 'recovery' has its roots in democratic and social rights discourses whereby service users are the expert of their own distress and are equal partners in making decisions about their 'treatment' (Jørgensen et al., 2020).

'Personal recovery' discourse emerged as an alternative construct to the biomedical perspective and involved the sharing of personal accounts of what it means to be 'mentally ill' and what helped to move beyond the subject position of 'patient' (Fernando, 2010). This alternative perspective emerged during a period where the post-deinstitutionalisation political Zeitgeist aligned with service user values of self-determination, increased personal responsibility, creating a fulfilling life within the limitations of 'mental illness', and regaining a 'positive' sense of self (de Jager et al.,

2016; Leamy et al., 2011; Slade, 2009). Anthony's (1993) conceptualisation appears to be the most cited in the literature and has been the basis for Government publications regarding ‘recovery’, as well as a defining feature of the Recovery College approach across the UK (Perkins et al., 2018).

> Recovery is described as 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 with 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. 7).

Mental health research studies specifically began to seek out narratives of ‘recovery’ contributing to the paradigm shift towards a ‘recovery approach’ in healthcare policy and practice (Llewellyn-Beardsley et al., 2019). Contributions to the literature were concerned with differing inputs to recovery-orientated services, highlighting the importance of art (Spandler et al., 2007), physical activity (Carless & Douglas, 2008), and employment (Fowler et al., 2009) in fostering ‘recovery’. These research topics reflect key issues in the rehabilitative construct such as an increased understanding of one’s own mental health difficulties, being able to engage in meaningful activities of the individual’s choice, and regaining confidence and independence (Wood et al., 2013). However, ‘recovery’ narratives appeared increasingly used by mental health services and campaigns as part of an agenda for service users to adhere to biomedical models, rather than presented as a rejection or reimagination of psychiatry (Woods et al., 2019).

In keeping with the Western inclination to produce nomothetic knowledge, many studies attempt to define and standardise ‘personal recovery’ (Le Boutillier et al., 2011), as well as to measure or aid this application in ‘recovery-oriented’ mental health

services (McLean, 2015; Smith-Merry et al., 2011; Weeks et al., 2011; Williams et al., 2012). The ‘recovery’ orientation of services refers to the degree to which mental health services and the attitude of staff endeavour to facilitate and promote ‘personal recovery’ (Fowler et al., 2009; Slade et al., 2014). Slade (2009) outlines his own framework for ‘personal recovery’, proposing what can and should be done by mental health professionals in recovery-oriented services through four ‘recovery objectives’. These focus on the mental health practitioner helping the service user to foster a positive identity, re-frame their experiences, and manage their own symptoms. McWade (2016) argues that someone like Slade who has “access to material and institutional power”, has used “recovery’s conceptual ambiguity” (p. 63) to manipulate the construct to align with dominant biomedical models of the human experience.

Leamy et al., (2011) similarly developed a conceptual framework of ‘recovery’ from the results of their narrative synthesis of a systematic review of 97 existing papers on ‘personal recovery’. They aimed to provide an empirically grounded framework for future recovery-oriented research and practice. The ensuing conceptual framework comprised three interconnected categories, which themselves contained five themes: values of recovery; beliefs about recovery; recovery-promoting attitudes of staff; the essential process of recovery; and the stages of recovery. The ‘recovery process’ contains further sub-themes, which are considered key to the ‘personal recovery’ process: connectedness; hope and optimism; identity; meaning and purpose; and empowerment (given the acronym CHIME). The CHIME framework has been implemented by various studies (predominantly by members of the CHIME research group) to validate the adequacy of pre-existing psychometric ‘recovery’ measures (Shanks et al., 2013); to develop a measure for staff support for ‘recovery’ (Williams et al., 2015); and to develop a “pro-recovery manualised intervention” (Slade et al.,

2015, p. 544) for use by mental health professionals. Stuart et al.,(2017) go on to propose the expansion of the CHIME framework to “CHIME-D”, by way of acknowledging the difficulties often faced by those trying to achieve ‘recovery’.

The survivor and consumer constructs of ‘recovery’ are argued to have been appropriated by mental health services, healthcare staff, research, and government policy which is now used to further disempower service users (Kalathil, 2007; Scanlon & Adlam, 2010). This co-opted construction of ‘recovery’ no longer seeks to challenge the basic epistemological claims of a biomedical experience and continues to carry the assumption that the ‘mentally ill’ are unable to live independently until they are cured of their ‘illness’ (Davidson, 2008). Responsibility remains with the individual but from this perspective, they are told to inwardly transform and develop skills to prevent relapse (Chassot & Mendes, 2015; Harper & Speed, 2014). The service user is expected to inscribe a vision of ethics within themselves, where the individual constitutes themselves as a moral subject of their own actions (Foucault, 1984). The central personal aspect of this discourse is said to be diluted, however, as the practicalities and constraints of service provision are imposed and a return to standardised outcome measures comes into play (Bonney & Stickley, 2008). The oppressive social structures the recovery movement worked to challenge remain firmly in the way of the rights of the mad (Davidson, 2008).

Moreover, the constructs of ‘race’, ‘gender’, ‘sexuality’ and ‘class’ remain almost unacknowledged and unexamined in much of the contemporary ‘recovery’ literature (Hopper, 2007; Wainberg et al., 2016), from either a biomedical or rehabilitative approach. Fernando (2010) highlights the dangers of the ‘recovery approach’ mimicking “the reductionist approach of western medicine” (p. 76), particularly if it continues to dismiss cultural diversity. Additionally, the emphasis placed on a personal

journey, may not align with individuals from a non-western cultural background where collectivism and community may be fundamental in supporting someone with their psychological needs. Stickley & Wright (2011) note that “it remains to be seen whether it is possible to bring together service users’ wishes and service provider obligations into a coherent system for mental health care” (p. 253).

1.5.1.1.3 Critical discourse

The acceptance and perpetuation of the limits imposed by ‘mental illness’ and the persistence of a deficit-laden view of the mad have been continuous landscapes for the varying conceptualisations of ‘recovery’ for over a century. The body of literature critiquing ‘recovery’ is small in comparison to the biomedical and rehabilitative constructs. A critique is emerging, but peer-reviewed journals within the British context are few and far between, particularly when in comparison to the Canadian context for instance (see M. Morrow & Weisser, 2012; Poole, 2014). Critiques are often based upon a more explicit social model where the authority of biomedical discourse in relation to mental health is seen to undermine broader social and structural understandings of ‘recovery’. From this perspective, “it is not bad genes, faulty cognitions or the Oedipus complex, but misfortune and the widespread abuse of power that mire so many in madness, addiction or despair” (Cromby et al., 2012, p.99). The counter-discourse presented here most often raises reservations with ideological, material, and practical relations of ‘recovery’, rather than how it is defined (Beresford, 2015).

‘Mental health recovery’ has been constructed as a Government strategy to cover up their economic failures to properly fund the welfare and mental health services, whilst shifting the ‘problem’ into the individual (Scanlon & Adlam, 2010). Whilst ‘recovery’s’ prospects and ideas are considered “seductive” (K. Turner et al., 2011, p. 345), they

are deemed misleading and dishonest by not doing enough to address social inequalities. Harper & Speed (2014) echo this problematisation of the focus on 'recovery' as an entirely positive newcomer in their documentary analysis of UK policy. They argue three consequences of the use of 'recovery' in a policy context, namely individualisation, the implicit persistence of deficit-based models, and the lack of focus on structural contributions to psychological distress. They conclude with a need for the implications of 'recovery' discourse to be further explored within the context of "structural experiences of distress, inequality, and injustice" (Harper & Speed, 2014, p.15).

The individualisation of social problems is something that is often problematised in critical discourse. McWade (2016) concurs with this view in their textual analysis of policy, arguing that "recovery-as policy is a form of neoliberal state-making that is discriminatory and unjust" (p.76). Rose (2014) comparably writes an editorial on the mainstreaming of recovery and explores how "liberatory discourse" became "instrumentalised and mainstreamed" (p. 217) to align with the neoliberal Zeitgeist of the 21st century. In keeping with the critique of individualistic discourse, they go on to suggest that the social world which we inhabit is rendered insignificant when the focus is placed on individual psychological makeup.

Other commentaries ask how someone is able to recover from something they never had in the first place and queries whether the 'recovery paradigm' is prepared or able to address the systemic disadvantages faced by those with experience of sexual violence, homelessness, unemployment, racism, and homophobia (Arenella, 2015). In the Canadian context, Morrow & Weisser (2012) call for an intersectional social justice framework for 'mental health recovery' which would comprise recognising the active discrimination faced by those diagnosed as 'mentally ill'; placing psychiatric

survivors at the forefront of mental healthcare development; changing the social welfare system to prevent the cyclical nature of poverty and dependence, and the continued challenge against biomedical discourse. As part of an 'anti-recovery' movement, Recovery in the Bin (RITB) is a user-led critical theorist and activist collective that is also calling for mental health to be placed within the context of social justice. Within their ten key principles, they echo that the concept of 'recovery' has been co-opted by policymakers, that autonomy can only be accomplished through a collective struggle, and that 'recovery' is an impossible expectation in the context of an oppressive society ('Recovery in the Bin', 2017). RITB recently named the "consequences of a politicised, poorly defined and understood 'recovery' in policy" (Edwards et al., 2019) 'neo-recovery', something they say is entirely unrelated to the original grassroots 'recovery vision' of the survivor movements.

Some papers are more accepting of existing structures of 'recovery' but highlight barriers in its realisation, such as stigma and discrimination, echoed in critical and counter-discourse. Instead, a rights-based approach is considered to address power relations and an alignment is made with the liberatory ambitions of the civil rights movement (Perkins, 2015; Repper, 2011). Not enough has been done to acknowledge diversity within the 'recovery' paradigm, with the findings of much of the literature generalised to all populations regardless of their social, ethnic, and cultural background. Tuffour et al., (2019) criticise the Eurocentricity of current conceptualisations of recovery and explore the experiences of Black African service users recovering from psychological distress. They used the results of their interpretative phenomenological analysis to form a conceptual framework of 'recovery' for Black African service users, depicted as six closely linked dimensions: clinical, spiritual, functional, resilience, identity, and social belongingness (Tuffour et al., 2019).

By advocating for a conceptualisation of 'recovery' that considers the socio-cultural contexts of other cultures, they aim to evaluate, rework, and contribute to the concept, rather than seeking to eradicate it. Comparably, on collecting 'positive' stories of 'recovery' from women within African, African-Caribbean, and South Asian communities, Kalathil, (2011) found that "for those who made sense of their mental distress in […] socio-cultural contexts, a significant part of recovery involved overcoming – or at least coming to terms with – oppressive experiences" (p. 28).

1.5.1.2 Recovery's emergence in policy

Introduced by a Conservative Government, the NHS and Community Care Act 1990 set the foundations for 'recovery-oriented' healthcare services in its outline of increased choice, empowerment, and service user rights (Clarke et al., 2007). This was institutionally realised through the commodification of mental health services and the introduction of the internal market within the NHS. Service users were consulted more and more to achieve services that were as cost-effective as possible (Cromby et al., 2013). The election of New Labour saw promises of a ten-year modernisation programme (Department of Health, 1999) and the introduction of being 'paid by results' within the NHS (Ramon, 2008). RITB notes that it is "glaringly obvious" (Edwards et al., 2019) that 'recovery's' role in policy during this time was largely underpinned by neoliberalism.

'Mental health recovery' came into full force in the 2001 Government paper The Journey to Recovery: The Government's vision for mental health care (Department of Health, 2001). Throughout the document, the healthcare system is presented as in crisis and change was to be accomplished through the safe and supportive services outlined in the modernisation programme. While there is some criticism of the medicalisation of psychological distress, the acknowledgement of any abuse and

neglect that took place within the system is located firmly in the past. McWade, (2016) highlights:

> In using the metaphor of ‘recovery’ to describe the modernisation of mental health services in ‘crisis’, policymakers appear to listen to patient voices. However, the history of user/survivor activism is precisely silenced in this policy commitment. Their challenges to concepts such as ‘lack of insight’, their critiques of the medicalisation of distress, forced treatment and detainment, and their assertion of expertise by experience are eradicated (p. 67).

Despite decisions said to be collaboratively made through the care programme approach (CPA), consultant psychiatrists persisted as powerful figures in the system and a focus continued to be placed on managing symptoms and a reduction of harm to self and others (Shera & Ramon, 2013).

Subsequently, the 2009 mental health strategy, New Horizons: A shared vision for mental health (Department of Health: Mental Health Division, 2009), used Anthony's (1993) conceptualisation of ‘recovery’ and explicitly specified that mental health services should be ‘recovery-focussed’. This entailed considering the significance of human rights to those who experienced psychological distress, as well as their future potential, right to be in control, and the importance of relationships in their lives (Perkins & Slade, 2012). Little was known, however, about how recovery-orientated services would be implemented and the ReFocus five-year project was launched to develop the evidence base to do so.

This policy was superseded by the Conservative / Liberal Democrat coalition Government strategy, No Health Without Mental Health (HM Government & Department of Health, 2011) which likewise offered six desired outcomes to improve

the population's mental health, despite simultaneously significantly reducing welfare provision (Cummins, 2018). The second of these outcomes makes 'recovery' an explicit goal and states that "more people with mental health problems will recover" and promised "better employment rates and a suitable and stable place to live" for the 'mentally ill' (HM Government & Department of Health, 2011, p.6). To support this government strategy, Implementing Recovery through Organisational Change (ImROC) was set up to transform mental health services. Originally a collaboration between the Centre for Mental Health and the NHS Confederation's Mental Health Network, ImROC is now a quasi-independent, not-for-profit organisation hosted by Nottinghamshire Healthcare NHS Foundation Trust (ImROC, 2021). ImROC first reviewed the challenges to implementing a recovery-oriented approach in 2009 and identified ten key organisational changes required by mental health services to address these, such as: changing the nature of day-to-day interactions with those experiencing psychological distress; 'genuine' co-produced learning opportunities between service users and staff; an understanding of, and commitment to a culture of 'recovery'; increased personalisation and choice of 'treatment' and support; a reduction in restrictive practice; and a move towards co-produced safety plans for risk management (Perkins & Slade, 2012). Being able to change the long-standing internalised identity of 'mentally ill' and the stigma attached to this was seen as entirely possible, but only when done by working with practitioners who genuinely believe that this was possible (Brohan et al., 2010). ImROC continues to work with mental health services to bring about these changes but a cross-national comparative study exploring factors that facilitate or act as barriers to personalised, collaborative, and recovery-focused care in community mental health services, "encountered little in the

way of shared understanding of recovery" at their six study sites across England and Wales (Simpson et al., 2016, p. 15).

'Recovery' was the guiding vision in government mental health policy but has been criticised for never being realised amongst an increasing implementation of austerity policies (Beresford, 2013). In 2016, the independent Mental Health Taskforce to the NHS published the Five Year Forward View for Mental Health (Mental Health Taskforce to the NHS, 2016) which outlined 58 recommendations to be achieved by 2020-2021. These included enhanced access to crisis teams, the integration of physical and mental health services, and the need for racial inequalities in the rates of detention being addressed. However, a recent inquiry by the All-Party Parliamentary Group on Mental Health (2018) on the progress of this vision found that socio-political and structural recommendations on housing and welfare, for example, have seen "little progress" (p. 3). The charitable organisation Young Minds published a response to the inquiry and whilst the introduction of specialist eating disorder teams across the country was embraced, they highlight that "these improvements do not go near to meeting the true scale of the challenge when it comes to children's mental health, with projections that by 2020/21 only 1 in 3 children with a diagnosable mental health condition will receive NHS treatment" (Young Minds, n.d.).

The Five Year Forward View for Mental Health (Mental Health Taskforce to the NHS, 2016) also set out plans to expand IAPT services, an objective that is reiterated in the recent NHS Long Term Plan (NHS England, 2019a). To maximise the collective impact of the psychological professions in delivering the objectives outlined in the NHS Long Term Plan (NHS England, 2019a), a document was produced detailing the vision of the psychological professions for England 2019-24. In The British Psychological Society's (BPS) response to NHS England, the need for evidence-based practice to

be applied more broadly to the psychological evidence is outlined alongside IAPT's current limitations in being able to meet more complex psychological needs (BPS, 2020b). With reference to the target of extending psychological therapies for adults with 'severe mental illness', the BPS emphasise that a wider range of therapies to meet these needs are not being made available through IAPT services. They continue:

> A major ramification of this clinical reality includes the risk of extinction of other treatment models and clinical values related to individualised and integrative practice. At the same time, the evidence base for other psychological therapies and interventions continues to grow and develop. We would welcome inclusion of evidence-based trauma-informed practice in the vision (BPS, 2020, p. 6).

1.6 Rationale for the current study

Overall, the review and critique of the current empirical research have problematised the mainstream, dominant constructions of 'mental health recovery'. Whilst there is an emerging contribution to the professional literature that critiques the current acceptance of biomedical and/or rehabilitative discourse, my doctoral thesis departs in both theoretical orientation and method from much of this and seeks to revive this critique. Foucault's considerations of discourse, knowledge, and power (Taylor, 2011b) allow for an entirely different exploration of 'mental health recovery' at a time in which challenging power relations and social structures within the UK is greatly needed. From this perspective, language is considered fundamental to how mental health practitioners provide psychological therapies within their services. In agreement with others (such as Harper & Speed, 2014; Jørgensen et al., 2020), I would argue that further research is needed on how 'mental health recovery' is constructed in mental health services. The ways in which it is spoken about are influenced by differing forms of knowledge, creating power relations that determine what is possible and/or

not possible within our current services. Furthermore, an ambition for counselling psychology has always been to expand the nature and definition of what 'science' and 'scientific evidence' are (Frost, 2012; Lane & Corrie, 2006). By broadening its epistemological and ontological perspectives, engaging with qualitative research enquiry, and disseminating new notions of what constitutes human reality, counselling psychology can contribute to the cultivation of a new definition of what constitutes evidence. This, in turn, challenges the real-world challenge and clinical reality of an increasingly limited approach to psychological distress.

Whilst a critique of 'mental health recovery' continues to emerge, the presence of this within peer-reviewed studies appears to have tailed off. Despite a well-defined need to further explore the effects of 'recovery' discourse (Harper & Speed, 2014; M. Morrow & Weisser, 2012), most of the literature is dated approximately five years ago, highlighting a need for a renewal of this intention. By exploring how mental health practitioners, with a significant responsibility relating to the development and provision of mental health care, talk about 'mental health recovery', we can highlight the possible implications for service provision, practice, and wider discourse. This allows for a contribution to a position from which change can be called for, in line with counselling psychology's social justice agenda (Cutts, 2013; Tribe, 2019).

1.7 Research questions

The overarching, broad research question is:

- How is 'mental health recovery' being talked about by mental health practitioners?

I aim to address this using sub-questions adapted from Arribas-Ayllon & Walkerdine (2017):

- What discourses are available to talk about ‘mental health recovery’?
- What subject positions are warranted by these constructions?
- What implications do these constructions have on practice, service provision, policy, and dominant understandings of psychological distress?
- Are socio-cultural and structural contributions to psychological distress considered within such discourses of ‘mental health recovery’?

2 CHAPTER TWO: METHODOLOGY

Foucauldian discourse analysis (FDA) was used to address the question: How is 'mental health recovery' being talked about by mental health practitioners? To best address my research question, I align with a critical realist social constructionist position.

2.1 Locating counselling psychology within a theoretical framework

Counselling psychology's foundations in philosophical and methodological pluralism encourage the profession to hold in mind various research paradigms, perspectives, and methods. It is a position that embraces a relational and pluralistic approach to understanding and exploring client's and/or research participant's experiences (Kasket, 2016) whereby the validity of several competing viewpoints is often acknowledged. In light of the above, counselling psychology often adheres to a distinct ontology and epistemology from those often held by mainstream psychology. Once the ontological assumption that the world is a "concrete structure" is relaxed, the prevailing objective approaches become increasingly "inappropriate" (Morgan & Smircich, 1980, p. 498) and are too narrow a methodology to capture the human experience. Counselling psychology's orientation towards a "humanistic, phenomenological framework for capturing and understanding human experience" (Skourteli & Apostolopoulou, 2015, p. 47) thus lends itself to qualitative inquiry (S. L. Morrow, 2007). However, I have come to understand that counselling psychology often needs to go beyond this framework to instil meaningful change and consequently shares many of the objectives and values underpinning critical psychology. Critical theorists had a fundamental impact on the creation of counselling psychology (Strawbridge & Woolfe, 2010) and in the years since its establishment, the profession has both embraced and engaged with theoretical developments in the areas of post-

structuralism, social constructionism, and postmodernism (Steffen & Hanley, 2013) signifying its ties to both critical psychology and social science. Consequently, I have engaged critically with the different paradigms concerned with ontology and epistemology throughout this thesis and acknowledge that I bring my own values to my research and practice. It is counselling psychology's critical stance towards our assumptions, way of thinking, reductionism, and so on, that contributed to the positioning of this thesis within a critical framework (Milton, 2010).

2.2 Social constructionism

Social constructionism has been described as a rubric for a series of differing perspectives that share a theoretical and methodological foundation and inference (Holstein & Gubrium, 2008). In philosophical terms, Burr (2006) describes that these diverse approaches include critical theory, post-structuralism, discourse analysis, and discursive psychology. Social constructionism demands a critical stance towards taken-for-granted knowledge and recognises that our understandings of the world are culturally and historically specific. Within this, language is underlined as constituting reality rather than reflecting it, and whilst meanings are made within social relationships, no two people will construct the same reality (O'Reilly & Lester, 2017). A social constructionist epistemology, therefore, assumes that 'mental health recovery' cannot be known empirically. Rather, it is understood as socially constructed and therefore carries variable social meaning. Macro-social constructionism, specifically, is preoccupied with the constructive nature of language, particularly how the social world is shaped by linguistic and social structures (Burr, 2006). As this thesis is informed by a macro-social constructionist perspective, an emphasis has been placed on the notion of power which is assumed to be embedded in historical and cultural discourses (O'Reilly & Lester, 2017). Approaches focussing on macro-level

discourse, including FDA, tend to adopt a critical realist ontological position (Brunton et al., 2018).

2.2.1 Critical realist social constructionism

The ontological and epistemological dichotomy between realism and relativism has been fiercely debated within social constructionism (see Parker, 1998). With its roots in phenomenology, counselling psychology would argue that our perception and knowledge are permeated by our values and it is, therefore, impossible to perceive an objective reality. Burr (1998) discusses how “we can only ever perceive something in terms of what it can matter to us, or do for us” (p.23), the implications of which is that the intentionality of our thoughts and perceptions transform our surroundings. Discourse, Burr (1998) writes, are manifestations of said intentionality. As Foucault (2002) maintains, knowledge and practice can therefore not exist independently, and the authority of discourse has very real-world implications. Whilst the critique of critical realist social constructionism is recognised, FDA is argued to be informed by both social constructionist and realist perspectives (Harper, 2012). Accordingly, it is underpinned by a realist ontological and relativist epistemological position. To this end, whilst the phenomena that are constructed by underlying and enduring structures cannot be accessed directly, they can be discovered through their effects on subjectivity and practice (Willig, 1999b). Consequently, how we see and experience the world varies according to the available discourses.

2.3 Rationale for methodology

My ambition from the outset was to use my work to critique dominant psychological theory and practice that individualises psychological distress and pathologises the human condition. Haverkamp and Young (2007) emphasise the need to achieve “a

match between purpose and paradigm to enhance the credibility of one's research" (p. 275), placing this thesis firmly in a critical-ideological paradigm (Ponterotto, 2005).

Social constructionism largely informs research methods that concentrate on language and culturally and socially located ways of understanding and talking about the world (Harper, 2012). Discourse analysis, which seeks to examine patterns of language and the social and cultural circumstances in which they are used (Willig, 2008) was arguably an appropriate approach considering the ontological and epistemological position of my research question. However, the emphasis that FDA places on how discourses maintain our practice and institutions (Georgaca & Avdi, 2011), corresponds more closely with my research aims. Narrative analysis was also considered in the project's early development, with the intention of recruiting research participants that identified as having experienced psychological distress. Narrative analysis, often rooted in a social constructionist perspective, felt more explicitly in line with counselling psychology values and existing literature identified significant gaps, such as what 'mental health recovery' means to those who require support from services to meet their psychological needs (D. Rose, 2014). Existing literature made further references to how 'mental health recovery' has become detached from its association with the psychiatric survivor movement and been appropriated by neoliberalist policies (McWade, 2016; M. Morrow & Weisser, 2012). However, on considering the ethical dilemma of "narrative co-optation" (Costa et al., 2012, p. 85) and the compelling case for a critical approach to how these narratives are operationalised (Woods et al., 2019), FDA was ultimately more in line with my value base. Whilst acknowledging these narratives as invaluable, I did not want to harness someone's personal story to further my own research interests.

2.4 Foucauldian discourse analysis

Foucauldian discourse analysis has been influenced by post-structuralist theory, as well as the work of Foucault (Arribas-Ayllon & Walkerdine, 2017). Foucault was particularly interested in how knowledge, power, and discourse related to one another and, amongst other works, traced the emergence of the modern concept of 'mental illness'. Considering its historical and socio-cultural context, Foucault argued that the presentation of madness as 'mental illness' as an objective, indisputable scientific truth, was in fact the product of remarkably questionable social and ethical standards. Power and knowledge were considered as mutual preconditions of possibility and, therefore, created a framework for the conditions of possibility for how 'mental illness' can be spoken about. FDA, therefore, provides a framework from which to study the role of language in constructing social and psychological life (Parker, 1994). Discourses appear within socio-cultural contexts and, along with power, allow and confine "what can be said, by whom, where and when" (Willig, 2008, p.172). In the context of 'mental health recovery', this is assumed to have implications for how a person experiencing psychological distress can have their needs met (Jørgensen et al., 2020).

From a Foucauldian perspective, analysts focus on the available discourses within a culture and the ramifications for those taking up subject positions within it. Whether the subject position is accepted or resisted by the individual, it has inevitable implications for their subjectivity and experience. Foucault (1971) suggests that whilst more than one discourse will exist in relation to a phenomenon, they exist in a hierarchical relation to one another whereby certain discourse will be privileged over others. How people talking about a topic can expose wider systems of meaning within that society. Some discourses, such as a biomedical discourse, appear so entrenched

within a culture that it becomes challenging to see how an alternative could emerge (Willig, 2013). Discourse provides institutions with a means to communicate, disseminate, and legitimise knowledge, consolidating their enmeshed relationship with power, subject positions, and the way in which phenomena can or cannot be spoken about. Within FDA it, therefore, becomes important to explore the structures of power and politics that may be concerned with maintaining the dominant discourse, and perhaps the subjugation of alternatives. This taken-for-granted knowledge can, however, be probed and challenged by counter-discourses.

2.4.1 Key Foucauldian concepts

Foucault's philosophical concepts are vast and often divisive. His unconventional and unsystematic thoughts are, considered by some, to be contradictory to the point of being unable to promote the change and liberation his philosophies intended. Others, however, "reject the view that the critical aspect of his philosophy eclipses its positive and emancipatory potential" (Taylor, 2011. p.3). Here I aim to introduce the reader to some of the key concepts which may be drawn upon during the process of analysis. As Foucault was disinclined to make any realist claims to a fixed understanding of the world (Taylor, 2011a), the use of 'thoughts', 'concepts', and 'theory' in relation to his work, are all used tentatively throughout my thesis. It should be noted that these are not presented as individual concepts, rather they are connected and are often embedded with one another within the literature.

2.4.1.1 Disciplinary power and subjected individuals

Power, as it is commonly understood, is considered restrictive, repressive, and traditionally understood as concerned with legal power or the power of the state. According to Foucault, however, power is an inescapable network of force relations

arising in all and any kinds of relationships. Although he presents several analyses of power across his work, the concept of disciplinary power emerged from Foucault's genealogical study in Discipline and Punish (Foucault, 1991). This notion of disciplinary power developed from an 18th-century design for a new kind of prison, the Panopticon. Comprising an all-seeing central observation tower, the supervisor would be able to constantly observe each prisoner within their cell, in contrast to the prisoners who are unable to see either the supervisor or their fellow prisoners. Regardless of whether the observation is actually occurring, this is said to create and maintain a "power relation" (Foucault, 1991, p. 201) where prisoners begin to regulate their own conduct and discipline to avoid punishment. Roberts (2005) explains how order is, therefore, guaranteed, eventually removing the necessity for the use of locks and chains. They go on to discuss how, for Foucault, this historical emergence was not only confined to the context of the Panopticon.

> The control, coordination, and observation of human beings within, for example, hospitals, schools and workplaces enabled research and experiments to be carried out upon those human beings: to experiment with different medications and monitor their side effects; to try out different educational strategies; to experiment with different working environments and regimes, and to try out a variety of 'techniques', punishments, rewards and 'therapies' (Roberts, 2005, p. 35).

This generalisation of disciplinary power to other contexts, such as psychological and psychiatric institutions, resulted in the possibility of the objectification of individuals into norms, diagnoses, and categories (Hoffman, 2011). In other words, through the process of disciplinary power, individuals are made 'subjects'. An individual regulated by their own conduct or performance is said to illustrate how individuals are subject to

control, as well as how they subject themselves to control (Taylor, 2011b). For Foucault, knowledge and power are inextricably linked and the knowledge that such power produces binds an individual to a specific identity, thus ensuring the individual is subject to a mounting amount of control. A psychiatric hospital ward can be used as an example to show how 'patient' observations, ward rounds, reviews, and record-keeping may create and maintain power relations as per disciplinary power (Roberts, 2005). This 'objectivising' of the subject is also commonly known as a 'technology' of power (Nilson, 1998).

2.4.1.2 Governmentality

Distinct from the thorough supervision pertaining to disciplinary power, governmentality refers to "the attempt to shape human conduct by calculated means" (Murray Li, 2007, p. 275). Whilst there is a place for the state in the "conduct of conduct" (Foucault et al., 2003, p. 138), it is considered to be only one authority amongst many. For Foucault, governmentality can be found within the family, workplace, distinct professions, and the wider population (Doherty, 2007). This general sense of the word, therefore, reflects its relevance to a wider context (philosophical, religious, medical) and one that applies to both the notions of technologies of the self (Nilson, 1998) and the governing of others (Lemke, 2002).

2.4.1.3 Confession

Derived from the Christian ceremony of admitting sins as a means of seeking penance, Foucault considers confession as central to the workings of the power-knowledge relation. With Pagan origins tracing back to the emergence of the care of the self, the materialisation of the confession within a contemporary context is so far-reaching that a hesitancy to confess is seen as a limitation.

> The confession is a ritual of discourse in which the speaking subject is also the subject of the statement; it is also a ritual that unfolds within a power relationship, for one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile (Foucault, 2020, p. 61-62).

According to Foucault, it was during the late 18th Century that several 'technologies' were at play in regulating people's sexuality. Confession is considered one such 'technology', where, in this context, individuals were required to disclose their sexual behaviours and desires to a priest. Thus, sex became an object of knowledge. This technology is understood to have spread from within religious confines, to psychological contexts, and then to the political realm.

2.4.1.4 The norm and normalisation

From a Foucauldian perspective, normalisation occurs "when new norms and ideas of social order, strategically constructed in discourse, become – or are strategically assumed to become – part and parcel of mainstream or common thinking" (Krzyżanowski, 2020, p. 435). The effects of power are said to be masked, often preventing a critical stance or analysis of the norm. Taylor (2009) uses the example of 'gender' to describe how "normalizing norms" (p. 47) encourages subjects to engage in appropriate behaviours and/or practices until they are perceived by the wider context as 'normal'. Thus, while acceptable 'gender roles' may vary and change depending on their historical and cultural location, the notion that 'females' and 'males' are fundamentally different is widely accepted in the West (Taylor, 2009). Foucault did not consider these to be predetermined, rather established through power-knowledge practices. Subjectification, therefore, occurs as a result of the individual internalising

‘the norm’. However, as there are rarely only one set of norms governing a specific social domain, disciplinary power is never able to secure total compliance, allowing for alternative or counter-discourse to resist the regulatory norms in said area of social practice (Dick, 2004).

2.5 Procedure

2.5.1 Ethical approval

Ethical approval was received by the University of East London’s School of Psychology Research Ethics Committee (Appendix A) and established ethical practices were adhered to throughout the research process. Each participant received an information sheet for the study (Appendix B) accompanied by a consent form to complete (Appendix C). Consent was given to confirm that the participant had been given a full explanation of the research project; had the opportunity to ask any questions; that they understood participation was voluntary and that they were able to withdraw at any time without repercussions up until the point of data analysis (three weeks post-interview); and that the transcripts would be anonymised and remain confidential to the researcher and research supervisors. Due to the research questions, I noticed that places of work were often spoken about in detail. To protect anonymity and ensure confidentiality, all identifiable information has been removed from the transcripts. At the end of the interview, each participant was provided with a debrief letter (Appendix D) which highlighted how the data would be used and, although not anticipated, provided resources to minimise any potential harm from taking part. The letter further provided my professional contact information, as well those of the Director of Studies and Chair of the School of Psychology Research Ethics Sub-Committee to monitor for professionalism and ethical conduct throughout the interview process.

Further ethical considerations arose due to my critical-ideological positioning and chosen methodology. Burman & Parker (1993) discuss the ethical issues that may result from analysing and interpreting the words of others and I spent a lot of time reflecting on the discomfort of taking a critical stance towards those who had kindly volunteered to be part of my study. I was concerned that I would appear critical of my participants, despite acknowledging that they are all engaging in meaningful mental health practices, as well as all but being obliged to engage in these dominant practices through their relationship with the existing dominant paradigms (Hanna, 2014). Harper (2003) proposes several "counter-balances" to avoid the analysis "being seen as implied criticism of individuals" (p. 85). This includes focussing solely on the talk and its implications with an attempt to move away from interpreting the motivations of any individual participant (Harper, 2003). Discourse analysis, after all, does not attempt to "use people's language as a means of gaining access to their psychological and social worlds" (Coyle, 2007, p. 100). Rather, the analysis will focus on the public and collective reality of 'mental health recovery' as constructed through language (Burman & Parker, 1993; Coyle, 2007). An engagement with reflexivity and how I have impacted and transformed the research was fundamental to this stage of my research and is embedded throughout the ensuing chapters.

2.5.2 Participants

The critical literature review and practicalities of the scope of the research determined the type of participants required for the study. Despite research focussing on narratives of those who identify as survivors (Costa et al., 2012; Woods et al., 2019) considered as invaluable, mental health policy and best practice guidelines appear to be driven from the other end. The current professional literature indicates that notions of 'mental health recovery' in UK mental health services have predominantly been

constructed by mental health practitioners (Harper & Speed, 2014; Perkins & Slade, 2012). For example, the independent Mental Health Taskforce that developed the Five Year Forward View for Mental Health was made up of members who hold “critical responsibilities” (Mental Health Taskforce to the NHS, 2016) related to the planning and delivery of care, such as NHS England, the Royal College of Psychiatrists, and the Department of Health. Due to the time constraints of carrying out research within a professional doctorate, a subset of the group identified as being able to be involved in the development of services and practice needed to be chosen. After research consultations with peers and colleagues who all identified as currently ‘delivering care’, those holding a Band 7 position or above, or that of the equivalent outside of the NHS, were chosen as the sampling criteria. Bands are defined by the NHS Job Evaluation Handbook (Job Evaluation Group, 2018). The IAPT Black, Asian, and Minority Ethnic Service User Positive Practice Guide (Beck et al., 2019) is a further example of an important and influential document authored by mental health practitioners that supports the choice of this sampling criteria. In this case, the four authors each hold posts equivalent to Band 7 and above, such as ‘clinical psychologist’ and ‘cognitive behavioural therapist’.

Seven participants were interviewed which was deemed sufficient in providing transcripts to be able to discern commonly used patterns of talk when speaking about ‘mental health recovery’. Larger samples of data have been said to add to the workload without adding anything of note to the analytic outcome (Coyle, 2007).

2.5.2.1 Recruitment

A purposive sampling approach was used to identify and recruit mental health practitioners that hold Band 7 positions or above, or that of the equivalent post outside

of the NHS. All participants were sent a standard invitation to participate, and consent was obtained at the time of arranging the interviews (Appendices B & C).

One practitioner was known to me personally through familial networks and was contacted regarding their willingness to take part in the research due to their meeting the selection criteria. Two further practitioners were known to me professionally through previous and current networks and were also contacted regarding their willingness and ability to take part in the research. Two practitioners were recruited via their responses to a call for participants via an advert posted to LinkedIn, one through my university peer network, and one via word-of-mouth from the aforementioned professional networks.

2.5.2.2 Profile of participants

Five participants that identified as ‘female’ and two as ‘male’ were interviewed. Five participants identified as White British, one as Asian British, and one as White European. The name, age, gender, and ethnicity of individual participants will not be included in their profile to further protect confidentiality. I have instead chosen to only include the practitioner’s job role and years working in mental health services. For the remainder of this research, I have chosen to use the gender-neutral pronoun “they” when referring to the participants and have also chosen neutral pseudonyms.

Participant	**Job title**	**Years working in mental health services**
Alder	Health psychologist	12 years
Birch	Speciality grade doctor	28 years

Cedar	Occupational therapist	34 years
Dahlia	General practitioner	10 years
Elm	Clinical psychologist	21 years
Fennec	CBT therapist	15 years
Ginkgo	Head of therapeutic programmes	14 years

2.5.3 Data collection

2.5.3.1 Interviews

All interviews were conducted via Microsoft (MS) Teams due to the ongoing coronavirus restrictions and were recorded using the function embedded in the online platform. Using a focus group was contemplated as a “less artificial” (Willig, 2013, p. 31) means of gathering data and a way to see how participants collectively constructed meanings of ‘recovery’. However, it was decided that this could be impeded by having to be conducted online over MS Teams.

Individual interviews followed a semi-structured interview schedule (Appendix E) made up of open-ended questions. The interview schedule was piloted, and the decision was made to no longer ask both questions: “What does the term ‘recovery’ mean to you?” followed by “What about ‘mental health recovery’?”, as participants were inclined to answer the first question already pertaining to mental health due to

their knowledge of the research topic from the information sheet. I was anxious at the prospect of interviewing and had to play around with the position I adopted as the interviewer considering the participant's presentation and what I gathered their cultural milieu to be. I consider myself to have taken a curious stance and tried not to follow a rigid interview schedule, using it to gently steer the discussions. At times I wondered about the need for neutrality, but in keeping with my epistemological position and methodology, the literature reminded me of the assumptions about participants "as active participants within the research process who *construct,* rather than *report on* reality" meaning "bias is regarded as both unavoidable and pervasive" (Speer, 2002, p. 511). I continued to try and reflect on how my questions would evoke specific types of responses and how I too would be entangled in the subject positions produced by the interviews (Georgaca, 2003).

2.5.3.2 Transcription

Interviews were transcribed verbatim three weeks after the interviews had been completed to allow for participants to withdraw their data if they wished to do so. No participants chose to withdraw their data. Transcription was conducted solely by the researcher to ensure confidentiality.

Pause lengths were categorised and represented in the transcripts as follows:

. = standard pause (of less than one second)

[pause] = longer pause (of between one and three seconds)

[long pause] = long pause (of more than three seconds)

Boxed brackets were used to describe non-verbal communications, such as [laughter], and any identifying details were omitted […] or changed to preserve anonymity and confidentiality.

2.5.4 Data analysis

There is widespread consensus that no manualised approach to FDA exists (Arribas-Ayllon & Walkerdine, 2008; Coyle, 2007; Georgaca & Avdi, 2011; Harper et al., 2008; Walton, 2007; Willig, 2008). After conducting discourse analysis with two accounts of soldiers leaving the army, Walton (2007) and his analytic group concluded that "'doing discourse analysis' seemed less to do with following the steps of a particular method than with developing a confidence in [their] use of analytic concepts and the reporting of [their] analysis in terms that were consistent with the theories and epistemological positions of discourse analysis" (p. 117). Due to my novice position as a researcher, however, I chose to use Willig's (2013) stages of analysis as a guide but placed particular emphasis on the careful reading and interpretation of the transcripts in line with Walton's (2007) conclusions. The stages were not followed as a rigidly linear process, rather a guide to ensure all aspects of analysis were carried out and to help structure the process for my novice researcher status. I empathised with the description of discourse analysis as a "craft-like process" (Harper et al., 2008, p. 194) and see it as important that I document my experience of carrying out FDA. My reflexive notes are central to how I conducted my reading of the data and the methodological process of analysis and are therefore included throughout this section.

2.5.4.1 Initial reading

Guided by the overarching research question and corresponding sub-questions, each transcript was read through in its entirety, and notes were made of initial ways 'recovery' was being spoken about (see Appendix F for samples). I initially felt overwhelmed with the amount of information in the transcripts and how I would decide which aspects of how 'mental health recovery' was spoken about were relevant to my research aims. However, through the process of reading and re-reading the data, I

was able to recognise some constructions that related to my literature review and some others emerging that were more difficult to discern. Lines from the anonymised transcripts were copied into a document with my informal initial research notes on discursive constructions, subject positions, and anything I noted as possibly important to return to and/or explore further (see Appendix G for samples). This included any mention of power and/or considerations of socio-cultural and structural contributions to psychological distress. At this stage, my awareness was heightened to how the context of my research and my position as a researcher may affect the analyses produced, often being drawn to discourse aligned with my values and priorities as a counselling psychologist.

2.5.4.2 Discursive constructions and identifying discourses

This stage of the analysis involved me trying to identify, organise, and categorise the various discursive constructions that emerged concerning 'recovery'. I was reminded once again of the discomfort of taking a critical stance towards the volunteers of my study and much of this stage of analysis involved trying to disconnect from the relational experience of the interviews and focus solely on the words the participants used regarding 'recovery'. This was aided by drawing on discourse analysis theories and concepts, such as the focus on the construction of a public and collective reality (Coyle, 2007; Walton, 2007). The discursive constructions found in each transcript were handwritten onto a piece of paper with the corresponding transcript or transcripts noted (Appendix H). The data was read and re-read until I thought saturation had been reached, acknowledging that another researcher (with differing values, histories, epistemologies etc.) may have identified entirely different discursive constructions. I continued to make notes on other aspects of the analysis throughout this process that I would be attending to at a later stage (Appendix I). With each of the discursive

constructions identified on the same piece of paper, I was able to note those that had been repeated in some way or another across all the transcripts before moving on to locate these within wider societal discourses. The frequency of occurrence of discursive constructions was significant to the research question as it could suggest which features are culturally available, but this did not mean that less frequent occurrences were ignored, such as mentions of power. I also thought about including some less frequently occurring constructions (e.g., *recovery as confession*) where they could be seen to overlap or contribute to those that were to be included in the write up. It was really only at this point that I started to feel as though I was grasping the key discourse analytic concepts and enjoyed playing around with some of the categorisations. Parker (2013) contends that discursive research is "all the better" (p. 224) for its ambiguities, meaning the researcher has to continuously "confront, develop, and redraw methodological boundaries" (Thompson et al., 2018, p. 94).

I found the identification of wider discourses a more complex process due to my questions over what essentially counts as a discourse and the seemingly limitless nature of these. Dick (2004) highlights, however, that "in critical discourse analysis, the researcher is seeking to identify social constructions that have regulatory effects, and which, to some extent, are presented as self-evident or common-sense features of the social domain that is being researched" (p. 205). In keeping with the principles of commitment and rigour (Yardley, 2015), I focussed on identifying discourses that were used by most of the participants, those prevalent in the current relevant literature (referred to by Fairclough (2009) as intertextuality), and those dominant in the current socio-cultural context of the research. From a social constructionist perspective, these are referred to as 'relative stabilities' (Dick, 2004). After discussing the initial discursive constructions and discourses in research supervision, I started writing up a draft of the

analysis as I found this process helpful in developing my ideas. Due to the time constraints of carrying out a professional doctorate, I moved on to Willig's (2013) following stages of analysis on these findings only.

2.5.4.3 Action orientation

The next stage of FDA involved exploring and interpreting what the functions of the talk in the transcripts might be and what is gained from constructing ‘recovery’ in this way. As the functions of discourse and language used are often not explicit, this was a difficult stage to grasp as a novice researcher. I had already grappled with not wanting to critique my participants and I felt opposed to further probing the possible function of their talk when I too considered myself, as a practitioner, as often powerless against the dominant system. It was during this stage that I, therefore, felt most aware of the analysis being a product of the choices I made in taking up a critical position. For example, it was often easier to interpret the action orientation of a biomedical or psychiatric discourse than a relational discourse, as I often perceived the latter as a more accurate construction of ‘reality’ that is similar to my personal views as a practitioner. The possible functions of the discourses identified were attended to as I wrote up a draft of the analysis and discussed where most relevant to the research questions.

2.5.4.4 Positioning

The process of considering positioning and subject positions followed on from previously locating ‘recovery’ within wider discourse. For Foucault, ‘positioning’ has unique effects on how the individual views themselves, in addition to how they feel and behave (Dick, 2004; Willig, 2013). For this stage, Harper (2003) highlights the risk of researchers losing their reflexivity and no longer recognising themselves as located

within the discourses occurring within the transcripts. Acknowledging that I was also implicated in positioning, both as a researcher and a practitioner, did not come easy but was an important part of constructing a balanced approach to my discussions.

2.5.4.5 Practice

Closely related to the identification of subject positions, this stage in the analysis sought to explore the relationship between discourse and practice. Namely, what are the possibilities for action offered by the discursive constructions and wider discourses? This was an important part of answering one of my sub-questions relating to the possible implications of the constructions of 'recovery' on practice, service provision, policy, and dominant understandings of psychological distress.

2.5.4.6 Subjectivity

The final part of the analysis focused on exploring the relationships between discourse and subjectivity. After previously positioning my participants as largely passive users of discourse with limited agency, I felt conflicted at attempting to assume how they spoke about 'recovery' and the implications for subjective experience. Considering my social constructionist, critical realist positioning, this stage felt highly interpretive and, considering the discursive object being discussed, felt less relevant to the research compared to other stages of the analysis. Coyle (2007) echoes this view, highlighting that some discourse analysts "contest the premises of this analytic stage" (p. 109). However, I sought some assurance in Willig's (2013) advice that "we can do no more than to delineate what *can* be felt, thought and experienced from within various subject positions; whether or not, or to what extent, individual speakers actually *do* feel, think or experience in these ways on particular occasions is a different question" (p. 136).

3 CHAPTER THREE: ANALYSIS AND DISCUSSION

3.1 Overview

Not all discursive constructions used throughout the interviews are presented in this chapter (see Appendix H for all the discursive constructions identified through analysis). Instead, I have chosen to present discursive constructions that were interpreted as occurring the most frequently, seem the most relevant in the context of my research and those that are best suited to answer the research question. These are used as headings or 'themes' to guide the presentation of the analysis. Wider dominant and counter-discourses that were drawn upon or produced by the employment of each discursive construction are considered under each heading. The analysis starts with the overarching discursive construction of *recovery as difficult to define,* to set the scene for those that follow. The structure is then organised within two dominant discursive constructions:

- *recovery as being well*
- *recovery as an ongoing process*

And two constructions interpreted as counter to the wider discourses produced by these:

- *recovery as being achieved through pluralism*
- *recovery as taking place in the interaction with others*

The process of analysis has been considered a discursive practice in itself and was discussed in detail in section 2.5.4. In searching for discursive constructions informed by my own subjectivity, I have 're-constructed' the data into the theoretical account presented in this chapter. Correspondingly, the discourses drawn upon by the participants are recognised neither as being purposely or consciously chosen to

construct ‘recovery’ in the ways discussed in this chapter, nor as being used as a deliberate or thought-out social action. Rather it is through how they speak about the discursive object that available resources to speak about ‘recovery’ can be identified.

3.1.1 Recovery as difficult to define

This discursive construction may highlight some scepticism and hesitancy around the construct of ‘mental health recovery’ and how it often appeared difficult for the participants to ‘find’ the words to talk about it. Alder, Birch, and Elm all query the concept labelling it as “difficult”, “tricky”, and “complex”.

Extract 1:

> **Alder:** I don’t know (.) recovery’s a difficult thing (.) What does it mean? I’m not entirely sure (Line 358)

Extract 2:

> **Birch:** Apart from that I find it a tricky concept (.) I find it a really tricky concept [‘…’] And recover to what? Yeah (.) it's just (.) it just seems like the wrong word (.) Yeah (.) evolve (.) I think it's the evolution stuff (.) yeah (.) that's (.) bad branding (.) I suppose is what I’m saying (Lines 345-352)

According to Foucault, mental health services are embedded in governmental structures suggesting mental health services, the practitioners that work within them, and ‘recovery’ are too governed by these structures. This includes the charity sector where “contract criteria; increasingly detailed specifications and targets; required performance data; and the language and means through which they are communicated” ensure an acceptance of “policy instruments and their underlying logics” (Milbourne & Cushman, 2015, p. 472). As the power at play in governmentality is said to operate at a distance, it could be argued that the participants are not

necessarily aware of how their conduct is being conducted (Murray Li, 2007). Following a poststructuralist line of thought, the discursive construction *recovery as difficult to define* may be interpreted as having the action orientation of signifying the struggle between practitioners producing and reproducing culturally privileged and dominant understandings of psychological distress and 'recovery', and their resistance to this way of being (LaMarre et al., 2019). That is not to say the participants are passive vessels for power, but that this could be seen to place the practitioner in the position of unconsciously reproducing discourses of a neoliberal agenda. As Alejandro (2021) highlights, "the discourses we produce both reflect the socio-political order we have internalised via socialisation, and represent the implicit medium through which we unconsciously legitimise, naturalise and normalise this socio-political order" (p. 152). Furthermore, these discourses often appear so entrenched within our society that it becomes puzzling to see how an alternative could emerge (Willig, 2013).

Extract 3:

> **Ginkgo:** I guess it's quite hard to define because it's so different per individual and like I think that's (.) that's probably the tricky bit about recovery in the literature (.) that you know there's this kind of need to evidence (.) but there is also like a person that that comes from (.) and how do we kind of bring that together? (Lines 45-48)

Extract 4:

> **Ginkgo:** I think probably in the way we've talked about it (.) shows that it is just (.) it is difficult to define (.) and I think that is reflective of the complexity of life and the complexity of people's experience (.) is that you know it's a generic

term (.) but has many different sub-headings [laughing] (.) I think (.) you know that come with it (.) (Lines 421-424)

Ginkgo's construction of *recovery as difficult to define*, particularly their reference to the "need to evidence", alludes to the normalisation of 'mental health recovery' within mainstream understandings of psychological distress and the authority invested in a biomedical and neoliberal discourse. Sugarman (2015) invited therapists to reflect on how their ideological position may shape their interactions with clients and how their therapeutic practice may endorse a neoliberal ideology. I would argue that Ginkgo speaks about 'recovery' with an ideological awareness of the dominant paradigms and highlights the collective reality of struggling to construct 'recovery' using language counter to what is most culturally available. According to Foucault (1982), power and knowledge mutually presuppose each other generating the conditions of possibility for how 'recovery' can be spoken about. I chose this as an introduction to the analysis to highlight that the dominant neoliberal ideology prevalent in the UK seems to shape the professional's ability to articulate 'recovery' and to resist its authority throughout all parts of their interviews and is, therefore, applicable to the remainder of this chapter.

3.2 Dominant discourse

3.2.1 Recovery as being well

Recovery as being well constitutes a dominant discursive construction, which draws from biomedical, psychiatric, and neoliberal discourses often focussing on diagnosis, remission, and functional improvements (Silverstein & Bellack, 2008). All research interviews began by asking the participant what 'recovery' meant to them, with several participants drawing on these wider discourses in some way or another.

Extract 5:

Elm: Mhmm [pause] getting a person to be able to be functional again (.) so (.) going back to a state that doesn't need to be an absolute concept of health (.) but basically for that person to be functional again (.) so (.) it gives me the sense that this person had an issue (.) had probably a crisis of something (.) not working enough as they used to work (.) so (.) basically giving this person the possibility to be functional again (.) and the level of functionality really depends on the (.) on the specific personal case and situation

Researcher: *Could you say a bit more about being functional?*

Elm: I would say the best level possible of health (.) physical health (.) psychological wellbeing and social interaction [pause] and under the umbrella of the social interaction I will put also a possibility to work if they are able to or have relationships (.) yeah (.) (Lines 19-28)

Elm conveys 'recovery' as the individual achieving physical health, psychological wellbeing, being socially interactive, having relationships, and being able to work. Here, Elm's talk is perhaps seen to perpetuate the social 'status quo' where the 'mentally ill' are constructed as non-functioning members of society against an imagined 'norm' (LaMarre et al., 2019) and the individual must then engage in a process of rectifying this. This appears in line with the normalisation of 'recovery' that is currently available in mainstream public discourse where the mad *should* be able to return to the community and lead an 'ordinary' life. Elm's reference to being "functional" when concerned with 'recovery' and specifically to the "possibility to work" is, therefore, bound up with a neoliberal discourse that constructs psychological distress as incompatible with being functional. Thus, the individual experiencing mental health difficulties is positioned as an economic actor, legitimising the need for a therapeutic intervention aimed at returning them to a state of productivity. Within a neoliberalist

context, the individual is held accountable for all aspects of their lives and consequently may think they have achieved ‘recovery’, or be seen as having achieved ‘recovery’, when they become less of a burden on the state and are able to serve the ambitions of capital accumulation (Davidson, 2008; LaMarre et al., 2019).

Systemic and structural contributions to psychological distress and barriers to being ‘well’ often remain unacknowledged within such discourses of ‘mental health recovery’ (Carr & Batlle, 2015). Instead, when individuals “do not reach the pinnacles of success promised by subscribing to neoliberal modes of life, this ‘failure’ is ascribed to those persons” (LaMarre et al., 2019, p. 241). This subsequently fuels the ever-present problematic distinction between those that are ‘ill and unemployed’ and those that are ‘hard-working taxpayers’ (McWade, 2016). Birch also draws from a biomedical discourse when asked about what ‘recovery’ means to them, constructing ‘recovery’ as dependent on the individual’s ‘diagnosis’ and by differentiating between “two models of illness” (Birch Line 34).

Extract 6:

> **Birch:** OK (.) Erm (.) oh I suppose there’s two models of illness that I kind of think about and talk to the med students about (.) That (.) um [pause] of you (.) you know that (.) I suppose (.) and depression is the best (.) best model of it really (.) That you know people generally (.) people will be well and can get depression and then get well and can not be depressed again (.) and that's it (.) they’re done with that (.) Whereas more (.) the area of psychiatry that I kind of find more fascinating is the more personality end of stuff (.) And obviously the eating disorders end of stuff which is perhaps personality driven or very closely linked to personality (.) (Lines 34-41)

Extract 7:

> ***Researcher****: In terms of the first one you mentioned where someone is 'well' and they might get depression (.) do you see things differently for 'those people'? In terms of recovery?*
>
> **Birch:** [Long pause] Yes (.) I think (.) and I kind of use depression 'cause that's one of the only times I've really seen it (.) Where they are (.) and I suppose it's the difference between that real sort of classical 'mental illness' (.) you know of that (.) "you're well (.) you get sick (.) you get well again" and that you know it's done and (.) And I think that is recovery (.) You can completely go back to who you were (.) I think? [pause] And I've seen people who have recovered (.) even with recurrent depression (.) but like in the middle (.) they are well and not traumatised by the depression (.) You know (.) it literally is like getting a flu or something else (.) But I think I've only seen it in depression (Lines 71-83)

Across Extracts 6 and 7, the construction of 'mental health recovery' appears guided by paternalistic power structures, where biomedical knowledge is considered superior as a framework for understanding and resolving psychological distress. This is conveyed by Birch's acceptance and use of psychiatric diagnoses when speaking about 'recovery', marking departures from the 'norm' as pathological and subjecting the individual to a range of presuppositions associated with being 'mentally ill' (N. S. Rose, 2007). From the position of 'sick' or 'patient', it becomes difficult to question the legitimacy of the biomedical framework and could place limitations on legitimate forms of how 'recovery' is actualised. Furthermore, comparisons to physical illness within Birch's construction of *recovery as being well* also draws on wider discourses of biomedicine and the medicalisation of psychological distress, also echoed by Alder.

Extract 8:

> **Alder:** I think that if you have been diagnosed with a mental health condition (.) I do think that there is an element of you're gunna (.) you're gunna need to be careful for the rest of your life (.) just like any other condition (.) If I had a knee problem (.) you know I had a dodgy knee (.) I'm going to have to keep an eye on it for the rest of my life (Lines 62-66)

Birch and Alder's comparisons of psychological distress to flu and knee problems could be seen to perpetuate the idea that 'mental illness is like any other illness', previously used by anti-stigma public health campaigns (McWade, 2016). This discourse engaged in 'educating' the public in exclusively biomedical models of psychological distress and incidentally appeared to promote 'us' and 'them' subject positionings (Walsh & Foster, 2021). Based on the historical emergence of biomedical and psychiatric discourses when an individual is positioned as 'mentally ill' they are 'invited' to understand themselves accordingly. From a Foucauldian perspective, the individual that is regarded as unable to engage in normative 'self-improvement', is positioned as 'abnormal'. If they take on this identity and understand themselves in this way, the individual may experience themselves as unproductive, dysfunctional, and feel dependent on mental health professionals to 'recover' (Dick, 2004; Willig, 2013). Roberts (2005) argues that "such an identity is used to legitimise explicit forms of psychiatric power and control, such as the compulsory admission and treatment of people under the Mental Health Act 1983, as well as the more refined, disindividualised and diffuse strategies of Panopticism" (p. 39).

In keeping with this line of thought, *recovery as being well* was often spoken about in terms of being facilitated by the practitioner and/or therapy. *Recovery as facilitated by the practitioner* is a discursive construction that involved participants talking about

"getting" someone better or functional (e.g., Alder Line 388; Elm Line 19), "ushering them into the light" (Birch Line 186), or "helping" people to do something (e.g., Birch Line 186; Cedar Line 47; Dahlia Line 253). Facilitating and engaging in psychological therapy to achieve 'recovery' has been institutionalised and established as a legitimate and long-standing cultural practice (Guilfoyle, 2005). According to Foucauldian thought, therapy could be considered as both an effect of power and as engendering power effects in its production of "discourses, practices, subjects and further power relations that become part of the broader cultural network" (Guilfoyle, 2005, p. 103). Remaining within the context of asking the participant what 'recovery' meant to them, Fennec's construction located within *recovery as being well* and *recovery as facilitated by the practitioner* draws from several culturally accepted discourses.

Extract 9:

> **Fennec:** I think it's about trying to get people to a point of being well (.) not necessarily a finished product (.) but getting them to understand that how they think (.) how they feel and how they behave are all interlinked (.) and having some responsibility about your journey (.) not always all (.) because as we know (.) mental health can be very severe for some people (.) but certainly people I see (.) I can normally see an improvement and they can normally see an improvement within the six to eight sessions that I tend to offer (Lines 51-57)

Fennec's talk of "trying to *get* people" and "*getting* them to understand" could be argued to prompt thoughts of persuasion, conversion, and/or perhaps even coercion. This construction might be seen to position the practitioner as 'truth teller' and advocates the use of therapy to 'understand' an individual and resolve their difficulties to achieve 'recovery'. Similarly drawing from a wider neoliberalist and individualistic discourse, the psychological difficulty is located within the individual and they must be

able to take responsibility for their own distress to ‘recover’. Fennec’s use of these discourses may be seen to perpetuate the neoliberal obligation placed on the individual to preside over one’s psychological wellbeing and have the capacity to look after oneself (N. S. Rose, 1999). Furthermore, speaking about ‘recovery’ in this way may act to keep the authority with the mental health professional, highlighting an asymmetrical power relation where the practitioner knows what is best. The ‘therapist’ and ‘client’ subject positions determine what can and cannot occur in the therapeutic interaction and, therefore, how ‘recovery’ may be achieved. This could be seen as an example of where the practice of therapy reproduces the discourses that authenticate them as a practice (Willig, 2013).

Extract 10:

> **Cedar:** helping people to (.) as I say (.) sort of see themselves (.) to have hope to have (.) you know (.) have the sense that they can recover a life I suppose (.) I suppose (.) that's worth living and that’s got meaning (.) and recovery (.) another (.) you know in terms of the control thing (.) you know (.) I think giving people the skills and tools to be able to manage their own mental health and feel that they've got (.) they've got some efficacy within their (.) with (.) you know (.) within themselves (Lines 52-59)

Akin to Extract 9, Cedar speaks of “helping” people to have hope they can “recover a life” and of “giving” them the skills to do so. Here, Cedar may be seen as supporting the idea that the pursuit of a life “worth living” is a collective and important ambition for all people. Whether taking up the subject position of ‘truth teller’, ‘giver’, or ‘helper’, a distinct therapeutic framework is created, involving a practitioner administering their expert knowledge on an individual that is the object of this knowledge. This framework consequently results in the foundation of an ‘appropriate’ route towards ‘recovery’. It

is in the context of this framework that Guilfoyle (2005) argues that “each person’s conduct relative to the other is organised, and power is given a (contestable) pathway through which to produce its effects” (p. 105).

Recovery as facilitated by the practitioner may also call to mind Foucault’s theories of confession. Accordingly, being ‘well’ is facilitated by the therapist through the act of confession by the client. Disclosing the ‘truth’ is something so admired in Western society that it exists in both the public domain, such as on TV talk shows and in autobiographies as well as within the private domain, such as therapy (Besley, 2005). Within the therapeutic setting, the service user is not only the speaking subject (the confessor) but also the subject of the therapeutic encounter. The ‘ritual’ of therapy, therefore, unfolds within the therapist/client power relation, whereby the individual confesses to the “authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile” (Foucault, 2020, p. 62). Freud’s psychoanalysis may be one of the most apparent examples of the departure of the confession from religious or spiritual confines, but confession has been normalised as part of a whole host of therapeutic approaches (Besley, 2005; Foucault, 1991). The therapeutic mode of confession is explored as an affirmation of ‘the self’ to reach ‘mental health recovery’ amidst what has been argued as a “slavish adherence to a narrative that worships ‘the self’ based on dictates of psychological and applied human sciences” (Scott, 2016, p. 426). This affirmation of ‘the self’, may be interpreted from Dahlia’s construction of ‘mental health recovery’.

Extract 11:

> **Dahlia:** I think recovery probably has something to do with accessing aspects of the personality that previously weren't so accessible and becoming kind of more authentically yourself (.) it’s quite philosophical [laughing] yeah (.) so I

> think (.) I think it's probably about expressing an individual's kind of unique self and (.) you know (.) being able to do that (.) being able to do that without too much criticism (.) self-criticism (.) and I think that has a natural kind of knock-on effect on how you function (.) you know (.) so what you see and how you behave towards others and interpersonal relationships (.) but you know (.) I think that the key (.) you know the core of it is probably (.) for me (.) is probably (.) you know (.) sort of being able to be authentically (.) it sounds very new age (.) but authentically who you are? (Lines 54-63)

Here, the practitioner takes up the subject position of 'expert' and through observation and interpretation determines whether the truth or the unconscious truth, has been vocalised. According to Foucault, therapies are based on certain technologies of the self, understood as specific practices by which subjects constitute themselves within and through systems of power. Where technologies regulate the individual self, the practitioner may be seen to "administer certain 'technologies' for speaking, listening, recording, transcribing and redistributing what is said" (Besley, 2005, p. 375), to actualise this construction of 'recovery'. As the individual develops this form of self-knowledge through the therapeutic encounter, they equally become known to the therapist involved in the process, which can, in turn, constitute 'the self' and 'recovery'.

3.2.2 Recovery as an ongoing process

Recovery as an ongoing process is another dominant discursive construction that was interpreted from the data, this time drawing from a wider rehabilitative discourse. Anthony's (1993) far-reaching definition concerning the rehabilitative construct also describes 'recovery' as a "process" (p. 7) and is used as the basis for government publications and the Recovery College approach across the UK (Perkins et al., 2018).

This is often akin to recovery being constructed as a journey (e.g., Alder Line 207; Cedar Line 283; Elm Line 49; Fennec Line 45; Ginkgo Line 61).

Like discourse in general, a Foucauldian perspective would argue that metaphors are integral in constructing our social and political worlds. Indeed, metaphor is both an implicit and explicit element in the promotion of public health in the UK, shaping ideas about what health, and mental health, may be (Talley, 2011). Fennec's use of metaphors come together to construct 'recovery' as an ongoing process and privilege a rehabilitative discourse, often described as 'personal recovery'.

Extract 12:

> **Fennec:** I think it's a multi (.) it's a multi [pause] it's a bit like a diamond (.) it's multifaceted I think recovery (.) rather than it being just a slab of something (.) I think I'd see it as a diamond (Lines 146-148)

Extract 13:

> **Fennec:** As I said earlier (.) not to negative label ourselves (.) be more constructive (.) be more helpful (.) but I think the road to recovery is like a (.) it's like a rollercoaster (.) that's the best way [pause] I see a little cart and it's got a roller coaster and I think that's what recovery is (.) it goes up and it goes down (.) change is a variable process (.) isn't it? (Lines 296-300)

Fennec's reference to a diamond may reflect some themes from 'personal recovery' discourse, such as its construction of 'recovery' as a unique process. Rose (2014), however, critiques the idea of everyone being seen as unique in its normalising of individualism. "The road to recovery", "cart", and "rollercoaster" all emanate from the overarching metaphor of 'recovery' as a journey and ongoing process. The rollercoaster metaphor may highlight the uncertainty and unpredictability of

psychological distress and ‘recovery’, contrary to the biomedical construct where there is an outcome to be arrived at (Slade, 2009). Here, ‘recovery’ is a variable process going up and down, sometimes quickly and sometimes slowly. Whilst the idea of a rollercoaster may counter the discourse of self-responsibility, it could also be synonymous with needing to learn the ‘skills’ necessary to manage this ‘ride to ‘recovery’ (Expert Patients Programme Community Interest Company, 2007).

Extract 14:

> **Cedar**: Yeah (.) I mean I guess you know (.) that word empowerment is so overused (.) isn't it? But the sense that people actually have control over their own mental (.) you know (.) over their own mental well-being (.) and they've got sort of skills and tools to be able to manage that (.) on the journey (.) the process that they’re on (Lines 65-69)

Whilst the rehabilitative construct of ‘recovery’ has its roots in democratic and social rights discourses where service users are seen as equal partners in making decisions about their ‘treatment’ (Jørgensen et al., 2020), Extract 14 could be argued to highlight how this discourse is increasingly encompassed by a Western neoliberalist discourse. Within a neoliberal context, the authority remains with the mental health professionals but from the subject position of ‘consumer’, the service user must take responsibility for learning to manage their mental health difficulties with “skills and tools” (Cedar Line 68). Although the ‘consumer’ may no longer be subjected to the identity of ‘patient’, they are now expected to be an active partner in taking control of their ‘recovery’ process (Mik-Meyer, 2010). The ‘consumer’ subject position is seen to accept a medical understanding of ‘recovery’, whilst concurrently rejecting it (Speed, 2011). These changes are visible in what Teghtsoonian (2009) calls “discourses of responsibilisation” (p. 29) that guide individuals to work on themselves in various ways.

If the ‘self’ does not embody autonomy, wellbeing cannot be realised or maintained (N. S. Rose, 2005). From within this discourse, inviting the client to consider primarily working on something over which they have control (their thoughts, reactions, or communication skills) becomes a legitimate form of behaviour during the therapeutic encounter (LaMarre et al., 2019). Such practices, in turn, reproduce the neoliberal and positivist discourses that legitimate them. The following extract further echoes the neoliberal obligation placed on the individual to become self-aware and in charge of their psychological distress concerning *recovery as an ongoing process*.

Extract 15:

> **Alder**: erm so I think I think it's an ongoing process (.) I think that it requires a lot of complex things that you need to do (.) you know (.) behaviour change in itself is complex (.) so (.) you’re changing your behaviours (.) but not only that (.) you’re trying to change your whole thought process (.) your being (.) the way that you are (.) your relationship with the self (.) so yeah (.) I think for all of those things it’s pretty complicated (Lines 69-73)

Here, Alder draws from an individualistic and self-responsibility discourse (McWade, 2016) that continues to be concerned with a transformation of the service user’s behaviour, thought processes, being, and relationship with the self. Service users are expected to gain insight into their psychological difficulties to ‘recover’ rendering the individual subject ‘responsible’ (Lemke, 2001). This also illustrates how disciplines of knowledge (in this case, psychology) seek to regulate the conduct and subjectivities of the individual (Augoustinos et al., 2014). ‘Recovery’ is constructed as a purely intra-psychic process that transpires when “people with a lived experience are successful in modifying or outgrowing their limiting thoughts, feelings and beliefs” (Price-Robertson et al., 2017, p. 110). By centring on the individual needing to change, the

social and material context of psychological distress and the effects of power are less likely to be taken into consideration (Harper & Speed, 2014; Smail, 2005). However, there were indications of participants alluding to possible social and structural contexts of psychological distress within the discursive construction of *recovery as an ongoing process.* In Fennec's case, this was spoken about at the end of the interview when asked if there was anything they would like to add.

Extract 16:

> **Fennec**: the only last bit we didn't really mention is that I do (.) all the way through the CBT stuff (.) talk about you know fallibility that people are not perfect or imperfect (.) that we appreciate that we all lead our own complex lives (.) and for those people attending [the charitable organisation] they have many ongoing conditions going on (.) as well as domestic arrangements (.) environmental situations (Lines 292-296)

Kinderman (2019) argues that in the absence of a recognition of social obstacles, psychological distress becomes "a crisis of individual conditions" (p. 163). Extract 16 was understood as making some reference to the wider context in which psychological distress may occur in their talk of "ongoing conditions", "domestic arrangements", and "environmental situations".

Extract 17:

> **Ginkgo:** I think the end goal really again is quite subjective (.) but it's probably (.) I think (.) a sense of feeling more in control of the things you can control (.) accepting of the things that you can't (.) and an increase in kind of avenues for support (.) ongoing support (.) and an understanding that recovery isn't an endpoint that you know (.) that life happens and that you know we're going to

> kind of go back and forth throughout our lives as to where we are in terms of our mental health and how we (.) how we manage certain situations (.) and it might not always be the same way we manage every time there's going to be lots of different factors that influence that (.) and I think (.) yeah (.) so I think for me perhaps an overarching theme is that recovery doesn't have an end point (.) that it is a journey and there are different twists and turns to that along the way (Lines 52-62)

Ginkgo's construction of 'mental health recovery' as a subjective process is further argued to draw from a rehabilitative discourse. Their talk of 'recovery' involving gaining acceptance and a sense of control also reflects key principles in the rehabilitative construct, affiliated with regaining confidence and independence (Wood et al., 2013). Ginkgo's use of a rehabilitative discourse, however, is understood to have been used to position them as counter to a biomedical conceptualisation of psychological distress (Chassot & Mendes, 2015). Ginkgo's acknowledgment of "avenues of support" and "different factors" that may influence the human condition, could be seen within this context to allude to wider structural inequalities. Furthermore, Ginkgo's positioning may problematise the medical model and allow for a service user's resistance against psychiatric power-knowledge relations (Roberts, 2005). When the biomedical approach is rejected, Kinderman (2019) argues there becomes a greater possibility for human and relational approaches to the human condition. This construction of *recovery as an ongoing process* appears to speak of life as a continuum, reminiscent of a sliding scale ("*that life happens and that you know we're going to kind of go back and forth throughout our lives as to where we are in terms of our mental health*" Ginkgo Line 57). This works to counter the 'us' and 'them' positionings, accentuated further by Ginkgo's use of the collective 'we'.

Extract 18:

> **Dahlia:** I think I'm very interested in a kind of progressive recovery (.) So (.) it feels like that is quite a multi-layered thing (.) and something that takes quite a long time and so (.) yeah (.) and I think it is something I'm very interested in and the different layers of it (Lines 91-93)

Whilst Dahlia's talk of 'recovery' as "progressive" and something that "takes quite a long time" is seen to construct *recovery as an ongoing process,* their reference to it being "multi-layered" is considered as suggesting a psychosocial understanding of psychological distress. Later in the interview, Dahlia makes explicit reference to these in the context of speaking about individuals who frequently attend the Accident and Emergency department.

Extract 19:

> **Dahlia**: Yeah (.) yeah (.) so (.) there's a sort of underlying structural (.) you know when I'm thinking about the frequent attender's team (.) I'm thinking that there is an underlying structural need that certain things need to concretely be in place like a GP (.) and like you know (.) not having health problems that need a specific intervention (.) and yeah (.) absolutely (.) another layer of housing and you know connection to other services like drugs and alcohol or whatever else you know (.) it's sort of the layers of structural (.) kind of (.) scaffolding needed (.) you know that needs to be met (Lines 219- 225)

This could be seen to ascribe deviance from 'the norm' to structural inequalities, rather than the individual. From this position, a therapist could contribute to a therapeutic encounter which invites other ways of storying experience that seek to invalidate, not perpetuate, neoliberal governmentality and technologies of the self (N. S. Rose, 1999).

3.3 Counter-discourse

Recovery as being well and *recovery as an ongoing process* exemplified two discursive constructions that draw from commonplace biomedical, rehabilitative, individualistic, and neoliberalist discourses. It has been previously argued that these dominant discourses shape the professional's ability to articulate 'recovery' and challenge their ability to resist their authority. Nonetheless, as Foucault (2020) maintained, where there is power, there is the possibility for resistance against it. Thus, although dominant narratives of 'recovery' generally present it as a result of neoliberal policies, other narratives do exist, albeit limited in their availability due to the operation of power.

3.3.1 Recovery as being achieved through pluralism

Pluralistic approaches to psychological distress would argue that different people are helped by different inputs and processes at differing times, and the best way of engaging in therapy is to involve the client in the practice of shared decision-making (Stoll & McLeod, 2019). As described by Cooper & McLeod (2010), pluralism "aims to be a way of practising, researching, and thinking about therapy which can embrace, as fully as possible, the whole range of effective therapeutic methods and concepts" (p. 12). The discursive construction *recovery as being achieved through pluralism,* is therefore used to depict when wider discourse constructing 'recovery' involves a diversity of therapeutic approaches, holistic ways of therapeutically engaging with an individual, and/or the talk of a variety of 'methods' and practices to meet client's psychological needs. Whilst a holistic approach may also consider socio-cultural and structural contributions to distress, pluralism differs in its argument for therapeutic diversity to actualise 'recovery'. *Recovery as being achieved through pluralism* has, therefore, been considered to draw upon discourse counter to the dominant

constructions for its critique of a ‘one-size fits all’, standardised, and predictable approach to the human condition so often endorsed by institutions and government funded services.

When speaking about their work at an inpatient ‘eating disorders’ service, Elm discusses a pluralistic approach when working with individual service users.

Extract 20:

> **Elm:** basically (.) we have a general goal to restore the physical health of the patients and the relational one as well (.) and we never set up a final goal in terms of BMI or in terms of what they need to do once they are outside (.) we don't really set up these at the beginning (.) it really depends on the way they evolve during the treatment and even from a strictly therapeutic (.) psychological point of view (.) I never know what kind of therapy I'm gonna use with them (.) I can use an integrated approach (.) but basically (.) I can use CBT (.) I can use MANTRA (.) I can use RO-DBT (.) I can be much more psychodynamic (.) depending on the person (.) so (.) of course (.) you look into improving their physical health (.) basically because otherwise they're not going to survive in this with this specific kind of client (.) but then psychologically and mentally (.) you look at what they can do (.) and basically then you learn about them and from what (.) considering their background also (.) you have then going where they want to go (Lines 56-67)

Elm draws from a pluralistic discourse produced in response to a question about whether ‘recovery’ manifests in their everyday work and may serve to emphasise the wide range of ways they engage with their clients. A pluralistic discourse continues to offer the practitioner the subject position of ‘expert’ but perhaps allows for a wider

understanding of psychological distress and ways in which ‘recovery’ may be actualised. Here, the values of pluralism are seen to impact directly on how therapy is provided by Elm. This appears to be echoed by Alder in the following extract.

Extract 21:

> **Alder:** So (.) I think (.) I think you can use multiple mental health models to (.) I suppose (.) help one person to recover (.) I think again (.) if I'm thinking about the NHS (.) that is where they are usually broken because they say this one model will fix you and actually no one has (.) kind of (.) thought of threading them all together and thinking actually what’s helpful for this person in this stage of recovery (.) versus a longer-term approach (.) And I think you can absolutely use parts of a model to help one person across a whole journey (Lines 201-207)

Alder similarly draws from a pluralistic discourse produced in response to the question about whether ‘recovery’ manifests in their every day. They speak of the dominance of CBT therapy provision in the NHS which could allow them to attribute responsibility for a lack of ‘recovery’ on the ‘one size fits all’ attitude promoted by our current government. This moves away from the individual being held responsible and constructed as ‘treatment resistant’ when they are not deemed to have ‘recovered’. Thus, talking about *recovery as being achieved through pluralism* allows for different possibilities for both practitioners and service users when it comes to ‘recovery’. A more explicit critique of the current system emerged from the discursive construction *recovery as achieved through pluralism* and will be discussed in detail shortly. However, Alder also draws from a pluralistic discourse in relation to a wider approach to ‘recovery’.

Extract 22:

> **Alder:** There is a heavy encouragement to involve people in stuff outside of their therapy (.) So (.) erm I'll give you an example (.) The refugee (.) kind of (.) team (.) er (.) they encourage people to kind of like take part in other activities (.) like football or erm I think for older women (.) not very old (.) but older women (.) they have a gardening club and it's just like a nice safe environment they use (.) I suppose (.) to help people recover in other ways and share experiences (Lines 227-232)

Whilst engaging in personally meaningful and/or socially valued activities for 'mental health recovery' draws upon a rehabilitative discourse, it could also reside in a pluralistic approach to psychological distress. Using alternative inputs outside of psychological therapies for 'recovery' purposes has been criticised for upholding the neoliberal agenda (Anonymous, 2018). However, it could be argued that people might be encouraged to engage in these practices, not with the purpose of becoming productive citizens but to experience greater wellbeing outside of what is considered the 'evidence-base'. This may allow for the individual to experience and/or process their distress in a way that feels more comfortable for them. A similar construction of 'recovery' appears to also be echoed by Dahlia.

Extract 23:

> **Dahlia:** so (.) I think part of the issue is that with a lot of the people that I (.) you know (.) by the time some people are coming to the high intensity team (.) they (.) you know (.) there is a problem (.) usually (.) of some kind (.) and there's often a relationship problem (.) you know (.) and a help seeking problem (.) that's why they're seeking help because they're not getting what they need (.)

but you know actually (.) providing that help can be quite intrusive (.) you know? So (.) actually if you listen to people who say (.) “well (.) gosh (.) you know you're very worried about your pain and let's talk about your pain endlessly and let's have you in for therapy three times a week with” (.) you know it's not something people would want to do (.) so (.) actually providing help on the level that people are asking for but then also having a bit of an interpersonal connection at the same time could be really (.) really useful (.) it might look like one thing (.) but actually be another thing (.) you know? [laughing] and perhaps that's quite hard to explain to somebody who's not from (.) a (.) you know (.) a therapeutic background (.) you know (.) somebody who's coming from an accounts perspective (.) or something (.) they might not understand that somebody who accompanies them to an appointment (.) might also be getting to know them and being able to then have a further conversation later (.) you know (.) I think these things might (.) erm although it might look like practical help (.) if you have practical help given by the same person who is (.) you know (.) seeing the same person week after week (.) it might actually have (.) you know (.) a therapeutic role as well in a way that might be acceptable to somebody where therapy just wouldn't be an option (Lines 360-380)

By constructing ‘recovery’ as a pluralistic process, where service users are meaningfully given “help on the level that people are asking for”, Dahlia allows for an alternative discourse in meeting the individual’s needs to emerge. This appears to position both the practitioner and client within a relational framework that opens up different ways of actualising ‘mental health recovery’. Despite speaking about the difficulty of communicating this approach to ‘the powers that be’, by positioning themselves within this discourse, Dahlia may feel less immobilised against the

prevailing system. ‘Recovery’ occurring outside of the therapy room is correspondingly spoken about by Ginkgo.

Extract 24:

> **Ginkgo**: but also (.) therapy isn't just where the support happens (.) there is that wrap around support in terms of community and (.) yeah (.) engaging in activities and courses that speak to that individual and speak to their talents (.) their likes (.) their interests (.) their needs in really creative ways and in ways that they can contribute and coproduce as well (.) um (.) so there is this sort of feeling of it not being (.) it's not a straight line (.) there is the most (.) this kind of like (.) there is some level of line in terms of the guided journey (.) but then there's all of these other interventions that can sit around it that really complement and support someone in achieving some significant changes for them [‘…’] I definitely see there is that (.) you know (.) there is a huge difference in the way that I've learned to approach looking at recovery through this work (.) I think there was already a bit of that in me (.) hence why I kind of moved from the (.) from the clinical side of things into the more charity sector (.) because I (.) I think I felt that there was a need for something a little bit more holistic for individuals (.) but I guess what I'm keen on doing now is to think how to work together 'cause there's a place (.) there's a place for both (.) you know? I don't think that one is superior to the other necessarily (.) but I think there's elements of both ways of working that could really complement each other to really support society and a larger scale (Lines 101-120)

Ginkgo draws from a pluralistic discourse when speaking about applying a wider range of services and approaches to mental health care. By talking about engaging in activities that “speak to that individual and speak to their talents” (Ginkgo Line 103),

they are seen to align with pluralism's commitment to prioritising the client's perspective with the focal point being what the client wants from their therapeutic experience (Athanasiadou, 2012). This may provide a means of expanding social discourse relating to therapy rather than remaining within the existing social framework that is discursively bound by society's prescriptions for what is accepted of therapy, and how a therapist and service user should legitimately behave. In taking up this discursive positioning, the practitioner may be afforded the power to facilitate alternative subjectivities. However, Ginkgo speaks of having to move to work in the charity sector to create this space of resistance but emphasises that this is not part of 'schoolism' or the 'therapy wars'. They continue to use a pluralistic discourse that consistently seeks to position the client as an active partner in a process of shared decision-making (Stoll & McLeod, 2019):

Extract 25:

> **Gingko:** I think front and centre is having that kind of level of choice and different things that people can be involved in and in having their different needs met largely at the same time (.) but not in a kind of way that feels uncomfortable (.) with [the charity] the way that it works is really unique to anyone who comes through the door really (.) so (.) you know when we assess them (.) we think about what they're saying they're finding difficult (.) we also ask them about what they like doing (.) their interests (.) their kind of future goals (.) if they have any (.) if they don't (.) that's fine [pause] and to already sort of start the process of making some recommendations collaboratively with them (.) you know (.) sort of saying these are some of the things that we have on offer here (.) for example regular phone support or you know perhaps someone like experiencing some physical health problems like we have some pain

workshops coming up we think would be really good for you to join (.) we have like a choir we think that would be really helpful for you (.) you're interested in music (.) it's a nice way to meet people and to see whether they want to kind of do some of those things (Lines 206-219)

In the extract, 'recovery' is constructed as involving the service user having choice, developing goals, and having their needs met through different processes and inputs. As someone with a significant responsibility concerning the development and provision of care within the charity, Ginkgo's construction of 'recovery' through discursive resources derived from pluralistic discourse has given rise to a particular version of 'recovery'. This subsequently seeks to promote a pluralistic and holistic way of therapeutically engaging with an individual and is understood as working to resist a standardised approach to mental health care. In this context, *recovery as being achieved through pluralism* positions practitioners and service users as part of a community, with individuals being free to choose how they enact 'recovery'. Of course, there are no entirely free choices, as this is always framed by the options being offered by the organisation.

A wider perspective spanning across differing professionals and services to promote 'recovery' was also spoken about by other participants when talking about *recovery as being achieved through pluralism.*

Extract 26:

Fennec: We're all sort of jigsaw puzzles that need attention (.) and so sometimes I can only put one piece back (.) but then if I put one piece back and ten other people put the other pieces in (.) hopefully at some point the picture starts to be clearer (.) you know? (Lines 107-109)

Fennec uses a jigsaw puzzle metaphor to speak about *recovery as being achieved through pluralism.* This is often used as a metaphor for life, with challenges likened to a fragmented jigsaw puzzle with its various disconnected pieces. Here, it is a wider pluralistic and perhaps holistic approach to the human condition that can help someone to 'recover'. They draw from pluralism to go on to speak about their experience of utilising a wider range of professionals to help achieve 'recovery'.

Extract 27:

> **Fennec**: we had a situation recently where I did some work with a lady who's had lots of issues of physical abuse from the ex-husband and stuff (.) and so we did some sessions which worked really well (.) and then she was going to court (.) but that's outside the scope of what I was doing (.) that was fine (.) I handed it over (.) but she kept on coming back to me about things (.) so I was able to say "tell me what it is" and then I raised it with [the manager] and [the manager] raised it with the appropriate individual who was dealing with the advocacy parts of the work they do (.) and so I was able to highlight my concerns and the immediacy of my concerns (.) and we were able to work together and as a result we actually got her moved (.) we supported some benefit changes (.) because she was very vulnerable (.) and it showed the importance of collaboration and thinking ahead (.) thinking outside the box (.) this person (.) I can see this is going to be a serious issue if we don't deal with this now rather than "well I've done my bit (.) it's not really something to do with me" (.) you know (.) no (.) I think you have to take a bit of responsibility for that (Lines 206-219)

The puzzle metaphor can be seen to continue in Fennec's talk, where they may be seen to represent the therapeutic puzzle piece. However, from a pluralistic

perspective, other puzzle pieces are also needed to help someone 'recover', additionally involving others to tackle psychosocial factors (such as housing and benefits) that could not be addressed by exploring intrapsychic processes only. By using this example to construct *recovery as being achieved through pluralism,* responsibility for actualising 'recovery' can be assigned to a number of professionals, rather than that of the individual or individual practitioner. Socio-cultural and structural contributions to psychological distress are also argued to, therefore, be considered within a pluralistic discourse of 'mental health recovery'.

In relation to a pluralistic discourse and the presenting discursive construction, an explicit critique of the dominant current system emerged. It may be important here to delineate between a critique of the IAPT system that applies a version of CBT and CBT as a theoretical model that existed prior to IAPT. Preceding this extract, Alder is speaking about how someone's 'recovery' could be impacted by a lack of pluralistic working.

Extract 28:

> ***Researcher:*** *Yeah (.) where do you think the responsibility lies for that in terms of (.) the kind of training that we're focusing on in this country?*
>
> **Alder:** Erm (.) central government (.) They went to the professionals and said (.) "what works and what's cheap" and the professionals said "well (.) the evidence says this" and they said "OK (.) let's do it" (.) That's literally what I think has happened (.) I don't think they have really thought about it if you want my honest opinion (.) "Let's manualise this programme (.) let's get people trained (.) we have an epidemic with mental health problems (.) let's train people so people can be treated (.) erm (.) boom (.) done" (.) And what happens to

> these people after six weeks? Ah you get stepped up (.) ah for what? More CBT [laughs] which hasn't worked the first time because (.) yeah (.) and then you're just in this merry-go-round (.) you know (.) so it's a problem (.) I think it's the government's short sightedness (.) that's created this (Lines 585-592)

Alder employs a critical discourse to condemn the Government's implementation of short-term CBT interventions within IAPT as a means of achieving 'recovery'. By speaking from the subject-position of 'critical of the current system', Alder appears to oppose the standardisation of the human condition. This could be understood as a form of resistance, denoting Foucault's notion that conflict is inherent to power (Foucault, 1982). Alder's critique may be seen to exemplify a reaction to top-down power, acknowledged in Foucauldian terms as 'tactical reversal' (K. Thompson, 2003). Although this may be limited in its possibilities for wider changes to healthcare, this is a position that is growing in the current literature. Loewenthal (2018) writes, "I now consider IAPT […] not as a well-intentioned, though sometimes misguided, attempt to improve the mental health of a nation but an ideological attempt at social control which is more part of the problem than the solution" (p. 249).

Nonetheless, a pluralistic approach has also been criticised for continuing to yield "to the therapeutocratic imperative to isolate issues within the individual" (Vermes, 2017). 'Therapeutocracy' was a term coined in 1988 by a German sociologist to depict the publicly funded positioning of therapists to reconceptualise complex social, economic, political, and legal difficulties into psychological terms (Ward, 2002). Speaking specifically from a counselling psychology perspective, Vermes (2017) argues:

> Like many models before it, pluralistic therapy is not devised to work with social collectives, such as families, groups, communities, cultures, institutions or political power-holders. As such, it inevitably positions the client's problem as

> something unique to the person, who must address it through creative personal adaptation such as self-reflection, goal-setting and behaviour change (p. 47).

Although working from a pluralistic perspective is also critiqued by the author for continuing to prioritise one-to-one therapy as the primary medium for psychological therapies, as an 'individualism impasse' is reached it is framed as advantageous within the current system.

3.3.2 Recovery as taking place in the interaction with others

Whilst the dominant (and arguably the counter) discourses discussed so far place a focus on the individual experience of psychological distress and 'recovery' from this experience, a resistance to this often constructs the human condition as being damaged by individualism. From this perspective, it is the "erosion of the social and relational" (White, 2017, p. 122) in our ever globalising and capitalist society that promotes angst about achieving emotional wellbeing. 'Recovery' is consequently constructed as *taking place in the interaction with others.* This is often spoken about with reference to 'connections'. In the following extract, Birch has been speaking about 'recovery' as psychic relief in the context of 'anorexia nervosa' and how one may actualise this.

Extract 29:

> **Birch:** And then group stuff is so important 'cause they're so (.) you know anorexia is an illness where you problem solve on your own (.) that's what you do (.) you break connections (.) like addiction is you know (.) you break connections (.) And the way back is (.) I think (.) by coming back to the group (Lines 189-192)

Where individualism encourages a view of the self as independent, self-reliant, and distinct from others, collectivism "fosters an interconnected view of the self that overlaps with close others, with individuals' thoughts, feelings, and behaviours embedded in social contexts" (Santos et al., 2017, p. 1229). Although Birch continues to draw from a biomedical discourse, 'recovery' is constructed as "coming back to the group". Here, the individual is embedded within a social context and is understood to process their distress within the connection with others.

Extract 30:

> **Cedar:** I think (.) um (.) helping people to feel connected with other people is really important and hearing (.) hearing (.) I think that's what's so powerful that we do here at the recovery college is the role of the of the peer trainers and their use of their own experiences as part of the training (.) so that would be important (Lines 62-65)

Despite both speaking about the importance of connections, Extracts 20 and 21 may speak more to the idea that we are beings in relationship *to*, rather than relational beings from the outset (Gergen, 2011). Thus, connections are constructed as a fundamental part of 'recovery' but only concerning their ability to contribute to or shape this phenomenon. Price-Robertson et al., (2017) argue that:

> From a relational perspective, the opposite of individualism is not collectivism, but rather something closer to interdependence; the kind of interdependence that underpins systems and ecological thinking, which see people as fundamentally inseparable from their environments. A relational perspective ultimately seeks to transcend the polarising duality between individualism and collectivism with a view of interdependence that takes seriously the needs of

> the individual and the needs of the collective (or community) in ways that understand and hold that they are inseparably linked (p. 114).

The following extract may be more aligned with this perspective. Here, Birch is speaking about a therapy group they developed for an inpatient 'eating disorders' ward.

Extract 31:

> **Birch:** And I was thinking about I want to start a kind of group therapy thing up (.) It's like oh my God (.) this is so important (.) it's about connections (.) it's about tribes and about humans not (.) not functioning as individuals (.) you know (.) we function as a tribe (.) this (.) and this is what the patients can't do (.) and so that's what it (.) so it's called Tribe and it's about how we connect (.) how our neurones connect (.) how we connect as neurones in a room and how (.) how you know *that* also is what happens on the ward (.) what happens in our families and happens in blah (.) blah (.) blah everywhere (Lines 264-271)

Birch's discursive construction of *recovery as taking place in the interaction with others* is located within a relational discourse where "functioning as individuals" has perpetuated psychological distress and the way to 'recover' is through reconnecting with others. With a view of interdependence, the use of relational discourse constructs the way in which the individual relates in the therapeutic group as emulating what happens on the wider ward, within family systems, and so on. From this perspective, the human condition and psychological wellbeing are inextricably linked to relating with others, despite the system upholding competitive self-interest as the ideal. Taking up the subject position of 'tribe member' may have very different implications for subjectivity compared to a neoliberal discourse. A subject position offered by a

neoliberalist discourse, may encourage self-surveillance; obscure the role of our environment in how we act, think, and feel; and perpetuate self-blame (Johnstone & Boyle, 2018). From the position of 'tribe member', on the other hand, it is not the individual that is located at the centre of 'mental health recovery', rather agency spreads through the group constellation (Price-Robertson, Manderson, et al., 2017). This possibly allows for a wider, psychosocial perception of psychological distress redefining what it is to 'recover'. Interestingly, Birch continues to utilise the 'patient' discourse within this wider relational construction, perhaps suggesting their belief that individualism is part of an underlying pathology or demonstrating the privileged position this discourse continues to hold in certain contexts.

Dahlia also speaks about *recovery as taking place in the interaction with others* in the context of group therapy. Here, 'recovery' is constructed as an "inherently social process" (Marino, 2015, p. 68).

Extract 32:

> **Dahlia:** I think it is something I'm very interested in and the different layers of it and allowing a sort of revisiting of it actually and probably re-visiting with other people as well (.) you know (.) I think it's something that you know (.) that you sort of witness (.) I really like groups for it because I think you can step back (.) actually (.) if you're facilitating a group and you can watch people's reactions with other people and they sort of (.) I think that some of that (.) some of the steps that you see people take towards recovery have been as a result of two people within the group (.) you know (.) not the facilitator actually (.) yeah (.) that's been very interesting over time (.) but you know (.) it's actually the sort of spiralling shape of people's progress really (.) that you know people seem to revisit the same thing again and again (.) and it can feel like it's not going

anywhere (.) but actually (.) you know (.) with a group that's happening over a long period of time you do feel like something may be happening (Lines 93-104)

Here, “progress” made and “steps” towards ‘recovery’ are described as an interpersonal process whereby relating to others is seen as the space in which ‘recovery’ takes place. Dahlia, therefore, speaks of the group as being the medium through which ‘recovery’ becomes possible. Whilst the practitioner is constructed as facilitating the space in which people can connect and be interdependent, they actually appear to take on a position of ‘observer’. Although the practitioner continues to be a component of a power system that yields oppression, from the subject position of ‘observer’ Dahlia may be able to help clients reclaim and explore their preferred subjectivities within this system (LaMarre et al., 2019). Dahlia continues:

Extract 33:

Dahlia: I think in terms of the progression (.) it seems to be a progression from sort of self out again and then back in again (.) actually (.) so back into sort of becoming more interested after that time (.) you know (.) sort of noticing someone else doing something and then becoming more interested in what people are doing themselves (.) and we don't look at it with a particular model (.) I mean our model is very simple (.) but that does seem to be a pattern of what happens in the groups (.) and it's sort of like an unfolding and folding back in again and then unfolding again (Lines 121-128)

Dahlia’s use of a relational discourse to construct ‘recovery’, particularly it being a process of “unfolding and folding back in again” evoked the concept of the rhizome for me. Deleuze & Guattari (2013) introduced the notion of the rhizome to describe the

interrelation of things within an assemblage, or therapeutic group, in this case. Following this interpretation, in their search for relief from their psychological distress, each group member can be connected to each other. Here, like the rhizome, 'recovery' has no archetypal structure, no beginning or end, and is not a linear or singular process. This notion is echoed elsewhere when concerned with the human condition. Marshall (2019) writes:

> The human experience is rhizomic, not tree-like. Therefore, to engage with experience holistically we might be flexible, open to dynamic interplays initiating at random points and in a continual process of unravelling and coming back together (p. 194).

Recovery as taking place in the interaction with others raises questions about the dominance of the top-down nature of knowledge production in psychology. This is understood to place the emphasis on objectivity, marginalise subjectivity, and create limitations on how people can talk about their experiences of psychological distress and 'recovery' (Johnstone & Boyle, 2018). The dominance of a discursive construction drawing from a relational discourse when talking about 'recovery' could be understood to highlight how dominant discourses are imposed on a group, rather than the group being listened to concerning ways in which they feel they could 'recover'. Ginkgo is seen to speak about this in their construction of *recovery as taking place in the interaction with others*.

Extract 34:

> **Ginkgo:** why the longer term support is important (.) because as much as we recognise that there's a place for individual interventions (.) whether that's therapy or something more course-based (.) what we really believe helps to

> sustain and kind of build on that (.) is this idea of epistemic trust (.) so really giving a sense for many of our members who perhaps have smaller support networks who have difficulties trusting the world because the world has not been kind to them [pause] to create a space where they can build that sense of a trusting relationship with one another (.) with us and with you know (.) society (.) with other parts of society as well (.) so growing that sense that they can (.) you know (.) just really experience it and practice it (.) also a space where people can try things (.) make mistakes and come back to us and say this didn't go very well and have a space where they're not judged and we can just talk through it (Lines 223-234)

Within this extract, the facilitation of epistemic trust is constructed as essential to 'recovery', highlighting the possible injustices experienced (due to unequal power relations) by marginalised groups who lack shared social resources to make sense of their experiences (Fricker, 2006). In taking up this position, Ginkgo may be able to remove barriers to the group's marginalised social and epistemic position by approaching 'recovery' within their service counter to the "totalising hegemonic force of the biomedical model" (Speed, 2011, p. 128). Whilst the practitioner continues to be a product and instrument of power (Guilfoyle, 2005), considering the limitations of the professional and cultural requirements, Ginkgo appears to be able to choose how power is deployed to actualise 'mental health recovery'.

In the context of *recovery as taking place in the interaction with others*, the individual and the community are inextricably linked and an interconnected view of the self overlaps with close others. It could be argued, therefore, that from within this construction of 'recovery', the makeup of the psychological (and wider) workforce becomes deeply important.

Extract 35:

> **Alder:** The other thing that I would say as well is working as you know (.) somebody who's from a BAME background in psychology (.) I know one other person who is the same colour as me and (.) er everybody else is white (.) and er that in itself (.) is that a barrier? Is that a barrier to people's recovery? ['…'] so yeah (.) there's all sorts of things (.) These all impact on people's recovery you know (.) I'm thinking of a case that I (.) I can just think of it (.) it was a 14-year-old boy (.) he's a black boy (.) suspected of being kind of a county line runner and he just disengaged with all of us because he was like (.) he was probably sitting there thinking like "what the hell (.) I don't know you guys (.) like you don't know my life (.) you don't know what I have to do and what I don't have to do" (.) Another person lost form the system (.) why? Because there wasn't somebody that could engage with him (.) simple as that (.) not because we don't have the skills (.) but because we (.) he perceived us as not being able to relate (.) and I get it (.) I completely get it (Lines 290-294; 309-317)

When discourse opens the possibility of a relational 'recovery', ethnicity, cultural background, and other features that may influence someone's personal and social identity are brought to the forefront of the therapeutic interaction. Here, Alder constructs 'recovery' as being impeded or enabled by whether the individual's view of the self intersects with those around them. As the individual or community cannot be separated from the larger relational processes of which they are a part (Gergen, 2015), the practitioner is unable to help them actualise 'recovery' when they are positioned as 'outsider'. When asked about what 'mental health recovery' should encompass, Ginkgo also speaks about "who gets the jobs".

Extract 36:

Gingko: I think as well (.) I think we do it well (.) but we can always improve as well is that kind of cultural recognition of what recovery means for individuals based on their cultural experience as well and how we use language to or how we are kind of more mindful of language in terms of helping to understand that and be able to work with that more (.) I think (.) you know (.) there's always much more room for member involvement in helping us with that as well (.) and kind of moving away from this expert (.) I don't know (.) white (.) expert psychology kind of frame (.) I don't think we sit very far in that (.) but you know (.) I think there is room to recognise that there are still elements of that because of the way society is and you know who gets the jobs basically ['…'] I think (.) across the board if other services or if you know the way kind of mental health is approached could hold that in mind more I think that would really kind of benefit because you know (.) as we know (.) a lot of black and people of colour are not getting the sort of mental health provision and support that they deserve and need and a lot of that [pause] well there's lots of reasons for that (.) but I mean (.) one of them is the kind of the distrust and fear as well around services (.) and I think the more that we can demonstrate that it's safe to do and we allow (.) we're able to provide spaces that are safe to kind of share their experience and work with it in a way that feels acceptable and feels comfortable for our communities (.) I think the better (Lines 338-358)

Thus, within the discursive construction *recovery as taking place in the interaction with others*, a cultural recognition of what 'recovery' may mean to the individual is privileged. Here, a culturally diverse workforce allows for a relational 'recovery' in its attunement to issues such as stigma, racism, discrimination, how different people seek 'treatment', or the various ways in which psychological distress is constructed. By

drawing on a social justice discourse when speaking about ‘recovery’, Ginkgo resists the dominant culture as an agent of disconnection and legitimises ways of ‘recovering’ that feel acceptable and comfortable for the community.

4 CHAPTER FOUR: SUMMARY & CRITICAL REVIEW

4.1 Revisiting the research questions and summary of analysis

This research aimed to explore how 'mental health recovery' is being constructed in mental health services by those with a significant responsibility concerning the development and provision of care. This was to gain an understanding of how the different ways of talking about 'recovery' are indicative of wider social and political struggles regarding psychological distress and any possible implications for current service provision. To facilitate clarity of the main findings, they will now be summarised and discussed according to the research questions. Each of these comes under the principal research question: *How is 'mental health recovery' being talked about by mental health practitioners?* At this point it may be pertinent to remind the reader that I do not seek an objective truth as a result of this research and that my own subjectivity has guided my unique presentation of this phenomena.

4.1.1 What discourses are available to talk about 'mental health recovery'?

Through Foucauldian discourse analysis, four main discursive constructions were identified: (1) *recovery as being well* (2) *recovery as an ongoing process* (3) *recovery as being achieved through pluralism* (4) *recovery as occurring in the interaction with others.*

From these four discursive constructions, *recovery as being well* and *recovery as an ongoing process* were considered dominant, based on the prevalence of the discourses they drew from amongst wider social and political contexts. Both constructions drew from neoliberal and individualistic discourses, with *recovery as being well* also drawing from a biomedical discourse and *recovery as an ongoing*

process, a rehabilitative one. The neoliberal and individualistic discourses construct psychological distress as incompatible with being 'functional' and 'recovery', therefore, is portrayed as being realised when the individual becomes less of a burden on the state. Whilst considered a variable process, the individual must gain 'insight' into their psychological difficulties and work on themselves to 'recover'. However, determining whether someone has 'insight' is to ask whether the person accepts that they have a 'mental illness' and that this is the cause of their symptoms, experiences, or difficulties (T. Knight, 2013). Here, a biomedical discourse is privileged and limits the possibilities for other ways in which psychological distress may be conceptualised. From within these discourses, 'recovery' is constructed as a purely intrapsychic process resulting in the recognition of psychological therapies, which invite the client to work only on that over which they have control, as a legitimate practice for 'recovery'.

Recovery as being achieved through pluralism and *recovery as occurring in the interaction with others,* on the other hand, were considered to draw from counter-discourses, providing resistance to the predominant and prevailing understanding of psychological distress and 'mental health recovery'. In opposition to dominant discourses, both of these discursive constructions drew from pluralistic, critical, and relational discourses. The pluralistic, critical, and relational discourses all query the dominance of the top-down nature of knowledge-making practices in psychology. From within these discourses, functioning as individuals and approaching the human condition with standardised approaches has only perpetuated psychological distress. 'Recovery' is constructed as being enacted through reconnecting and relating with others and the possibilities for expanding social discourse relating to therapy are opened up. However, these discourses appear to be less culturally available, constrained by dominant political ideologies and power structures that are so

entrenched within our society that it becomes challenging to see how these alternatives could advance and exist within our cultural milieu (Willig, 2013). This was highlighted by the discursive construction of *recovery as difficult to define.*

4.1.2 What subject positions are warranted by these constructions?

Where *recovery as being well* was deployed, practitioners were constructed as 'truth tellers', 'helpers', and 'givers' of knowledge. This provides a legitimate framework from which to deliver their expertise for an individual to actualise 'mental health recovery' and upholds psychology's privileged standing as a way of knowing people and finding a solution to their distress (Guilfoyle, 2005). These subject positions were also seen to facilitate confession (Foucault, 2020), where 'recovery' unfolds within a power relationship of 'therapist' and 'client'. Several culturally discursive factors, such as the western construction of the self-contained individual (N. S. Rose, 2005), mean these subject positions are taken up almost automatically by both parties. From the subject position of 'client' the individual is both the object, and subject, of certain ways of knowing.

Furthermore, the individual experiencing emotional distress may be positioned as a 'consumer' when *recovery as being well* and *recovery as an ongoing process* were implemented. Here, the individual holds a tension between accepting a biomedical understanding of their distress and rejecting the subject position of 'passive participant' (Speed, 2011). The subject position of 'consumer' within the construction of *recovery as an ongoing process,* is a position that attempts to attribute *some* subjective positioning to individuals, such that they are "not defined [solely] by their illnesses" (Cedar Line 52). Where the individual is positioned as an economic actor, the need for therapeutic interventions aimed at 'returning' them to a state of productivity is not only accepted but privileged in the NHS. From within the discourse

of the neoliberal consumer, the individual is made to feel responsible for their psychological wellbeing, rather than being able to acknowledge any social inequalities and injustices that may have contributed to their experience.

The discursive constructions *recovery as achieved through pluralism* and *recovery as taking place in the interaction with others* were interpreted as offering subject positions motivated by resistance. Positioned within a critical and pluralistic discourse, practitioners appeared more able to challenge taken-for-granted ways of knowing. Existing in this discursive location thus allowed for alternative possibilities to emerge, such as how psychological difficulties are named and how 'recovery' is attended to. Whilst the practitioner continues to be a product and instrument of power (Guilfoyle, 2005), this subject position appeared to provide participants with a greater choice in how power is deployed to bring about 'mental health recovery'.

When *recovery as taking place in the interaction with others was* used, practitioners were constructed as something closer to 'facilitator' or 'observer'. This allowed for an alternative way to actualise 'recovery', where perhaps the asymmetrical power dynamics habitually found in the therapeutic relationship can be slightly reduced. This positioning is also understood as helping clients reclaim and explore their preferred subjectivities within this system and dynamic (LaMarre et al., 2019). Additionally, from within this discursive construction service users were positioned as 'tribe members' or as part of a collective. Whereas a neoliberalist discourse offers a self-surveillant and responsible subject position, a relational discourse offering the position of tribe member decentres the individual and the agency for 'recovery' occurs in the group constellation (Price-Robertson, Manderson, et al., 2017). This may highlight the importance of services structured as communities.

4.1.3 What implications do these constructions have on practice, service provision, policy, and dominant understandings of psychological distress?

In line with discourse analysis theory (Willig, 2013), here I will summarise how the ways in which participants spoke about 'recovery' may have implications for their material 'reality'. Whilst discourses are not said to 'determine' things, they are argued to "intervene in the relations of what can be known, said, or practiced" (Arribas-Ayllon & Walkerdine, 2017, p. 120). In taking up a critical realist social constructionist approach, I am also able to consider why the participants drew upon certain discourses; explore the impact of material practices on discursive practices; and position participants talk within the 'reality' that they are negotiating (Sims-Schouten et al., 2007). However, the scope and scale of the research project was unable to answer each component of this sub-question and I have, therefore, attended to some of these more than others.

Biomedical constructions of 'recovery' were most often located within the 'reality' of inpatient settings and participants from a psychiatric background, which is no surprise bearing in mind the historical emergence of psychological distress and 'recovery' explored in the literature review. Chouliaraki & Fairclough (1999) discuss the more stable a discourse, the less likely it is to change. Participants' use of a biomedical and neoliberal discourse, therefore, appeared indicative of the prevalence of these constructions. It is not considered that the participant's biomedical and/or neoliberal constructions had implications on their practice, rather that these have already intervened in the relations of what can be known, said, or practiced in these contexts (Arribas-Ayllon & Walkerdine, 2017). These constructs, therefore, were seen to construct representations of the participant's common ways of understanding the

world they inhabit (Parker, 2015). This could also be true of the rehabilitative construction of 'recovery', where projects such as ImROC have informed services like Recovery Colleges, resulting in the cultural availability of discourse in line with their principles. However, rehabilitative constructions did appear to have some effect on the participant's practice, both in their ability to attribute more subjective positioning to individuals and, at times, to consider socio-cultural and structural contributions to psychological distress.

The construction of 'recovery' being achieved through pluralism was seen to intervene in the relations of how some participants practiced across their various mental health service contexts. On a small scale, for example, Elm's pluralistic construction of 'recovery' was seen to play out in the material 'reality' of the many psychological models they choose to use with a client. Similarly, a relational construction of 'mental health recovery' appears to have led to the development and facilitation of therapeutic groups in which participants felt 'recovery' could occur. Perhaps concerning a wider impact, Ginkgo's pluralistic and relational constructions of 'recovery' appeared to have implications for what their charitable organisation offers members, for example its structure as a community. Equally, however, it could be argued that Ginkgo drew upon these discourses as this is the everyday 'reality' that they negotiate. It would be interesting to explore this further in a study with participants that were homogenous in their management of service provision.

With hindsight, asking about the implications on policy and dominant understandings of psychological distress is too large a question for the scope of this study and whole studies have been dedicated to critiquing the implementation of 'recovery' as a policy object (e.g., McWade, 2016). However, the discursive constructions *recovery as being*

well and *recovery as an ongoing process* could certainly be argued to mirror current neoliberal policies and commonplace understandings of psychological distress.

4.1.4 Are socio-cultural and structural contributions to psychological distress considered within such discourses of 'mental health recovery'?

When asked in the interview about what 'recovery' meant to them, none of the participants entirely rejected the concept. Nor did any of them initially speak about 'mental health recovery' in a way that indicated a pressing need for the social conditions leading to childhood adversity, relative poverty, and/or social inequality to change for this to be accomplished. However, socio-cultural and structural contributions to psychological distress did emerge when participants were asked about what 'mental health recovery' *should* encompass. Taking up a critical discourse did also appear to intervene in the relations of what can be known and said about the 'origins' of emotional distress. This could be indicative of wider social issues whereby psychological distress is still understood as needing to be 'solved' through intrapsychic processes and that a psychosocial perspective is only just emerging. Having chosen to be a counselling psychologist myself, it has been important to reflect on my own privileging of psychological therapies as a means for relief from emotional distress. I could only imagine, therefore, that I too would construct 'recovery' using the pluralistic and relational discourses that appeared to allow for an opening up of different ways of 'knowing' 'recovery', rather than rejecting the concept entirely. Whilst *recovery as achieved through pluralism* and *recovery as taking place in the interaction with others* continue to uphold psychology's powerful position in the 'management' of the human condition, they do appear to enable a discursive space that allows for a broader range of understandings and approaches to psychological distress.

4.2 Original contributions to knowledge and relevance to counselling psychology

The existing literature indicated a need for the implications and limitations of 'mental health recovery' discourse "to be much more fully elaborated" (Harper & Speed, 2014, p. 52). However, a critical approach to the concept of 'recovery' within the literature appears to have petered out since the original furore. Attuned to counselling psychology's inquisitive, reflexive, and critical attitude (BPS, 2020a), I set out to explore problematic political and professional assumptions that continue to limit our psychological approach to the human condition and how we engage with psychological distress. As a result, this thesis offers counselling psychologists, and other practitioners, a reflexive gaze by which to interrogate their use of discourse and its possible implications for their professional knowledge and 'truth claims' about psychological distress and what constitutes 'recovery' from this phenomenon. Although modestly broadening the lens is not enough in and of itself to challenge the systems that constrain us all (practitioners and clients alike), disseminating research that raises awareness may be a starting point for individuals realising a 'recovery' that is more in line with their subjective experiences.

Considering the tribulations associated with applying the findings of discourse analytic research (Harper, 1995) and the understanding that there are a variety of stories to be told, I present these contributions and interventions in line with my political standpoint and motivations as a trainee counselling psychologist.

4.2.1 Social critique, policy, and service provision

First, this research contributes to a critique of 'recovery's' role in disciplining and controlling those who are trying to manage the traumatising impact of childhood

adversity, relative poverty, and/or social inequality and has demonstrated how the continued use of neoliberal and individualistic discourses can limit an exploration of these within current provisions of therapy. The ongoing privilege of biomedical, neoliberal, and individualistic discourses as ways of understanding ourselves is argued to limit the use of other psychological therapies being made available on the NHS and show how the system in place continues to disregard the complexities of the human condition. In their response to the NHS England Psychological professions vision for England 2019-24, the BPS highlighted the "clear need for psychological professions to work together to challenge and present alternatives to the biomedical model" (BPS, 2020b, p. 2) and underlined the need for the vision to embrace the movement towards a psychosocial model. This research has presented two alternative constructions of 'recovery' that allow for a greater understanding of socio-cultural and structural contributions to psychological distress. As the research has highlighted a subjective and interpersonal construction of 'recovery' that authorises pluralistic and relational ways of working, I would argue that its use in mental health policy as a measure of success or failure is entirely unhelpful. Comparable to psychological 'interventions', 'recovery' is not a one-size-fits-all concept. This research argues that when 'recovery' is constructed as a pluralistic and relational process, further consideration should be given to how services are structured (e.g., as communities) and to what therapies should be available. Particularly where the intention is to roll IAPT out to 'long term conditions' (NHS England, 2019b), approaches to therapy that privilege counter-discourses, such as narrative therapy (Guilfoyle, 2005; M. White, 2007), can be utilised so as to focus on social structures and cultural ideologies rather than the individual.

4.2.2 Counselling psychology training

My research has contributed by showing how practitioners may help construct certain notions of psychological distress, common ways of understanding 'recovery', and how positioning the client in particular ways can influence how psychological wellbeing is actualised. Willig (1999a) contends that discourse analysis as a social critique pertains to 'exposing through publication' how language can be used to legitimate and preserve unequal power relationships. Having just come to the end of the training myself, I would argue that by publishing and disseminating this research, trainees will have the opportunity to engage with the contradictory demands that will be made upon them; the different positions they can accept, resist, and enforce on others; and the possible personal, social, and political functions served by differing discourses and subject positions. This is significant to developing trainee's awareness of how their language can reinforce the power imbalance between themselves and service users, something of particular importance to counselling psychology values. This could involve the publication of my findings in ways that are more accessible to students, such as an article in The Psychologist. Furthermore, attempts to publish in academic journals (such as, Discourse & Society or Critical Discourse Studies) may help the findings reach as many students as possible who might find them useful, contributing to the possibility that they may critique, resist, and challenge dominant constructions.

Furthermore, the discursive construction *recovery as occurring in the interaction with others* raised particular and ongoing issues regarding recruitment to counselling psychology and other psychology programmes. In 2016, Leeds Clearing House for Postgraduate Courses in Clinical Psychology found that only 4 percent of the 6 percent Asian/Asian British groups and 2 percent of the 4 percent Black/Black British groups who applied to the doctorate programme were accepted, compared to 91 percent of the 84 percent of white groups (York, 2020). If 'recovery' is realised through the

interaction with others and the individual or community cannot be separated from the larger relational processes of which they are a part, 'recovery' should be implemented by a culturally diverse and representative workforce. As such, courses should aim to both prioritise recruitment from Black/Black British and Asian/Asian British groups and work to address issues which may prevent these students from entering the psychological professions. In their doctoral thesis, Ragaven (2018) highlights that these barriers include: poor visibility of existing Black, Asian and minority ethnic professionals in psychology; lack of trainee exposure to cross-cultural and African/Asian centred therapies; and experiences of racism, microaggressions, and biases at both an academic level and within services once qualified.

4.2.3 Practitioners

As it stands, I would argue that most clinicians working in the field of counselling psychology and beyond, continue to be bound by the pervasiveness of a neoliberal system and the assumptions within which this operates. In agreement with LaMarre et al., (2019), it is practitioners that are best positioned to address neoliberal power and therefore provide more "socially-just and contextually-linked therapy" (p. 251) for the individual that wishes to 'recover'. It was only when carrying out this research that I became acutely aware of how individual models of psychological therapies continue to dominate counselling psychology training (and need to because of the expectations from employers) despite being well aware of the importance of broader circumstances of our lives (Gergen, 2015; Vermes, 2017). Without suggesting a fantastical transformation of the profession, for qualified practitioners, I would hope that this research could contribute to better recognition of how and when neoliberal and individualistic discourses appear in the therapeutic encounter. From this, we may be able to build spaces of resistance to actualise alternative enactments of 'recovery' and

ways to engage with the human condition. Envisaging these spaces of resistance, however, is no easy task from already within the system. Suggestions have been made to rework HCPC counselling psychology training requirements, so we alternatively train to work with projects that aim to address socio-cultural and economic inequalities (Vermes, 2017). Of course, this may be seen to sidestep the existing system rather than challenge it. Perhaps, for now, this research can contribute to raising awareness of micro pockets of resistance. This may instead involve practitioners trying to: offer critical formulations of psychological distress, both with clients and in more public domains, such as case conferences (Guilfoyle, 2005); prioritise the relational needs of an individual (Bondi, 2005); explore social influences that mediate experiences of power, resistance and liberation (e.g. social GRAACCCEESS) (Afuape, 2011); and attempt to use therapeutic models, such as narrative therapy, that are argued to challenge the therapist-client power relation (Afuape, 2011; Guilfoyle, 2005).

4.3 Evaluation and critical review

The critical evaluation of the study is presented in line with Yardley's (2015) criteria for evaluating qualitative research, namely sensitivity to context; commitment and rigour; and transparency and coherence. The impact and importance of the research has already been considered in section 4.2.

4.3.1 Sensitivity to context

Throughout this research project, I have endeavoured to explore and present how ‘mental health recovery’ is being constructed by practitioners with an awareness of the multiple contexts involved in the research. The first chapter of the thesis demonstrates attentiveness to the existing literature and the historical emergence of the phenomena

in question. I have also attended to my own position by addressing issues of reflexivity embedded throughout the thesis. A significant attempt was made in explaining and attending to my position by documenting a detailed experience of carrying out FDA (see 2.5.4.). The findings presented in this thesis are, therefore, shown to have been constructed through the process of carrying out this research, and have not been stipulated in advance.

4.3.2 Commitment and rigour

Arguably using FDA as a research methodology for my doctoral thesis with no prior experience shows a huge commitment to my epistemological position and demonstrates an in-depth engagement with the topic (as the methodology was informed by a research question that emerged from the literature review). It could be quarrelled, however, that this could have affected the methodological competence and skill. I would argue, however, that due to my novice position the opposite ensued, with my undertaking of extensive reading around FDA and in-depth discussions with my supervisor and/or other professionals regarding the process of analysis.

4.3.3 Transparency and coherence

I have endeavoured to ensure coherence and transparency in explicit descriptions and reflections on my methodological and analytical choices, as well as how I may have influenced the research, through the use of reflexivity. Yardley (2015) further proposes that transparency is established through a 'paper-trail', examples of which can be found in the appendices (see F-J).

4.3.4 Limitations

Considering the consensus that no manualised approach to FDA exists, it may be seen as a methodology that is limited in its ability to contribute to a position calling for

changes to policy and guidelines that oversee psychological provisions. As Kasket (2016) writes: “given the hierarchies of evidence employed by bodies such as the National Institute for Health and Care Excellence (NICE), which place single qualitative studies toward the bottom of the barrel, it limits the contribution of counselling psychologists to the guidelines that govern mental health care in the United Kingdom” (p. 233). However, I believe that it is important that counselling psychology continues to engage with qualitative research enquiry to disseminate new notions of what comprises human reality and contribute to the cultivation of a new definition of what constitutes evidence.

Another limitation perhaps relates to the participant group. This study recruited seven mental health practitioners to collect sufficient data for analytic purposes. Whilst homogenous in their belonging to posts equivalent to Band 7 and above, the group turned out to be heterogeneous in their roles and responsibilities. Whilst homogeneity it not a requirement of FDA, this could be seen to limit arguments considering discourse’s implications for service provision. However, as it is not only one profession that has a significant responsibility concerning the development and provision of care, I believe that a homogenous sample could have limited the availability of discourses in the data. Instead, the heterogeneity may be considered a strength whereby wider social and political struggles are seen across a range of mental health settings and disciplines, arguing for the relevance of the thesis outside the scope of counselling psychology. The sample could also be argued to represent the reality that services are often made up of several different professions that come from differing ideological backgrounds. I have also thought about whether the implications of ‘recovery’ on practice are most significant for practitioners working in IAPT services and subsequently whether a participant group made up of IAPT practitioners could have

been more relevant. However, it was deemed that pervasive neoliberal policies and service cuts are affecting a whole range of services and that this too would have limited the data. For example, The NHS Long Term Plan discusses 'recovery' across a range of settings such as diabetes, IAPT, and inpatient services. Yet, if I were to carry out future research, I imagine that choosing a participant group that was homogenous in their management of services or active contribution to policy could help strengthen the argument for discourse's implications for service provision. It is, therefore, acknowledged that the findings of this study only represent the seven participants who chose to participate. Inevitably, a different sample may have produced different accounts and constructions of 'mental health recovery'.

4.4 Summary and final thoughts

This research aimed to explore how 'mental health recovery' is being constructed in mental health services by those with a significant responsibility concerning the development and provision of care. This was to gain an understanding of how these different ways of talking about 'recovery' are indicative of wider social and political struggles and whether this has implications for service provision. Like many taken-for-granted concepts, several unintended consequences emanate from the use of 'recovery' in psychological discourse, policy, and practice. The findings suggest that prevailing dominant neoliberalist and individualistic discourses remain culturally available to speak about 'recovery' which continue to legitimise forms of psychiatric power and control. Nevertheless, pluralistic and relational discourses were interpreted as resisting and intervening in the relations of what can be known and said about 'mental health recovery'. These are understood as offering alternative ways of actualising wellbeing that are better able to consider wider social and structural causes

of psychological distress and understand that the needs of the individual and the collective are inextricably linked.

I would like to acknowledge once again that this research has constructed one of many possible readings, a process that often appeared mysterious and cryptic. Throughout this research, I have often spoken about avoiding the idea that the participants were calculative in their talk to have the effects that I have described. Nonetheless, as the participant's accounts have undergone interpretation and critique, I want to highlight that I hold great respect for each of the research participants, their knowledge, and work as practitioners and that I am incredibly grateful for their participation. The exploration of discourses, subject positions, and so on, modestly offers other ways for all psychological practitioners to probe and critique their use of taken-for-granted knowledge within their practice. I believe this is an ethical responsibility of all practitioners and this research has certainly allowed for an in-depth exploration of my own knowledge-making practices. In particular, this research has enabled a critical reflection of the tensions in my own positioning within a system that I am critical of and an understanding of how difficult it is to transcend the status quo. An impasse is reached as I consider the barriers faced in actualising a system that prioritises a psychosocial approach to psychological distress, as well as the limited resources and scale of this vision. As I continue to work in the NHS, it again comes down to the micro-level of what I can do as a practitioner in my interactions with psychological distress and 'recovery' from this phenomenon.

I will not 'recover' until the world recovers

(Anonymous, 2018, National Survivor User Network)

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APPENDICES

APPENDIX A: Notice of ethics review decision

School of Psychology Research Ethics Committee

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

REVIEWER: Miha Constantinescu

SUPERVISOR: **Cristina Harnagea**

STUDENT: Harriet Walker

Course: Professional Doctorate in Counselling Psychology

Title of proposed study: A Foucauldian Discourse Analysis of Mental Health 'Recovery'

DECISION OPTIONS:

1. **APPROVED:** Ethics approval for the above-named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

2. **APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES** (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

3. **NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED** (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

DECISION ON THE ABOVE-NAMED PROPOSED RESEARCH STUDY
(Please indicate the decision according to one of the 3 options above)

1. Approved - one minor thing, I couldn't find the information on how consent forms will be signed (sent by post maybe?) but I will leave this to the supervisor.

Minor amendments required *(for reviewer)*:

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature):* Harriet Walker
Student number: u18020415@uel.ac.uk

Date: 01.06.2020

(Please submit a copy of this decision letter to your supervisor with this box completed, if minor amendments to your ethics application are required)

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

Has an adequate risk assessment been offered in the application form?

YES / NO

Please request resubmission with an adequate risk assessment

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

[ ] HIGH

Please do not approve a high-risk application and refer to the Chair of Ethics. Travel to countries/provinces/areas deemed to be high risk should not be permitted and an application not approved on this basis. If unsure, please refer to the Chair of Ethics.

[ ] MEDIUM (Please approve but with appropriate recommendations)

[x] LOW

Reviewer comments in relation to researcher risk (if any).

Reviewer *(Typed name to act as signature)*: Dr. Miha Constantinescu

Date: 12.05.2020
This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee

APPENDIX B: Participant invitation letter

PARTICIPANT INVITATION LETTER

You are being invited to participate in a research study. Before you agree it is important that you understand what your participation would involve. Please take time to read the following information carefully.

Who am I?

I am a postgraduate student in the School of Psychology at the University of East London and am studying for a doctorate in Counselling Psychology. As part of my studies, I am conducting the research you are being invited to participate in.

What is the research?

I am interested in how mental health 'recovery' is currently being talked about by mental health professionals in the hope of exploring possible implications for the types of psychological services offered. My research has been approved by the School of Psychology Research Ethics Committee. This means that the Committee's evaluation of this ethics application has been guided by the standards of research ethics set by the British Psychological Society.

Why have you been asked to participate?

You have been invited to participate in my research as I am looking to involve mental health professionals holding a Band 7 position or above, or that of the equivalent outside of NHS settings. A self-expressed interest in the concept of mental health 'recovery' is desirable but not essential. I emphasise that I am not looking for 'experts' on the topic I am studying. You will not be judged or personally analysed in any way, and you will be treated with respect. You are free to decide whether to participate and should not feel coerced.

What will your participation involve?

If you agree to participate you will be asked to discuss the topic during a conversational interview with myself that will be audio recorded and subsequently transcribed. Interviews will last approximately 60-90minutes and will take place in a private room at the University of East London, Stratford Campus. If current restrictions due to Covid-19 remain in place, the interview will be conducted via Microsoft Teams.

I will not be able to pay you for participating in my research, but your participation would be very valuable in helping to develop knowledge and understanding of my research topic.

Your taking part will be safe and confidential. Your privacy and safety will be respected at all times. The standard limits to confidentiality apply, where disclosure of risk to self and/or others may need to be escalated further. Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research. Participants do not have to answer all questions asked of them and can pause or stop the interview at any time.

What will happen to the information that you provide?

The audio recordings you provide will be kept securely on a password protected digital file and will only be accessible to me. All identifiable data, including names, service information and locations, will be anonymised using pseudonyms, both in the transcripts and the final thesis which I will type up. The Director of Studies and examiners will only read extracts from the anonymised interviews. After the degree has been awarded, all audio recordings will be permanently deleted. As the research may be developed for publication, electronic copies of the pseudonymised transcripts will be kept securely for 5 years in the UEL Data Repository. Data is reviewed every 5 years thereafter.

What if you want to withdraw?

You are free to withdraw from the research study at any time without explanation, disadvantage, or consequence. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

Contact Details

If you would like further information about my research or have any questions or concerns, please do not hesitate to contact me: Harriet Walker Email: u1820415@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact the research supervisor Cristina Harnagea. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: c.harnagea@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.lomas@uel.ac.uk

APPENDIX C: Consent to participate

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

A Foucauldian Discourse Analysis of Mental Health 'Recovery' Talk

I have the read the information sheet relating to the above research study and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed.

I hereby freely and fully consent to participate in the study which has been fully explained to me. Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason within 3 weeks of the data being collected. I also understand that should I withdraw, the researcher reserves the right to use my anonymous data after analysis of the data has begun.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

APPENDIX D: Participant debrief letter

PARTICIPANT DEBRIEF LETTER

Thank you for participating in my research study on how mental health 'recovery' is currently being talked about by mental health professionals. This letter offers information that may be relevant in light of you having now taken part.

What will happen to the information that you have provided?

The following steps will be taken to ensure the confidentiality and integrity of the data you have provided:

- The data gathered will only be handled and analysed by myself, the researcher.
- Participants will not be identified by the data collected, on any written material resulting from the data collected, or in any write-up of the research.
- The raw material you provide will be kept securely on a password protected digital file and will only be accessible to me.
- All identifiable data, including names, service information and locations, will be anonymised using pseudonyms, both in the transcripts and the final thesis.
- The Director of Studies and examiners will only read extracts from the anonymised interviews.
- After the degree has been awarded, all audio recordings will be permanently deleted. As the research may be developed for publication, electronic copies of the anonymised transcripts will be kept securely for 5 years in the UEL data repository. Data will be reviewed every 5 years thereafter.

You are free to withdraw from the research study at any time without explanation, disadvantage, or consequence. Separately, you may also request to withdraw your data even after you have participated, provided that this request is made within 3 weeks of the data being collected (after which point the data analysis will begin, and withdrawal will not be possible).

What if you have been adversely affected by taking part?

It is not anticipated that you will have been adversely affected by taking part in the research, and all reasonable steps have been taken to minimise potential harm. Nevertheless, it is still possible that your participation – or its after-effects – may have been challenging, distressing or uncomfortable in some way. If you have been affected in any of those ways you may find the following resources/services helpful in relation to obtaining information and support:

- Mind (National): Provides advice and support to empower anyone experiencing a mental health problem. Infoline: 0300 123 3393 Website https://www.mind.org.uk/
- BPS Directory of Chartered Psychologists: An online source to locate professional psychologists https://www.bps.org.uk/public/find-psychologist

- BACP (British Association for Counselling and Psychotherapy): A membership organisation that sets standards for therapeutic practice Phone: 01455 883 300 (to locate a professional counsellor)

If anything has been raised regarding issues at work, please refer to the following resources:

For NHS Employees: https://www.nhsemployers.org/retention-and-staff-experience/raising-concerns-whistleblowing/information-for-staff

If you're a professional working in the NHS or in adult social care and you have concerns about the care that a patient or client is getting, this page tells you where to start to raise the issue: https://www.citizensadvice.org.uk/health/nhs-and-social-care-complaints/whistleblowing-how-a-staff-member-can-report-a-problem-in-the-nhs-or-an-adult-social-care-service/

You are also very welcome to contact me or my supervisor if you have specific questions or concerns.

Contact Details: Harriet Walker Email: u1820415@uel.ac.uk

If you have any questions or concerns about how the research has been conducted, please contact the research supervisor Cristina Harnagea. School of Psychology, University of East London, Water Lane, London E15 4LZ,

Email: c.harnagea@uel.ac.uk

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr Tim Lomas, School of Psychology, University of East London, Water Lane, London E15 4LZ.

Email: t.lomas@uel.ac.uk

APPENDIX E: Interview Schedule

Interview Schedule

Start introducing the interview, frame, confidentiality, recording, right to withdraw and explain the structure of the interview.

✓ Questions & sign consent form

Interview Protocol

1. How long have you been involved in mental health? And in what capacity?

2. What was your motivation for taking part in this study?

3. What does the term 'recovery' mean to you? (*broad, what words come to mind)*

4. And 'mental health recovery'? *(for you)*

5. And how does this manifest, if at all, in your everyday? *(In your work, in your service, with your clients, who with, in policies)*
   If so, in what way, could you provide examples

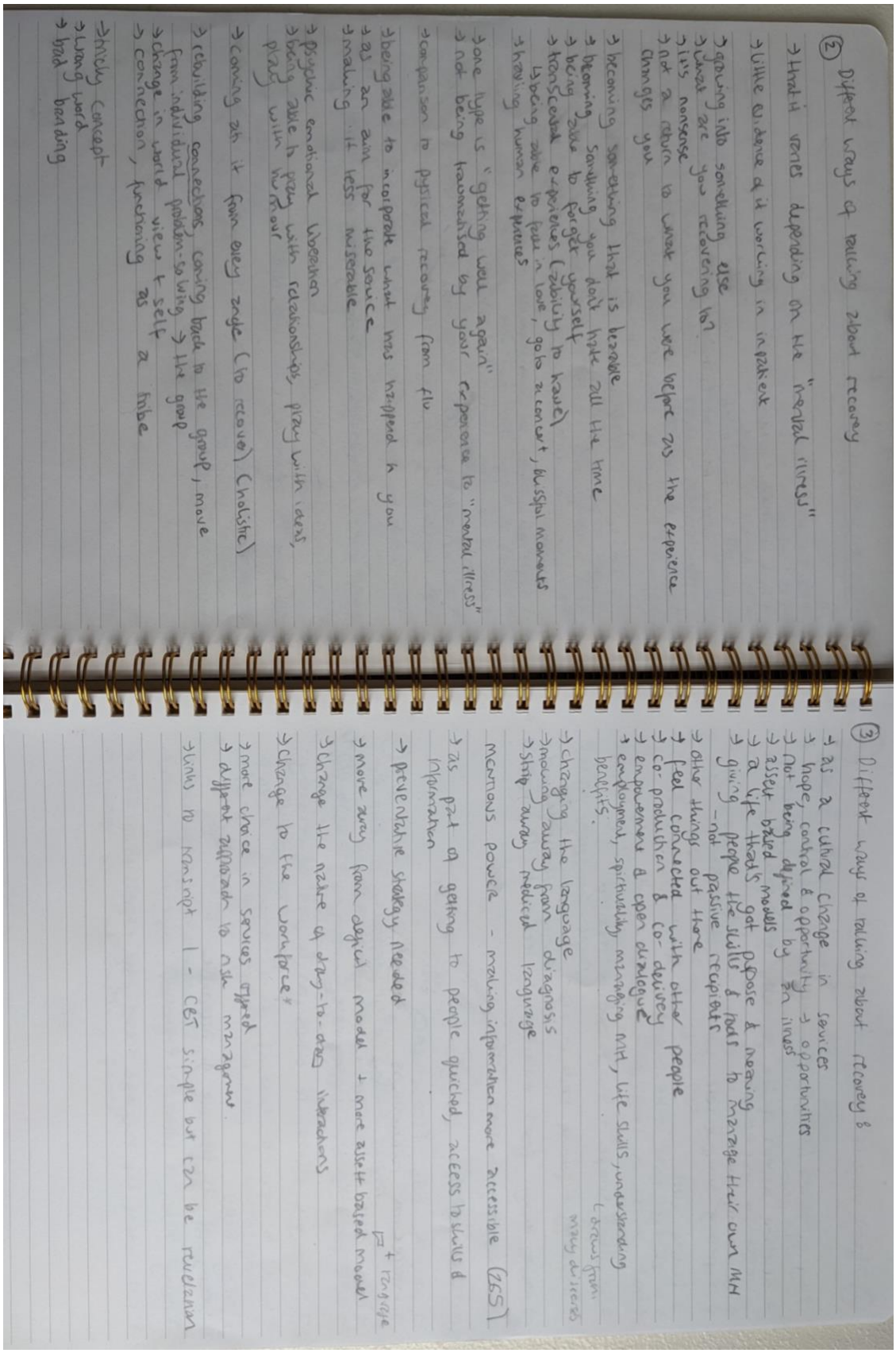
6. What do you think mental health 'recovery' should encompass? *(Is this different from your practice? The service you work for. Why do you think it is not the way you described?)*

7. Is there anything else you would like to add?

✓ Thank for time

✓ Debrief form

APPENDIX F: Sample of initial analysis notes (paper)



APPENDIX G: Sample of initial analysis notes (typed)

P1 52 recovery is an ongoing process (.) I don't think it's like "yay I've recovered (.) like that's me done" *recovery as an ongoing process= rehabilitative discourse*
61 something that you work on for your whole life
61 I think there is this misconception and I think it's kind of sold to our patients with the lie that you can make a full recovery (.) And bang! And I just think that that is not true at all *critical discourse? Recovery as a misleading concept*
65 *service user discussed as needing to be careful for the rest of their life*
66 If I had a knee problem (.) you know I had a dodgy knee (.) I'm going to have to keep an eye on it for the rest of my life *recovery as a comparison to physical illness/ ailment, biomedical discourse?*
67 Then I think that there's a lot of marketing that's been done which is a bit incorrect (.) Which is (.) you know you can make a full recovery (.) well (.) what does that even mean? I don't necessarily know *marketing, economic discourse? Practitioner positioned as not knowing what it means. Recovery as difficult to define/construct?*
70 erm so I think I think it's an ongoing process *recovery as an ongoing process= rehabilitative discourse*
70 I think that it requires a lot of complex things that you need to do (.) you know (.) behaviour change in itself is complex (.) so (.) you're changing your behaviours (.) but not only that (.) you're trying to change your whole thought process (.) your being (.) the way that you are (.) your relationship with the self (.) so yeah (.) I think for all of those things it's pretty complicated *recovery as something done by the individual, individual responsibility? The individual needs to change= individualistic. Psychological discourse? Recovery as something complex*
77 And it's an ongoing thing (.) It's not something that you can just achieve and done *recovery as an ongoing process= rehabilitative discourse*
84 I think recovery is an individual thing *no blanket definition, recovery as an individual process that differs from person to person*
90 I think behaviour change is one element to some people and I think attitude change is another element for some people *recovery as the responsibility of the individual? The individual needs to change?*
91 So (.) I think I think it depends on the individual (.) and I think that that is one reason why you're really never gunna get the cut and dry mental health treatment options for all people (.) You know (.) that's why so many treatment options exist because people are unique and they are diverse and what they need is so different (.) say from one person to another
116 *medication offered as the only option meant individual did not think they could recovery*
119 There's recovery in terms of what we can do as clinicians or when somebody is under our care (.) And then there is that whole bit before and I think that that's why we have quite high rates of suicide in this country because it's that bit before that's not properly managed
168 So (.) in the [NHS trust] we work to kind of a recovery model (.) And it's like a holistic recovery model but every clinician interprets that in kind of like a different way *recovery as something interpreted differently by different people, context related?*
171 trying to make our patients more aware of the impact that their physical health can have on their mental health and on their mental health recovery to be specific *(something in the use of "make"?)*
183 You're trying to link kind of everything together and make people aware that actually (.) you know it's not just your mental health that is affecting the way you feel (.) it effects the way you sleep (.) the way you think (.) the way you breath (.) the way you communicate with other people (.) You know it got this kind of lingering kind of you know ***make*** *=how are practitioner & service-user positioned here?*
189 Like it's something that you yes (.) may not have any control over right now (.) but it is something that you do need to become more aware of *recovery as awareness= rehabilitative discourse / responsibility with the individual*
206 I think you can use multiple mental health models to (.) I suppose (.) help one person to recover *Recovery as achieved by various models= holistic/pluralistic discourse?*
208 if I'm thinking about the NHS (.) that is where they are usually broken because they say this one model will fix you and actually no one has (.) kind of (.) thought of threading them all together and thinking actually what's helpful for this person in this stage of recovery (.) versus a longer-term approach (.) And I think you can absolutely use parts of a model to help one person across a whole

P2 38 you know people generally (.) people will be well and can get depression and then get well and can not be depressed again (.) and that's it (.) they're done with that *biomedical discourse*
42 I think the idea of recovery is much more controversial and I don't believe it as much (.) and I suppose I have little evidence (.) working as an inpatient doctor of recovery (.) because I'm not there (.) if there is 'recovery' *something they do not believe in*
45 I think it's such a kind of pervasive illness and personality stuff that you're always going to be affected (.) have been affected by it (.) you know it's so ingrained that it's (.) I think it's about growing into something else (.) What are you recovering to? *Changed by the experience of psychological distress? Possibly rehabilitative discourse but is counter to biomedical*
49 it's developing into something else (.) I suppose that's (.) that's what I think is a more realistic recovery (.) and you know (.) even if you're not symptomatic in like schizophrenia (.) even if you're really well medicated and not symptomatic ever again (.) you've had schizophrenia! You've been psychotic! That is going to have massively affected you (.) and so you're not (.) you're not returning to something you were before (.) you're not (.) I don't believe *counter discourse within a framework of a biomedical discourse?*
59 I suppose recovery is becoming something that is (.) bearable? Is that too bleak? Something (.) becoming someone that is (.) that yeah you (.) so bleak (.) but becoming something (.) you don't hate being all the time *recovery as someone bearable to the self?*
64 And being able to enjoy those brief moments of forgetting yourself (.) having transcendental experiences (.) you know (.) being able to fall in love (.) being able to go to a concert and have blissful moments (.) Which I don't think (.) you know (.) my patients aren't able to do that (.) it is foreign to them (.) they don't know what we're talking about when we talk about "these things" (.) you know (.) these very human experiences *drawing from a relational discourse? Unable to relate when distressed? psychological distress constructed as being less than human?*
76 I suppose it's the difference between that real sort of classical 'mental illness' (.) you know of that (.) "you're well (.) you get sick (.) you get well again" and that you know it's done and (.) And I think that is recovery (.) You can completely go back to who you were *recovery constructed as different for different psychological experiences, locates the difficulty within the individual*
82 And I've seen people who have recovered (.) even with recurrent depression (.) but like in the middle (.) they are well and not traumatised by the depression (.) You know (.) it literally is like getting a flu or something else *recovery possible when not traumatised by the distress, comparison to medical illness, biomedical discourse*
90 Yeah (.) that's what I think recovery is (.) it's incorporating it functionally (.) incorporating what's happened to you (.) which we all do (.) don't we? *Recovery as incorporating your experience of distress,* ***we all*** *do this*
102 that recovery is being out of hospital for a number of months (.) and that's as good as it gets (.) and you know making it less miserable is as good a recovery as we're going to get *constructed as varied on the person and illness*
109 *practitioner positions self as saviour, as healer, as integral to recovery*
117 but it's about attempting to make it less miserable (.) Or yeah (.) again (.) for a moment if that's in the interaction (.) if that's me making them laugh because I'm being stupid (.) you know that (.) that can be enough *as the experience being less miserable, as existing in the everyday interactions, practitioner as saviour?*
127 And they do have that (.) fantasy of erm (.) not having any pain and any angst in their lives *recovery as no pain or angst from the perspective of the patient*
142 because you tell them (.) you talk to them (.) that's what the rest of us do *as being able to share/ communicate your distress*
148 They're just terrified of all the life stuff *recovery as 'doing' life?*
155 Liberation (.) It would be that it would be a kind of psychic emotional liberation.
159 they suddenly become funnier (.) They suddenly become a bit more reckless and adventurous and yeah and less restricted (.) less restricted-terrified *as emotional freedom, psychic liberation*
164 And going from that (.) sort of nihilistic darkness of (.) you know (.) everything is so terrifying and pointless (.) it's pointless (.) to going (.) everything's so terrifying and pointless so fuck it let's play *existential? Philosophical discourse? As an acceptance of reality?*

know (.) the wellness and recovery action plans and those types of things (.) you know they seem so simple and yet they (.) um (.) are a revelation I think to people (.) *Links to P1? Knowledge is simple and is not being given out as accessible*
483 you know real simple things (.) but I think people forget that they (.) or they don't know (.) or they don't realise that they've got all those tools that they can learn some of those things and recognise that they do have control over or some control over what's happening

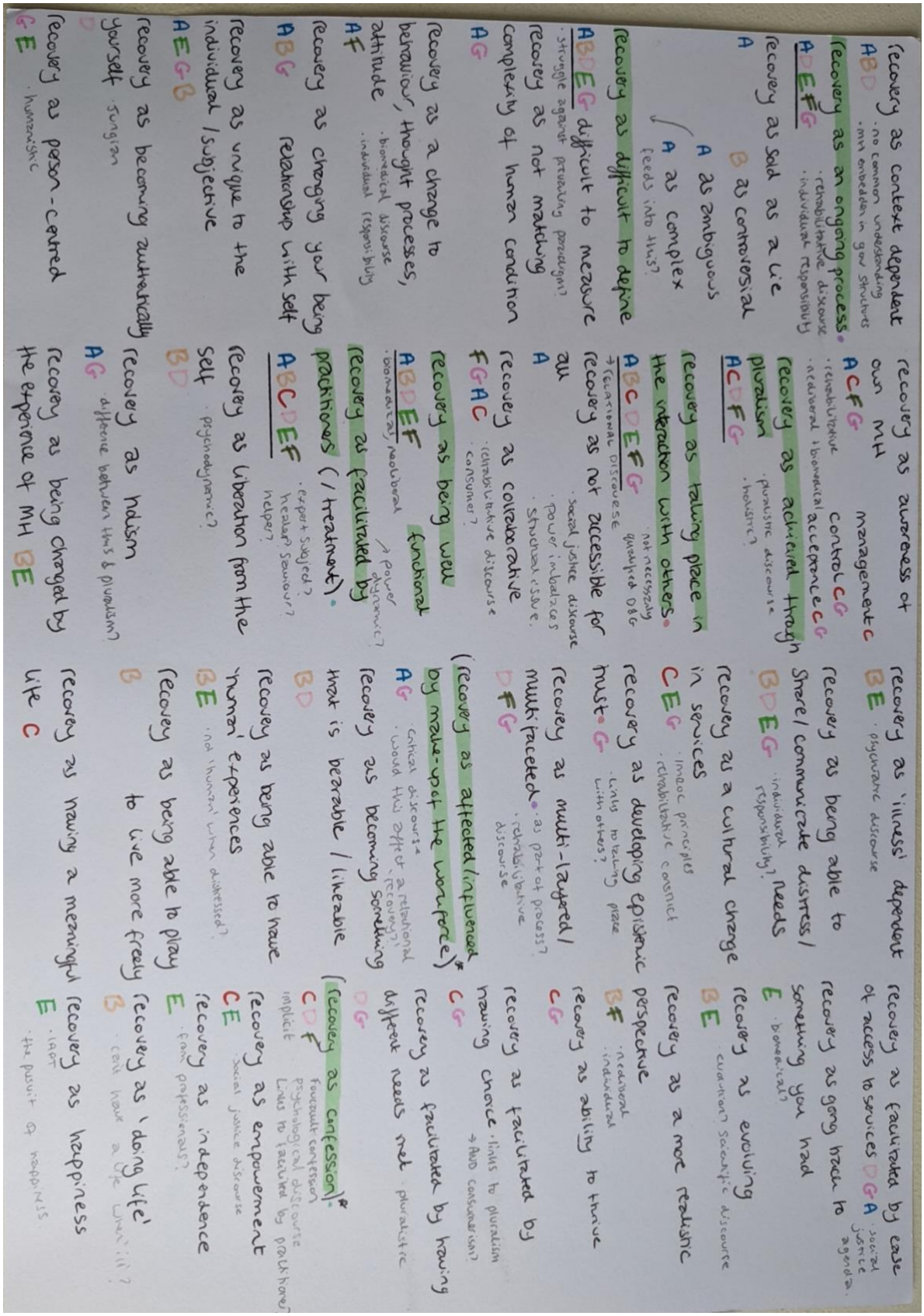
P5 19 getting a person to be able to be functional again (.) so (.) going back to a state that doesn't need to be an absolute concept of health (.) but basically for that person to be functional again (.) so (.) it gives me the sense that this person had an issue (.) had probably a crisis of something (.) not working enough as they used to work (.) so (.) basically giving this person the possibility to be functional again (.) and the level of functionality really depends on the (.) on the specific personal case and situation *as functioning again, biomedical discourse? But context given of individual*
26 I would say the best level possible of health (.) physical health (.) psychological health and social interaction [pause] and under the umbrella of the social interaction I will put also a possibility to work if they are able to or have relationships *productivity?*
31 because now thinking better about it I would say recovery is a process (.) for me rather than a specific end point (.) so yes (.) recovery happens daily in my work *rehabilitative discourse, as a process*
35 Again (.) it's a range [pause] I can think about people arriving to our service with a very severe eating disorder (.) so very low BMI (.) not able to eat independently (.) not able to have relationships (.) not able even to have eye contact with others and then at the end of a (.) for example (.) five or six months admission (.) can have a healthy BMI (.) all the blood parameters will be fine (.) they will be socially able to interact with people (.) even able to go out and find the work (.) a job (.) but I can also think about daily little things when someone (.) through therapy and being admitted in our ward after a few months will be able again to talk with friends or to eat independently (.) not be so terrified (.) this is recovery as well for me *as varying depending on the person*
45 it's basically if I think the word recovery (.) it's going back to something you had (.) isn't it (.) so even each little steps forward you might do is recovery in some way (.) again (.) this depends on what we want to consider as recovery (.) if we want an absolute concept looking at some standard (.) some guidelines or if we want to look at the beginning of the journey and see the movement *biomedical frame? Counter to experience changing someone, acknowledges differing constructs and impact of ideology on the concept*
72 I think with the eating disorder I feel is harder to get to a point where the recovery is really an absence of illness *biomedical discourse, absence of illness*
77 *variations between manifestations of distress*
82 I think (.) even if you never go back to where you were (.) usually I would say they even go to something that is better than the square one (.) as if they developed from their experience (.) but in terms of continuing their life looking in today (.) future ideas (.) their plans (.) some way they need to get in touch again with the healthy part of themselves (.) and then of course they can change direction (.) they can move forward *links to p2, changed by the experience of distress*
98 I think maybe we all [pause] we all as a service are oriented to recovery (.) but I feel that sometimes is the personal perception of each one of the members of the team that makes the difference (.) so (.) if I (.) and I know I'm always focused (.) I'm always looking for a recovery even with the most chronic and ill patients (.) so (.) I know that's my direction every time I sit with them (.) even if I feel that they're very still and stuck in that position (.) I'm looking for something forward for them (.) so that's what helps me in my daily job (.) where I can see the difference is when I see the colleague saying "oh this person is never gonna change (.) this person is never gonna get better" and you consider the way they work with them is completely different because of course (.) if you don't believe something is going to change (.) so you're then (.) you kind of pushing against something (.) but it's like [pause] do you say this in English? The prophecy that (.) would auto fulfil *recovery orientation as important to an individual's recovery, role of hope? Held by the practitioner?*
114 I'm a bit extreme like I always see possible recovery everywhere (.) everywhere (.) that probably is too much (.) but it's what else may [pause] I think that without this I wouldn't be able to do my work (.) where I would say that 30% (.) probably in the 30% of my colleagues or cases (.) people do not see this *as something not believed in?*

51 I think it's about trying to get people to a point of being well (.) not necessarily a finished product *rehabilitative discourse? 'product' neoliberalist? Economic? Person as a product*
52 but getting them to understand that how they think (.) how they feel and how they behave are all interlinked *getting someone to do something? Responsibility lies within the individual*
54 and having some responsibility about your journey (.) not always all (,) because as we know (.) mental health can be very severe for some people (.) but certainly people I see (.) I can normally see an improvement and they can normally see an improvement within the six to eight sessions that I tend to offer *Responsibility lies within the individual*
65 but I think for me it's about facilitating people (.) even if it's just a few steps on (.) it might be that then they go and see somebody else (.) or they might even come back (.) as they have done (.) to come and see me months or years later for something else *therapist takes a central position/role in this construction?*
70 thinking (.) hopefully moving from negative (.) unrealistic (.) sometimes problematic (.) or difficult thinking to a more balanced perspective (.) realism about situations (.) maybe moving (.) if I think from CBT (.) from anxiety provoking matters to feeling a realistic (.) healthy concern (.) because I make sure they realize I have no pill therapy (.) I can't do a cure and it's all about managing their expectations and for me (.) the words I use (.) is (.) you know (.) CBT is a reality-based intervention (.) so I'm trying to bring some reality to their lives because sometimes they don't have that for whatever reason *psychological discourse? CBT framework, distress constructed as problematic? Something to get rid of / not based in reality?*
79 you know (.) having realistic expectations (.) you know (.) not expecting things to be perfect (.) not damning everything, not being [pause] not thinking in a very catastrophic end-of-world apocalyptic scenario (.) not negative labelling of themselves or others (.) um (.) you know that sort of thinking *cognitive discourse, problem with the individual*
99 I would like to think that through my intervention (.) it's a joint effort (.) isn't it? But through my intervention I can steer them towards a slightly better place (.)
104 well if you (.) even if you just pick up on the fact you need to work on yourself and you need to do it regularly (.) and the fact that she had someone to listen (.) and I suppose there was some rapport (.) even that might be part of a recovery (.) somebody else might not see it quite like that (.) but I think it's all helpful, isn't it? *Individual needs to work on themselves, then relational discourse?*
108 We're all sort of jigsaw puzzles that need attention (.) and so sometimes I can only put one piece back (.) but then if I put one piece back and 10 other people put the other pieces in (.) hopefully at some point the picture starts to be clearer, you know? *Pluralism? Relational?*
142 so I think different people can bring (.) don't they (.) a different experience (.) different knowledge (.) a different dynamic (.) I think it would be arrogant to think that one person could just bring everything (.) I just don't think it's possible (.) really *pluralism?*
149 so the last session becomes a sort of a (.) a summary of all the key things that they've learned (.) all the key techniques that we put together for them (.) and so then the last session as we go through all of that (.) we highlight all the things that I think they should really think about going forward to maintain their recovery *rehabilitative? Educational?*
156 yeah (.) you recover (.) you're recovering as you go through it (.) but you've also got to do the assignments and the work (.) that's part of the recovery
161 I think it's a multi (.) it's a multi [pause] it's a bit like a diamond (.) it's multifaceted I think recovery (.) rather than it being just a slab of something (.) I think I'd see it as a diamond
303 I think the road to recovery is like a (.) it's like a rollercoaster (.) that's the best way. [pause] I see little cart and it's got a roller coaster and I think that's what recovery is (.) it goes up and it goes down (.) change is a variable process (.) isn't it?

P7 46 I guess it's quite hard to define because it's so different per individual and like I think that's (.) that's probably the tricky bit about recovery in the literature (.) that you know there's this kind of need to evidence (.) but there is also like a person that that comes from (.) and how do we kind of bring that together? *Pluralism= using both ideologies? Humanistic, counter discourse?*
49 So for me (.) mental health recovery is person centred (.) it is something that is elicited and discussed and collaboratively come to with someone (.) an individual (.) or it could be a community as well (.) if there are kind of shared needs like there are (.) I feel like there are indirect ways of like

APPENDIX H: Discursive constructions identified through analysis

APPENDIX I: Discursive constructions with notes



APPENDIX J: Example of analysis process

18	*That sounds great (.) so yeah (.) if I say recovery* (.) *what does that mean to you?*
19	Mhmm [pause] getting a person to be able to be functional again (.) so (.) going back to
20	A state that doesn't need to be an absolute concept of health (.) but basically for that
21	person to be functional again (.) so (.) it gives me the sense that this person had an issue
22	(.) had probably a crisis of something (.) not working enough as they used to work (.) so
23	(.) basically giving this person the possibility to be functional again (.) and the level of
24	functionality really depends on the (.) on the specific personal case and situation
25	*Could you say a bit more about being functional?*
26	I would say the best level possible of health (.) physical health (.) psychological wellbeing
27	and social interaction [pause] and under the umbrella of the social interaction I will put
28	also a possibility to work if they are able to or have relationships (.) yeah (.)

Stage 1: Discursive constructions: *recovery as… being functional again, having physical health, having psychological wellbeing, being able to social interact, being able to have relationships*

Stage 2: Discourses: *neoliberalist discourse, individualistic (responsibility with individual)*

Stage 3: Action orientation: *legitimises need for therapeutic intervention aimed at returning to state of productivity*

Stage 4: Positioning: *offers an individual the position of burden on the state*

Stage 5: Practice: *difficult to acknowledge social & structural contributions to psychological distress, difficult to question legitimacy of biomedical framework*

Stage 6: Subjectivity: *individual is 'ill and unemployed', experiences self as unproductive and feels dependent on mental health practitioners to 'recover'*