A Narrative Study Exploring Survivor/Service-User Professionals' Accounts of Sharing Personal Experiences at Work

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ABSTRACT

Fighting for voice, equal rights and greater power has been central to the survivor/service-user movement. 'User involvement' (UI) can be seen as a State response to this. UI proliferates throughout policies but is neither routine nor extensive. Limitations may relate to contradictions between assumptions/ practices underlying UI, and other dominant discourses constructing survivors/service-users (especially with ‘psychosis’) as irrational, incapable and dependent on ‘expert’ professionals. UI neglects survivor/service-user professionals but limited research (Adame, 2011; Lindow & Rook-Matthews, 1998) suggests similarities with 'peer workers'. Aiming to understand the function of UI, this research explored how survivor/service-user professionals negotiate these different discourses, and to what effect, through asking: *How and why do mental health professionals who have experienced ‘psychosis’ share their personal experiences in their work?*

A social constructionist epistemology was employed, with a qualitative, 'unstructured' interview design. Four professionals working in the 'mental health' system in England, who self-reported a label of 'psychosis', participated. Data was analysed using a 'critical poetic breaks' (Emerson & Frosh, 2004) approach to narrative analysis, which sits within Mishler's (1995) *politics of narrative* group of models, working with 'narrative as praxis' (Mishler, 1999).

Different narrative forms storied: a precarious, chameleon-like position; the ability to share changing over time; that being believed is key (and paradoxical); a relationship between ‘crossed-roles’, power and safety.

A mirroring of the narratives and UI literature informs an understanding of UI, 'mental illness' and 'professional boundaries' discourses, functioning to maintain power relations. Strategies of resistance are highlighted, with survivor discourse key for constructing an alternative subjectivity. Recommendations are made for research, policy, service planning/delivery, and education/training.

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PREFACE

Interest / position

My interest in this arises from experiences in the 'mental health' system as a survivor, staff and trainee. These experiences raised questions about what 'knowledge' is valued and how people who have experienced 'mental health' problems and people who work in 'mental health' services are thought of, particularly thought of dichotomously. Although detailed discussion is beyond the scope of this thesis, I describe three salient, exemplary experiences.

Firstly, I have been struck by the introduction of different topics during training, particularly whether it was acknowledged that we may have 'personal experience' of the topic. This seemingly carried implicit messages about expected experience and divides between us, as trainees/professionals, and what/who we were studying. This was explicit during teaching under the 'psychosis' umbrella; a lecturer stated: “unlike common conditions, you will not have personal experience of this”. This was particularly poignant as my cohort knew I had this diagnosis. I wanted to, and did, challenge this assumption.

I felt less able to challenge assumptions in a team meeting where it was debated whether a service-user should 'be allowed' to become a nurse. One colleague supported it and pointed out service-user involvement policies, whilst two were against it, arguing the person would: be unable to manage the job/stress, always “be on the patients' side”, and not be 'objective'. I felt silenced by implied assumptions of incompetence and wrongness of being 'on a patient's side' (and there being opposing sides).

Contrastingly, experiences of sharing my history with people in my work and training, and others sharing theirs, suggested benefits (as I experienced and from feedback) derived from challenging those assumptions. For example, a client stating that their admission would preclude them from a desired career in health care, spoke optimistically about their future/potential after I shared my admission history.

Negotiating an 'us-and-them' paradigm I do not fit, has made me curious how others approach it and what this can show about the concepts of 'professional' and 'service-user' more generally. I believe my 'survivor' and 'professional' identities cannot be separated; I position myself as a ‘survivor-researcher’, using my experience in my practice and bringing these two attributes together to form a ‘double-identity’ (Rose, 2009).

Values

These experiences have shaped my values, influencing my research approach. Three related areas are key: language, 'objectivity', and experiential knowledge. I believe language and our use of it, does not describe the world in neutral, referential ways but is a social act with material consequences for speaker and subject. (Burr, 2003; Gergen, 1994). Dichotomously constructing 'professionals' – 'service-users' has consequences bound up in power relations, bestowing different rights, actions and claims to 'truth' (Campbell, 2009).

Although various terms (e.g., service-user, patient, consumer, survivor) are used, these have different origins, meaning and ideological associations (Crossley, 2006). Therefore, “survivor/service-user” is employed here to incorporate these multiple perspectives, unless one particular meaning is intended. Similarly, common terminology (e.g., ‘mental health’) reflect a dominant but contested medicalisation. Encompassing all understandings would be incomprehensible or impossible. Following Wittgenstein (1963), that meaning comes from use, I am entering a particular 'language game', using but critiquing dominant terminology, placing contested terms in inverted commas.

I also believe 'objectivity' is a myth; it is impossible to observe the world – especially non-material phenomena like 'mental health' – outside of subjectivity. It is inherently tied to power as 'objectivity' is considered more 'true' (Burr, 2003; Harding, 1993). In practice, clinicians' subjectivity is afforded 'objectivity' status, authorising their defining of service-users' realities. Rejecting 'objectivity' means rejecting positivism and 'neutral' research/researcher; my subjectivity shaped the design, conduct and interpretation of this study. Rejecting objectivity leads me to value 'experiential knowledge' – knowledge gained through lived experience of a phenomenon rather than through teaching and study. 'Experiential knowledge' is essential for developing a useful, meaningful knowledge-base and challenging power relationships where voices/stories are subjugated, appropriated and silenced (Beresford, 2005; Campbell, 2009).

1. BACKGROUND

This chapter sets out the background to the present study. It begins by framing the study and user involvement (UI) within the work of the survivor movement and the concept of voice. The chapter proceeds with an exploration of the UI literature. The policy context of UI and different types of involvement are defined, then recurring themes regarding the benefits of and barriers to UI are highlighted. Tensions and contradictions between UI and other discourses and policies in the 'mental health' system are explored and some of the implications of these contradictions are discussed.

The highest framework for this study is the concept of ‘voice’. Voice is more than short-hand for point-of-view, it represents a claiming of 'personhood' and power in the face of dehumanisation and oppression (Basset & Stickley, 2010; Campbell, 2009). Its existence “presents a profound argument that we are conscious human beings rather than disease entities. By coming to voice we reclaim domain over our mental subjectivity and create a social identity” (Campbell, 2009:116). In bringing voices together, a culture of recovery, resilience and resistance has emerged around survivors/service-users' stories (Campbell, 2009).

Fighting for voice and equal rights has been central to the survivor/service-user movement, as with other social movements that influenced it (e.g., civil rights, disabled people’s movement; Crossley, 2006; Rogers & Pilgrim, 1991). The survivor/service-user movement has highlighted and contested damaging, unequal power relationships, and argued that survivor/service-user experiences/perspectives are valid and essential for improvement (Beresford, 2005; Tait & Lester, 2005). Social movements, like voice, are indications of agency/resistance; people are capable of assessing their situations and acting to challenge and change them (Crossley, 2006).

The development of UI can be seen as the State's response to these criticisms and demands, or at least influenced by them. This thesis examines this response.

A literature review was conducted to find English language abstracts relating to UI. Combinations of the terms *service-user/consumer/survivor/patient/user, involvement/participation/partnership *mental health,* were used to search articles published between 1970–2012 in two databases*, Psychinfo* and *Medline*. Research papers (including reviews), 'commentaries', theoretical papers and editorials were included. Book reviews and articles exclusively about drug/alcohol services or carer involvement were excluded. Of 293 abstracts found, 176 were research papers (e.g., reviews, evaluation of UI, research involving users), 41 described but not formally evaluated UI projects, and 76 provided 'commentaries'.

1.1 **Policy context**

Statements about the importance of involving service users proliferate through health policies and guidance, since the NHS and Community Care Act (1990) first set out formal requirements to include service-users in service planning (Tait & Lester, 2005). These include (among others) the National Service Framework for Mental Health (DoH, 1999), NHS Plan (DoH, 2000) and accompanying Mental Health Policy Implementation Guide (DoH, 2001). The recent Equity and Excellence health strategy (DoH, 2010) and mental health strategy (DoH, 2011) continue these themes. The rhetoric of UI has become commonplace, associated with 'personalisation', 'choice' and ‘empowerment’ discourses (Beresford, 2002; Hui & Stickley, 2007). 'Involvement’ should span the whole 'mental health' system, from individual treatment, evaluating and developing services, commissioning, policy development, education/training, and research; there should be “no decision about me without me” (DoH, 2010:3). For example, service-users should be offered choices which “promote independence”, within services that are “acceptable…[and] well-suited to those who use them” (DoH, 2001:6).

1.2 **Defining involvement**

User involvement is an ambiguous concept; models of UI are not homogeneous

(Beresford, 2002; Tait & Lester, 2005). Sweeney and Morgan (2009) define four levels of UI in research, applicable to other areas, differentiated by control over decision-making (i.e. the power relationship between those identified as ‘professionals’ and ‘users’). At the lowest level, *consultation*, survivors/service-users are invited to comment on some aspect(s); decisions about when and on what to consult, and how to use the consultation, sit with the researcher. Researchers retain this decision-making power when inviting survivors/service-users to make a *contribution* to some aspect of the process (e.g., conducting interviews). Power is shared equally in *collaboration,* although the genuineness and ability of agendas to converge is disputed (Rose, 2009; Telford & Faulkner, 2004). The fourth level, *user-controlled research*, gives survivors/service-user all decision-making power and is a distinctive form with its own history (Beresford, 2009).

Beresford (2002) distinguishes two approaches to UI, *consumerist* and *democratic.* The former, dominating health and social care policy, uses a market model, framing services as ‘products’ and service-users as ‘consumers’ entitled to quality and choice. ‘Involvement’ takes the form of 'product improvement' through market testing and consumer feedback; decision-making power remains with governing bodies (Beresford, 2002; Hui & Stickley, 2007). Embedded in a broader historical, political-social human rights framework, the democratic approach explicates and challenges power inequality, aiming to increase the say people have in systems affecting them (Beresford, 2002). Associated with the survivor/service-user movement, it is “liberatory”, committed to “personal and political empowerment” (Beresford, 2002:97) through individual and collective action.

These approaches, despite some overlapping interests, have different origins, rhetoric and agendas which lead to preference for different levels of involvement; particular methods suit some agendas more than others and these agendas *require* different levels for *meaningful* involvement. Therefore, types and levels of involvement occurring in the literature can suggest which agendas are dominant. Currently, low levels of involvement (consultation and contribution) dominate research whilst higher levels are largely restricted to discussion in non-research papers, such as commentaries about collaborative or user-led research. Involvement in 'micro' areas of individual care and service-evaluation similarly dominate research. Very few papers focused on service provision (e.g., employing survivors/service-users in services), across all papers[1] (see Appendix I for a breakdown of levels/areas). This supports claims that a consumerist agenda dominates UI in the 'mental health' system (Beresford, 2005; Minogue, 2009).

1.3 Benefits and barriers

There are examples of user involvement in all areas (research, education and training, service provision/evaluation/development, and policy development), with evidence of UI in all stages for research (Tait & Lester, 2005). Despite this breadth, it is neither routine nor extensive, even when it is a statutory requirement (Beresford *et al.*, 2006; Telford & Faulkner, 2004). Evaluation of UI tends to focus on process, providing limited evidence of effectiveness (Crawford *et al.*, 2002; Simpson & House, 2002; Wykes, 2003). Furthermore, there is confusion over what constitutes involvement, for example, claiming there has been UI in research when survivors/service-users are only involved as research participants (Telford & Faulkner, 2004).

1.3.1 Benefits of user involvement

Reported benefits fall within five interrelated themes/categories; each is demonstrated with examples.

(1) Changing roles / power relations between survivors/service-users and professionals

This is particularly reported where survivors/service-users are employed in services or teaching. Repper and Breeze (2007) systematically reviewed involvement in training, including advisory groups and surveys (consultation), co-

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[1] Considering this, service provision, specifically peer workers, would seem over-represented in effectiveness research

producing learning materials and recruiting survivors/service-users as course members/trainers (contribution). This 'broke down barriers', with emphasis placed on having a more equal relationship as colleagues. Students have reported reversing roles from 'helper' (as staff) to 'helped' (as students), changed their attitude from 'us-and-them' to one of 'partnership' (Rush, 2008).

(2) Dispelling myths / 'seeing the person' (versus seeing only the diagnosis)

UI is reported to challenge negative stereotypes. Trainees and students with survivor/service-users trainers showed more positive attitudes towards employees with 'mental illness' and to 'mental illness' in general, more concern about the impact of 'illness' on people's lives, and used less jargon (Repper & Breeze, 2007; Simpson & House, 2002). Involving survivors/service-users as voluntary staff in a community gym, provided “a means of de-stigmatising mental illness, in demonstrating capabilities...often doubted by others” (Truman & Raine, 2002:140). Survivors/service-users employed as health care assistants (HCAs) in an Assertive Outreach Team (AOT), were valued by clients as successful role models (Craig *et al.*, 2004). Some staff felt the HCAs' presence changed “the language they used when talking, or referring, to clients” (Doherty *et al.*, 2004:75).

(3) Improving validity / focusing on survivors/service-users' priorities

Research with survivors/service-users involved has delivered different results to similar research without UI. For example, service-users reported less satisfaction with services and treatment when interviewed by survivors/service-users and in survivor/service-user-led research, compared with staff interviewers and professional-led research (Mental Health Foundation, 2003; Simpson & House, 2002). Staff and service-users have also differentially rated levels of, and priorities for, service-user needs (Slade, Phelan & Thornicroft, 1998; Thornicroft & Slade, 2002); importantly, only service-user-rated unmet need was predictive of quality of life (Slade *et al.*, 2004). In addition, survivors/service-users have identified methodological issues with professional-led research which may have led to inflated rates of service-user satisfaction (Rose *et al.*, 2003).

Involving survivors/service-users in setting research agendas and designing studies influences what knowledge is produced. Survivors/service-users have identified social and psychological research priorities (particularly stigma and involvement), which are different from the biomedical 'professional agenda' (Rose, Fleischman & Wykes, 2008; Thornicroft, *et al.*, 2002). They have also identified service priorities (housing and employment) and skill priorities (caring, respect, 'seeing the person'), which are different from the professional concerns of those with technical skills (Lindow & Morris, 1995; Repper & Breeze, 2007). UI in developing training has led to these priorities becoming outcomes for trainee evaluation (Barnes, Carpenter & Bailey, 2000), and in research, to the development of outcome measures which recognise that survivors/service-users idiosyncratically weigh the risk-benefit trade-off of 'treatment' in different life domains (Wykes, 2003).

(4) Improving services

The benefits of UI in improving services mostly involved consultation and employing 'peer workers'. Outcomes often reflected service priorities (e.g., 'engagement'). Employing 'peer workers' resulted in improved service-user quality of life and social functioning, fewer reported life problems, and a longer time without, fewer and shorter hospital admissions, with no detrimental effects (Simpson & House, 2002). After twelve months, clients allocated a peer HCA reported fewer unmet needs, greater satisfaction with care and larger social networks. They also demonstrated an improved uptake of and engagement with services, compared with 'care as usual' (Craig *et al.,* 2004). Crawford *et al.* (2002) reviewed of involvement (mostly consultation with user groups) in health care planning and development. The most common changes made to services in response to UI included the provision of new/adapted information for service-users, commissioning services (e.g., advocacy) and 'culture shifts' (becoming more open to UI).

(5) Empowering survivors/service-users

Many articles referred to the 'therapeutic value' of UI for involved survivors/service-users (Tait & Lester, 2005), including confidence/self-esteem and gaining skills, such as interviewing, teaching, etc. (Crawford *et al.,* 2002;

Telford & Faulkner, 2004). Peer HCAs reported benefits in: their knowledge being valued; their occupying a more powerful role; and not having to hide their 'mental health' history (Doherty *et al.*, 2004). Clients valued and were 'empowered' by peer HCAs' “'inside' knowledge...[and] their capacity to act as advocate between the client and the clinical team” (Craig *et al.,* 2004:68).

1.3.2 Limitations/barriers

A number of limitations and barriers to UI recur through the literature. Contrarily, some of these limitations/barriers are the same as what are reported as being changed when UI is beneficial (e.g., negative stereotypes about survivors/service-users).

(1) Representativeness of involved survivors/service-users

Professionals surveyed cited 'representativeness' as the biggest obstacle to UI, user groups cited staff resistance (Crawford *et al.*, 2002), and it has been suggested that raising concerns about representativeness is a method of professional resistance to UI (e.g., Tait & Lester, 2004). This is particularly as representativeness is often raised in relation to survivors/service-users but rarely in relation to professionals and other stakeholders (Beresford, 2007; Telford & Faulkner, 2004). In addition, where representativeness has been examined, similar service development priorities have been identified by user groups involved in UI and a sample of non-involved survivors/service-users (Crawford & Rutter, 2004).

(2) Survivor/service-user capabilities

Gates and Akabas (2007) reported some mental health staff believed peer workers were unreliable, unable to go beyond their own perspectives, and “'cheap' labour…unable to deal with the stress of working, whose presence...had the effect of 'dumbing down' professional staff” (p. 297). Some staff in the AOT felt they had to be more 'sensitive'/'guarded' with the HCAs (Doherty *et al.*, 2004). Clinical psychologists interviewed stated UI only works with the right service-users in the right role (Soffe *et al.*, 2004), begging the question what the 'right' service-user/role is.

Interviewing lecturers, Felton and Stickley (2004) concluded survivors/service-users who appeared too confident and knowledgeable about professional systems were considered unrepresentative (and, thus, having nothing to offer). Survivors/service-users who appeared to be unable to cope, unpredictable and dependent, were considered to be 'representative'. However, they were then considered incapable of successfully fulfilling a UI role, creating a *catch-22* situation.

(3) Difficulties negotiating 'role boundaries'

This was particularly reported in service provision and included issues with managing confidentiality, access to files, role-conflict and 'self-disclosure', including service-users worrying about peer staff (Doherty *et al.*, 2004; Truman & Raine, 2002). It is noteworthy these issues were mostly raised by 'non-peer' staff. Gates and Akabas (2007) concluded that integration of peer workers "was undermined by role conflict and confusion, inadequate policies and practices… [and] poorly defined job structure" (p. 302).

(4) Lack of wider structures necessary for supporting UI

These included: long-term infrastructure, funding and resources (Telford & Faulkner, 2004; Thornicroft & Tansella, 2005); conflict with the requirements of professional bodies and other institutional structures, limiting power-sharing (Barnes *et al.*, 2000; Basset, Campbell & Anderson, 2006); and survivor/service-user group dependency on statutory organisations for funding/contractual agreements making challenging them difficult (Barnes & Bowl, 2001; Lindow & Morris, 1995).

(5) Tokenism

Concerns have been reported that UI is used to 'rubber-stamp' decisions or 'tick boxes'. Peer workers were often in temporary positions without paths for promotion and not compensated comparably to 'non-peer' staff, "[conveying] the message that peers were less valued...[reinforcing] the rationale for sidelining peers by nonpeer staff" (Gates and Akabas, 2007:301). Peer HCAs were uncertain that their views were respected and reported staff attitudes[2] did not change (Doherty *et al.,* 2004). Survivor/service-user lecturers were not valued by course participants as highly as high-status professionals (Barnes *et al.*, 2000).

These could be seen as 'teething problems', highlighting areas for improvement. However, they could be indications of more fundamental issues.

1.4 Tensions and contradictions

'User involvement', as both policy and discourse, does not exist in isolation from other policies and discourses within the 'mental health' system. Whilst it may 'fit' relatively easily with some, there would seem to be tensions or contradictions with others. Lindow and Morris (1995) argued that traditional assumptions/practices underlay many barriers to UI. The interaction of UI with three discourses – 'mental illness', 'risk', 'evidence-based practice' – is explored.

1.4.1 'Mental illness'

The dominant paradigm for understanding survivors/service-users' experiences and behaviour is the medical model, constructing them as meaningless symptoms of 'mental illness', a fault/dysfunction *within* an individual (Crowe, 2000; Roberts, 2005; Stickley, 2006). Categorically different 'normal' and 'abnormal' experiences/behaviours are created, with 'abnormal' constructed as unproductive, irrational and unpredictable – often considered as 'stigma' (Crowe, 2000; Vatne & Holmes, 2006). Studies demonstrate that belief in biological causes of 'mental health' problems increases 'stigma'/prejudice (e.g., Angermeyer & Matschinger, 2005; Read, 2007; Walker & Read, 2002); "the categorization of behaviour and language as disordered has the effect of creating a distance between those people experiencing mental distress and the rest of

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[2] A mixture of concern, compassion, over-protectiveness and "usage of disparaging terminology" (p. 79)

society” (Crowe, 2000:76). ‘Psychosis’[3] is particularly bound up in 'mental illness' discourse, arguably, incorporating the most 'stigmatised' diagnoses (Boyle, 2002; Byrne, 2000; Read & Harré, 2001).

Telford and Faulkner (2004) point out a contradiction between this view of people and the kind of rational thinking implied in being a researcher. This is applicable to involvement in other areas. As Stickley (2006:571) notes, “how can service users (those technically considered by society as 'mad', therefore irrational) work in partnership with those who hold institutional power?” In addition, categorising someone as 'mentally ill', “subject[s] that person to a variety of presuppositions... that characterise [them] as *dependent*” (Roberts, 2005: 38), i.e. having a chronic illness making them unable to govern themselves, thus requiring medical treatment. Therefore, 'mental illness' discourse constructs survivors/service-users as dependent on the professionals who should be 'involving' them.

Health professionals demonstrate more pessimism than the general population about 'illness' and life outcomes of people diagnosed with 'depression' and, especially, 'schizophrenia' (Jorm *et al.*, 1999)[4]. Professionals, particularly psychiatrists, endorsed more negative stereotypes (e.g., 'dangerous', 'unreasonable') about people with 'mental illness' in general (Nordt, Rőssler & Lauber, 2006)[5]. Hospital staff used distancing, objectifying language, and “tracked [patients] as risk-laden objects” (Hamilton & Manias, 2006:91). The attitudes and practices of the mental health system were the most frequently cited sources of 'stigma' among survivors/service-users, and lead them to doubt their own abilities, feel angry and demotivated (Reidy, 1993).

It is unsurprising that mental health professionals have 'stigmatising' attitudes; this *is* how the legitimate construction of 'mental illness' is taught. It is unclear how survivors/service-users can meaningfully participate, or professionals work in ‘partnership’ with them, within this discourse. It also inhibits people from publicly

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[3] 'Psychosis' used throughout as an umbrella/generic term (Boyle, 2006)

[4] The public were even more optimistic when they knew someone with the diagnosis

[5] The public were more likely to see vignettes describing 'illness' as normal responses to life stresses, professionals to 'misidentify' the 'non-ill' vignette.

identifying as survivors/service-users (Snow, 2002). *No Health Without Mental Health* (*NHWMH;* DoH, 2011) discusses the importance of addressing 'stigma' but through 'educating the general public', with little mention of the need to do this within services and also within 'mental health' policies.

1.4.2 'Risk' and the Mental Health Act

'Mental illness' discourse justifies legitimised control/coercion (Barnes & Bowl, 2001; Vatne & Holmes, 2006). Individuals receiving 'psychosis' diagnoses are the most likely of all 'mental health' service-users to experience overt coercion, such as involuntary admission and forced medication (e.g., Bindman *et al.*, 2006; Jarrett, Bowers, & Simpson, 2008; Salize & Dressing, 2004). Nordt *et al.* (2006) found most (>98%) professionals endorsed the need for the provision of compulsory admission (a third of the public was opposed). However, they did not endorse other 'restrictions' (e.g., revoking driving licenses) as much as the general public. This suggests professionals agree with limiting rights which bring survivors/service-users under their control. A circular relationship between control and objectification is suggested; if we use language that “constructs a person as absent, 'off' or 'gone' in some way, then the ethical problem of encroaching on human rights, that is inherent in coercive treatment, is perhaps attenuated” (Hamilton & Manias, 2006:89).

Concurrent with an increased rhetoric of 'involvement' there has been an extension of legal powers to control (MHA, 2007). These issues are in direct conflict (Vassilev & Pilgrim, 2007). *NHWMH* superficially acknowledges this, ignoring the inherent contradiction between involvement and control and impossibility of offering 'full choice'; “[when someone is] treated *without their consent*…it can be *difficult* to offer *full* choice” (DoH, 2011:32, emphasis added). It also acknowledges that the *public* perception of dangerousness is disproportionate but it can “recognise the public’s concerns” (DH, 2011:27). Its proposal to change the public perception of dangerousness, is through greater intervention and monitoring to prevent incidents of violence by 'the mentally ill', which it states create this perception. Thus, the State promotes the misconception that all such incidents are preventable (Laurance, 2003), whilst sanctioning discrimination. Professionals must ensure that a limited ‘mad-and-dangerous’ population do no harm, by using powers for monitoring and compulsory intervention which are applied to a much larger population of survivors/service-users.

Seemingly, a professional duty to control takes precedence over involvement. Compulsory powers render patients and professionals untrustworthy and 'risky' to one another (Vassilev & Pilgrim, 2007). Service-users cannot be trusted to act in non-risky ways, so will be surveyed and controlled; powers (delegated from the State) to serve third-party interests mean staff cannot be trusted to act in patient-centred ways (Vassilev and Pilgrim 2007). This untrustworthiness/riskiness presumably makes 'partnership' difficult, if not impossible.

1.4.3 'Evidence-based' practice

There is opposition between UI and 'evidence-based' practice (EBP; i.e. clinical practice based on an established and relevant evidence-base). EBP limits what 'choices' services can offer. What is found effective will be based on what has been researched, currently dominated by biomedical models (Del vicchio & Blyler, 2009; Telford & Faulkner, 2004). The EBP hierarchy used by the National Institute for Health and Care Excellence (NICE), to evaluate the strength of evidence determining standards/recommendations (DH, 1999), uses a positivist approach to explicitly place personal experience as the lowest form (Rose, Thornicroft & Slade, 2006). Therefore, “the focus on experience in user research means that it would be relegated to the bottom of the hierarchy and so accorded less power in the fields of knowledge, policy and practice” (Rose *et al.*, 2006:112).

NICE guidelines recommend 'treatments' based on diagnosis; *NHWMH* repeatedly refers to increasing choice of 'treatment' but those offered should be 'evidence-based' (DH, 2011). This limits choice, both in offering 'treatment' (with the 'illness' model implied) and what those 'treatments' will be (Rose *et al.*, 2006). 'Partnership' is linked to ‘improving outcomes’, specified as “treatment adherence” and “understanding of their health status” (DoH, 2010:13); i.e. acceptance of 'illness' and compliance. The conditions for choice/control are having “the right information at the right time” (DoH, 2011:30); the language throughout is of ‘better’ and ‘more’ information provided by professionals. 'Professional' (medical model) knowledge is, therefore, explicitly valued above 'experiential' knowledge and alternative frameworks.

1.4.4 Summary

There are clear contradictions between the assumptions and practices associated with UI and 'mental illness', 'risk' and 'EBP' discourses. Survivors/service-users (categorically different to everyone else) are 'mentally ill' – i.e. seen as irrational, dangerous and incapable, particularly those with 'psychosis'. Their views and knowledge are considered less 'truthful' than professional knowledge; professionals thus need to 'educate' and protect them and protect others from them. Responsibility to 'involve' survivors/service-users, or make decisions based on their preferences, is secondary. Thus, it would seem that 'mental illness, 'risk' and EBP discourses delineate limits to the rights and responsibilities constituent to UI. This is very different to the principle of 'no decision about me, without me'. That this forms the discursive context, does not mean those involved in UI are not trying to do something different, especially if one takes seriously the idea that individuals have agency to resist the dominant discourses they are subject to (Burr, 2003). It may, however, explain why UI has not become extensive and has remained at low levels without decision-making power. It also questions the function and consequences of UI in this context.

1.5 Assimilation and depoliticalisation

There are clear differences between survivor/service-user movement and State constructions of involvement. The former explicitly focuses on power relations and human rights, the latter is consumerist and ambivalent (Hui & Stickley, 2007). Power is retained by the State (by implication) in all decisions, sustaining reliance and dependence since “power must be given by the government in order for its ownership by others to occur” (Hui & Stickley, 2007:424). Ambivalence and dependency characterise *NHWMH:* “people can, *as far as possible*, control and manage their own support so that it matches their needs and aspirations...*feel* they are respected as equal partners, and *know what* choices are available to them and *who to contact* when they need help” (DoH, 2011:24, emphasis added).

Even within a consumerist model, consumer power is contingent upon access to an open market offering genuine choice. State mental health services do not meet this criteria: they are locality-based and, increasingly, organised on diagnosis-based service-lines. People cannot choose a service, one must go where one is referred, to a service whose referral (including diagnostic) criteria one must meet. There is little choice in 'treatment', with standardised guidelines based on diagnosis. Finally, compulsory powers severely limit the right to refuse, rendering the consumer model redundant.

Criticism of forced 'treatments'/commitment and other human rights violations have been driving (and uniting) aims of the survivor/service-user movement (Barnes & Bowl, 2001; Beresford, 2002; Crossley 2006). However, since UI was introduced, compulsory powers have been extended and the use of these powers increased (Curran & Bingley, 2009; Curran, Zigmond & Grimshaw, 2010; DoH, 2011). Stickley (2006) argues UI will reinforce the power/knowledge position of dominant discourse while it remains in the control of service providers. Stickley, among others (e.g., Beresford, 2002; Hodge, 2005), argues that real change to the system can only be effected through 'emancipation' – acting outside the system in ways which claim power, rather than waiting to be given it.

Conducting discourse analysis on meetings of a mental health charitable organisation forum of professionals and service-users, Hodge (2005) concluded service-users *could* question mainstream understandings of mental health and make assertions drawing on alternative understandings, including their lived experience. However, these challenges were never meaningfully incorporated into the discourse of the forum. Lived experience was objectified, valued only where it could be incorporated into instrumentalized, action-orientated discourse (Hodge, 2005). If survivor/service-user perspectives/knowledge are only used to 'back up' dominant professional knowledge and practices, not valued or acted upon in and of themselves, UI initiatives become mechanisms to give greater legitimacy to the decision-making processes of State agencies, whilst 'unacceptable' voices are excluded and problematic structural issues ignored (Hodge, 2005). Hodge (2005) also argued that professionals could not 'speak up for' alternative frameworks representing fundamental epistemological challenges to the system. Professional training and regulation “act to ensure that only those knowledge and skills that reflect the dominant discourse are endorsed as competent clinical practice” (Crowe, 2000:72).

In UI policies, the ‘us-and-them’ dichotomy of survivors/service-users and professionals is reinforced with clearly defined roles where professionals do not add ‘personal’ knowledge, nor survivors/service-users contribute ‘professional' knowledge. None of these policies refer to the possibility of professionals also being survivors/service-users and, therefore, also able to contribute a 'user perspective'. Thus, “there is an inherent discursive inequality between service users and officials that reflects and reinforces the unequal power relations that pertain throughout the system” (Hodge, 2005:173-4). Peer workers' explicit ‘peer’ status sets them apart from other staff members, “this survivor automatically wears a label saying 'I am a survivor' whereas in an organisation of any size they will inevitably be working alongside survivor workers without such a label” (Snow, 2002:51). Thus, criticisms of the current system, alternative approaches and ‘user views’, would appear to only be welcomed from those in a clearly defined, devalued and less powerful ‘user role’.

This suggests an impression is being created of greater power-sharing, listening to (and valuing) survivor/service-user voices and addressing 'stigma', without actual change, diverting resources away from attempts to effect more radical change. As Campbell (1996:14) has argued, “it is in the interests of those who maintain the services that form the spine of the wider mental health system to sanitise our work, to depoliticise it and to confine it to the narrowest possible context”. Voice is subverted into UI, silencing the most radical (threatening to the system) challenges and maintaining the status quo, including the stigmatising ‘mental illness’ construct, the ‘us-and-them’ divide and legitimised discrimination.

Thus, it could be argued that UI assimilates and deflects survivor/service-user criticisms and demand for 'voice' (Stickley, 2006). The discourses which enable this oppression remain dominant.

Survivor/service-user professionals are not easily accounted for within these discourses and sharing/using their 'lived experience' would seemingly represent a challenge to the discursive inequality. Therefore, survivor/service-user professionals can be considered a 'site' from which to explore the relationship between UI and these other dominant discourses.

2. DEFINING THE PRESENT STUDY

This chapter discusses survivor/service-user professionals as a 'site' from which to explore the relationship between user involvement and other dominant discourses in the 'mental health' system. It then outlines the focus of the present study as an exploration of this 'site'. The professional literature regarding survivor/service-user professionals is first explored, specifically the literature which relates to the principles and practices underlying UI (i.e. valuing and using 'lived experience'). The 'self-disclosure' literature, first-person accounts by survivor-service-user professionals and empirical studies exploring survivor/ service-user professionals' experiences, are each examined and comparisons drawn with the UI literature. Important gaps in the literature are highlighted and the relevance to clinical psychology of researching these is discussed, providing a rationale for the present study. Finally, the chapter sets out the research aim and questions.

2.1 Survivor/service-user professionals

As noted, survivor/service-user professionals are neglected in UI, which speaks of the dichotomous construction of professionals and survivors/service-users. The professional literature regarding professionals using 'personal' experiences/knowledge seems mostly limited to constructions of 'self-disclosure', assessing rates of 'mental illness' and related experiences (e.g., child abuse), and discussions about predicting and preventing 'impairment' (e.g., Phillips, 1997; Sherman, 1996; Tyssen, *et al.*, 2000; Warne & McAndrew, 2005). The self-disclosure literature is largely conservative, restricting and problematizing disclosure of personal experiences (Barnett, 2011; Gutheil & Gabbard, 1998; Knox & Hill, 2003). Although some 'self-disclosure' is generally recommended, disclosing experience of 'mental disorders' is particularly cautioned against, "even if those struggles are similar to those of their client, and...are successfully resolved" (Henretty & Levitt, 2010:72). 'Disclosure' to others, such as colleagues, is neglected. As valuing 'lived experience' underlies UI, the conceptual divide between 'self-disclosure' and 'user involvement' can be seen as maintaining the distance and power imbalance between those positioned as 'professionals' and as 'survivor/service-users'.

There is little research on survivor/service-user professionals, mostly first-person accounts (e.g. Bassman, 1997; Chadwick, 2010; Deegan, 1996; Frese, 2000; Gilbert, 2010; May, 2000). Two studies were found (Adame, 2011; Lindow & Rooke-Matthews, 1998) and Snow (2002) reports the first national conference of survivor workers (including survivor professionals) in mental health and social care in the UK. There is likely more than was found; anecdotally, I have experienced people 'speaking out' across a range of platforms. The difficulty of navigating the professional literature was seemingly due to a lack of shared terminology for referring to survivor/service-user professionals. This is, perhaps, a consequence of the dominance of 'us-and-them' discourse rendering a 'both' position invisible and preventing a common language with which to discuss it (Snow, 2002).

2.1.1 First-person accounts

Experiences as survivor/service-users are often positioned as a driving force for becoming professionals, particularly a desire to change the system (e.g., Frese & Davis, 1997; Schiff, 2004). Some have explicitly linked this to regaining power and status, for example, Deegan's (1996) experience of, and outrage about, forced 'treatment' made her decide she “wanted to get a powerful degree and have enough credentials to run a healing place myself” (p. 96). Survivor/service-user experiences are described as leading to greater insight, empathy with clients, motivation for working collaboratively and knowledge that can be utilised in their work (Frese & Davis, 1997).

An important 'insight' is into the socialisation of professionals into damaging positions and beliefs: “having experienced both sides of the treatment model, I have the dubious privilege of seeing the discrimination, stigmatization, and devaluation that permeate...I see good professionals unwittingly underestimating potential and overvaluing diagnosed weaknesses while inadvertently limiting precious hope" (Bassman, 1997:240). Being a role-model of hope to service-users is a common theme (e.g., Bassman, 2000; Frese & Davis, 1997), countering, by being a professional, the devastating "prognosis of doom" (Deegan, 1996:93), implicit in dominant discourse and often explicitly given to survivors/service-users.

Although recognising 'challenges', such as their disclosure of 'mental health' problems being seen by others as lessening their credibility, Frese and Davis (1997) argue 'prosumers' (their term for 'professional consumers'), can be role-models to colleagues, using their empathy, motivation and insight to model genuine collaboration. Schiff (2004) extends this further, positioning 'prosumers' as a 'bridge':

> prosumers are in a unique position to liaise between consumers and professionals. Professionals value learned experience over lived experience, and a prosumer who has both types of experience is in a position to educate professionals about the lived experience of consumers, and *can be taken seriously by professionals because of their credentials*. (p. 213, emphasis added)

However, if 'prosumer' voices are only legitimised by their professional position, how is the value of lived experience raised? Even if more weight is given to *their* experiential knowledge, this will be different for other survivors/service-users. Unless professionals value the experience/knowledge of all survivors/service-users, the 'education' will be based on the 'prosumer's' experience, as if they speak for everyone, while others without this credibility continue to have their voices ignored. What happens when the 'prosumer's' lived experience challenges or contradicts the learned experience? It is unclear how a single individual can challenge the power of a system that includes professional socialisation, policies, practices, etc., which can prevent professionals *acting* from alternative frameworks (Hodge, 2005). Finally, other aspects of survivor/service-user discourse are more challenging than valuing 'lived' experience; professionals engaging with survivor/service-user discourse must be willing to see "a difficult and painful profile...of ourselves as oppressors” (Deegan, 1992:3).

2.1.2 Research studies

Similar themes were found in the empirical studies; survivor/service-user professionals found their experiences valuable in their work, providing understanding, empathy and more positive attitudes, whilst being a 'positive model' of a survivor/service-user (Lindow & Rooke-Matthews, 1998). Importantly, people first using services after becoming professionals, felt the experience significantly changed how they worked: “I don't think I had the slightest understanding about what it was like...I learned so much very quickly from my fellow patients, things I'd never really understood or even had any conscious thought about as a professional” (Lindow & Rooke-Matthews, 1998:486).

Despite valuing these experiences/position, some felt unable to disclose it for fear of being considered 'incompetent'. Some waited until they had worked long enough to establish their competence. This is unsurprising considering that participants reported discrimination from employers, colleagues and educators, in statutory and voluntary sectors. They faced accusations of 'over-identifying' with clients or crossing professional boundaries, were treated as more vulnerable and subjected to more surveillance than their colleagues, and complaints about the service or working conditions were discounted as 'symptoms' (Lindow & Rooke-Matthews, 1998).

Adame (2011), noting a lack of research into identity and a tendency to neglect it in personal accounts, used narrative enquiry to explore the integration of activist and clinical identities with five 'survivor therapists'. As in the previous study, survivor identities and experiences were foundational to, and a resource in, their professional work. For example, these experiences (rather than training) taught them to recognise the therapeutic relationship as the catalyst for healing, question the medical model and regard “psychological suffering as an inevitable aspect of human experience” (Adame, 2011:331). However, the dominance of the medical model made it difficult for them to use their position to lessen 'us-and-them' dichotomies between professionals and service-users, as showing colleagues how they and service-users were alike represented a fundamental threat to professional knowledge (Adame, 2011).

Survivors/service-users were not immune from this view, and this was one reason participants rarely disclosed to clients (exceptions were occasionally made to promote connection and hope). One participant recalled a client questioning his competence after 'finding out' his survivor background on the internet. Others in the survivor movement regarded the participants with distrust and as 'them' because they were also professionals. For some, this led to re-examining some of the ideas of the movement, whilst one participant stated, “it is easy to fall into the trap of internalised oppression when you start to question who you are when you do not fit neatly into other people's conceptions of what you should be” (Adame, 2011:330).

2.2 Summary and rationale for the study

The exploration of 'user involvement' and 'mental illness' discourses clearly demonstrates fundamental contradictions between them. The latter, and other related professional discourses, delineates the limits of UI (valuing survivors/service-users' voice and autonomy). The neglect of survivor/service-user professionals in UI discourse would seem to be both an indication of the 'us-and-them' dichotomy and a reinforcement of it. 'Self-disclosure' provides another discourse, one which problematizes and restricts using 'personal experience', in contradiction to the value (supposedly) placed on it in UI. There are, therefore, various conflicting discourses that provide a context within which survivor/service-user professionals act. The limited research suggests survivor/service-user professionals see value to their 'duality', largely mirroring the benefits in the UI literature. Some of these depend upon 'revealing' it, however, this was rare, possibly due to stigma and discrimination.

With a dearth of research, there are numerous gaps in 'evidence' and theory. As the conceptual separation of UI and survivor/service-user professionals seems to reinforce an 'us-and-them' position, it would be helpful to bring survivor/service-user professionals and UI together. Whilst the literature clearly demonstrates a range of different discourses available for survivor/service-user professionals to use and resist, it is unclear how they negotiate them, particularly the conflicting positions they incorporate. Research is needed both into how they position themselves within their work, and how others position them, the consequences of this and conditions that enable or prevent it. This includes how they use their survivor/service-user position and experiences. This negotiation is, therefore, the focus of this research, and in doing so, an attempt to bring together survivor movement, UI and self-disclosure discourses.

'Psychosis' is most strongly bound-up in 'mental illness' discourse and individuals receiving these diagnoses are more likely than other service-users to experience overt coercion. Arguably, they are also the most stigmatised. Similarly, stigma and discrimination are reported to be common in statutory services. As what is considered as the 'stigma' of 'mental health' *is* the legitimate construction of ‘mental illness’ taught to professionals, it is likely that this also occurs in other 'mainstream' areas of the system, such as teaching and research institutions. Although stigma/discrimination has been reported in the voluntary sector as well (Lindow & Rooke-Matthews, 1998), coercion and control are more present in the former and this is foundational to criticism by survivor/service-user movements. This suggested it would be particularly useful to use in this study survivor/service-user professionals with 'psychosis' diagnoses who were working in 'mainstream' institutions.

2.3 Relevance to clinical psychology

This research aims to further the field's understanding of the function of 'user involvement', through exploring how it interacts with other dominant discourses in the 'mental health' system, which is relevant to all professions within it, including clinical psychology. The re-examination of 'self-disclosure' in relation to UI, should particularly be of interest to clinical psychology as the discipline from which most of the literature has come (followed by mental health nursing).

The attention to ways in which these discourses reinforce or challenge 'us-and-them' dichotomies is also relevant, as it has implications for collaborative working and addressing power imbalances, stigma and discrimination (identified by users/survivors as critical for well-being and particularly encountered from services and professionals). Further, this research aims to contribute to the fight against stigma/discrimination by creating space for survivor/service-users' experiences to be heard and proudly adding my voice to those who demonstrate that ‘professionals’ and ‘survivors’ do not neatly divide into ‘us-and-them’.

2.4 Research aim and questions

The aim of this research was to explore how survivor/service-user professionals negotiate different discourses and to what effect, through asking the following research question:

> *How and why do mental health professionals who have experienced ‘psychosis’, share their personal experiences in their work?*

Based on the literature, three interrelated questions were identified to address the research question:

(1) What are participants’ accounts of sharing personal experiences with colleagues, clients and others (including how, the context and response)?

(2) How do participants identify/position themselves, and how have others positioned them, in relation to the survivor/service-user–professional dichotomy?

(3) How do participants narrate experiences of stigma/discrimination, including challenging stigmatising/ discriminatory attitudes and practices?

3. METHODS

In the following chapter, the research methods employed in the study are detailed. The social constructionist epistemological approach used is first described, including the position taken in some of the key debates in social constructionism, namely, accounting for embodiment and agency. The research design is outlined and principles are set out for evaluating the quality of the research. Details are provided regarding participants and recruitment, research procedure, and ethical considerations. The narrative method of analysis is then discussed, which includes a discussion of the rationale for choosing the particular model of narrative analysis employed and a description of the analytic procedure followed.

3.1 Epistemology

The values outlined in the *Preface* and aim of the research, led to adopting a social constructionist epistemology. These, in turn, shaped the specific research questions and design.

3.1.1 Social constructionism

There is no one social constructionist position but a 'family' of positions which share certain key assumptions but differ in how they are applied (Burr, 2003; Cromby & Nightingale, 1999). Social constructionism challenges the realist view that we can observe the 'real' nature of the world using positivist frameworks to gain 'knowledge' based on these observations. Instead, the ways we understand the world (including ourselves) are historically and culturally specific. 'Knowledge' (and thus known 'reality') is constructed through social processes, particularly language, in which people are constantly engaged (Burr, 2003; Gergen, 1985). Different constructions lead to different possibilities for actions and positions, meaning 'knowledge' and action are entwined. For example, constructing a behaviour as part of an illness leads to specific roles (e.g., doctor/patient) and actions (treatment). These constructions are, therefore, “bound up with power relations because they have implications for what it is permissible for different people to do, and for how they may treat others” (Burr, 2003:5).

Burr (2003) distinguishes two broad approaches she terms 'micro' and 'macro' and Danziger (1997) calls 'light' and 'dark' social constructionism. The former focuses on the situated, performative use of language, how, within interactions, people “actively construct accounts to try to build defensible identities or have their version of events legitimated or endorsed” (Burr, 2003:57). Macro approaches, rooted in Foucault's work (e.g., 1972; 1977), focus on the relationship between constructions, social structures and practices, and processes by which some discourses become dominant and others subjugated. Power relations, particularly inequalities and resistance, are central and, therefore, it has particularly been used to explore issues of identity/subjectivity, social inequalities and change (Burr, 2003; Danziger, 1997).

As this research is concerned with exploring the impact of, and resistance to, dominant discourses, a 'macro' social constructionist perspective is adopted, although the situated use of language is also considered as a synthesis of the 'micro'-'macro' (Burkitt, 1999). Following a 'macro' perspective, discourse is defined as inclusive of language and associated social practices/institutions. These practices (including language) “systematically form the objects of which they speak” (Foucault, 1972:49), thus they constrain and enable phenomena to be constructed in certain ways and not others, in any given time and culture (McHoul & Grace, 1993).

3.1.2 Identity and self

Identity and positioning are key ideas in this research. Identity is socially constructed from available discourses, fabricated within interactions, inherently social and unstable/fragmented, in contrast to the essentialist 'personality', seen as a unified, coherent quality *within* a person (Burr, 2003). Discourses produce different positions, rights and possibilities for action. Foucault (2003) argues that this process is part of a technique, or form of power, that “categorizes the individual, marks him by his own individuality, attaches to him his own identity, imposes a law of truth on him that he must recognize and others have to recognise in him" (p.130). Dominant discourses can be explored and critiqued by examining resistance to this power, how identities are claimed, accepted or resisted (Burr, 2003; Foucault, 2003).

Social constructionism has been criticised for failing to adequately address 'gaps' left from the deconstruction and rejection of the essentialist 'self', particularly accounting for embodiment and agency (e.g., Nightingale & Cromby, 1999). We have an awareness of self, even if it is socially constructed and changeable. Furthermore, agency is implied in both micro (e.g., *choosing* different discursive strategies) and macro approaches (*resisting* subjectivity) but poorly accounted for. Similarly, differences are often not explained, such as why one person in a particular context resists and another accepts. Failure to account for an individual who is both product and constituent of social processes, maintains an unhelpful dichotomy between individual–society (Cromby & Standen, 1999).

By conceptualising *individual/society* as an ecosystem, individuals and the social structures/practices (i.e. discourses) they live within, engage with, and which shape thought and experience, are seen as aspects of a single phenomenon (Burr, 2003). This is particularly important because, if we actively produce and manipulate *and* are products of discourse, this "allows us the possibility of personal and social change through our capacity to identify, understand and resist the discourses to which we are subject" (Burr, 2003:125).

The 'self' conceptualised here is embodied, physically located in space and experiencing the physicality of the world through the senses (Burr, 2003; 1999; Cromby & Nightingale, 1999). Burr (1999) argues that embodied ways of 'knowing' the world should be regarded as 'extra-discursive', providing examples of the arts and 'experiences' people struggle to communicate in words. 'Personal-social histories' (Cromby & Standen, 1999) are considered important for explaining individual differences in how discourses are used. These histories provide unique mixes of discourses people are exposed to and subject positions available to them (Davies & Harré, 1999). Personal-social histories also influence how able people feel to adopt or reject different discourses and subject positions, particularly through their past experience of doing this (Davies & Harré, 1999).

There are many debates within social constructionism about ontology and how (or whether) to approach the physicality of the world and whether a relativist position creates a 'moral vacuum' (Burr, 2003; Nightgale & Comby, 1999). A relativist position does not claim that there *is* no reality but rather that we cannot directly access it, and therefore can make no ontological claims (e.g., Gergen, 1985). In this research I take an ontologically critical realist, epistemologically social constructionist position (Harper, 2012). This means I take the position that there is a material reality which people experience through their senses, that influences the social constructions which can be created. These constructions, in turn, produce material conditions in the practices and institutions constituent to dominant discourses. Thus, one cannot just construct any reality (Parker, 1992; Willig, 1999); social constructions must account for material conditions and embodied experiences, and any analysis needs to recognise the material reality created by these social constructions.

This does not mean, however, that one can know the 'truth' of this material world, in some way, *from* social constructions (as some have argued; e.g., Willig, 1999). This would be taking a critical realist epistemological position. I hold to a social constructionist epistemology as, if language is a pre-requisite to thought (Burr, 2003), then embodied experience becomes discursive when thinking occurs and there is no way to communicate about experience of the physical world without language. Nonetheless, I believe it is important to take an ontologically critical realist position on material reality in this research, for two main reasons.

Firstly, there is a historical (and current) context of survivors/service-users' experiences and perspectives being routinely ignored or dismissed by professionals (and society at large) as meaningless, suspect and lacking credibility. As a piece of research situated within the work of the survivor movement to challenge this, it would be inconsistent to risk reinforcing this invalidation by not acknowledging the reality of the embodied experience within survivors/service-users' constructed narratives. Secondly, the material conditions created by dominant discourses such as 'mental illness', have serious consequences for those constructed as 'mentally ill', which construct their material reality and should be acknowledge. For example, the Mental Health Act allows people to be physically removed from their homes and held against their will in a particular physical space (dominantly constructed as 'involuntary admission' to a 'hospital'), and physically held down and injected with chemicals which have physical effects (dominantly constructed as 'restraint' and 'compulsory treatment'). Both of these situations, I believe, create a moral impetus to take an ontologically critical realist perspective.

3.2 Design

3.2.1 'Unstructured' interviews

Qualitative methods were most appropriate to the research question and epistemology as they can “address the problem of inappropriately fixing meanings where these are variable and renegotiable...[and] can act as a vehicle for bringing the relationship between researcher and researched into view” (Henwood, 1996:27-28). Although there are first-person accounts from survivor/service-user professionals available, few include sharing experiences in their work. Therefore, interviews were used to gather data. Other qualitative methods could have been applied, particularly participatory action research (Whyte, 1991), but this was beyond time and resource limits.

The method of analysis determined the interview style, so requires explanation here. Narrative analysis (NA) was adopted for three main reasons. Firstly, stories are easily accessible as they are “a basic tool that individuals use to communicate and create understanding” (Feldman *et al.*, 2004:147). Storytelling is considered a key way people make sense of their experiences and create meaning, organising experiences in relation to others (Bruner, 2004; McCance, McKenna & Boore, 2001). Langellier (2001:700) states, “embedded in the lives of the ordinary, the marginalized, and the muted, personal narrative responds to the disintegration of master narratives as people make sense of experience, claim identities, and 'get a life' by telling...their stories", making NA a good method for studying experience and identity.

Secondly, NA can be approached from a social constructionist position and can then explicitly attend to power and discourse. Some authors have argued that social construction occurs through narratives, particularly life narratives and construction of the 'self' (e.g., Gergen, 1994; Sarbin, 1986). Narratives represent storied ways of communicating and knowing (Riessman, 2005), showing possible ways of knowing available within a particular time, culture and situation (Bruner, 2004; Gergen, 1994). They demonstrate how discourses construct, prevent or marginalise available identities and positions, including the power issues and social practices in which they are bound (Emerson & Frosh, 2004).

Lastly, it is possible in NA to acknowledge interviewer/researcher influence, allowing me to reflexively use my experiences and positioning as a survivor-researcher, and thus, hopefully, conducting research as social action. These three capacities of NA makes it "a specific discourse methodology capable of critically contributing to the interplay between personal and social change" (Emerson & Frosh, 2004:8), important as inequalities are central to this research.

Discourse analysis (DA) and Foucauldian discourse analysis (FDA) are methods perhaps more frequently used in social constructionist research, however, they experience the same limitations in accounting for 'self'/agency as micro and macro social constructionism (Burr, 2003; Emerson & Frosh, 2004). A view of individuals as both products of discourse (the macro social constructionist perspective taken in FDA) *and* actively producing and manipulating discourse (the micro perspective taken in DA), is central to the topic and research question. This was a key reason for choosing narrative analysis, which can synthesise (Burkitt, 1999) these two approaches. Emerson and Frosh (2004) argue that, by combining a focus on constructing processes through which people account for their lives, with the 'critical gains' from DA/FDA in centralising social processes/

language, NA can be more useful for exploring “subjective meaning-making, social processes, and the interpenetration of these in the construction of personal narratives around 'breaches' between individuals and their social contexts” (p. 9).

As narrative analysis was adopted, the interviews were 'unstructured', more appropriate for eliciting narratives than structured or semi-structured interviews, which constrain more what participants can say (Emerson & Frosh, 2004; McCance *et al.*¸ 2001). There is always some structure as the interview is occurring to answer particular questions, and 'unstructured' is used to differentiate from 'semi-structured'. Both interviewer and participant had a list of 'topics' and prompt questions which could be added to, approached in any order and were explicitly positioned as partial/incomplete. This aimed to: 1) enable/ encourage narrative form; 2) explicitly recognise the topics/prompt-questions will be different from those others would identify from the research question; and, 3) create space for these to be discussed.

3.2.2 Evaluating quality

Assessing the quality of qualitative research within a social constructionist epistemology requires different standards to the positivist-derived concepts of representativeness, generalizability, reliability and validity. This epistemology precludes the possibility of achieving an 'objective' position (we always have a particular perspective rather than another) and making 'truth' claims, as “all knowledge is provisional and contestable, and accounts are local and historically/culturally specific” (Burr, 2003:158). Thus, the research is a co-production between researcher and participant and cannot be replicated.

Despite the rejection of a positivist-derived concept of generalizability, research from a social constructionist position still, arguable, needs to be able to make some claims about the transferability of its results beyond the specific situation of the study. Stoddart (2004) argues for using a model of generalizability in postmodern research which draws on Prus's (1994) concept of 'generic social processes'. Instead of generalizing from samples to populations (which are socially-constructed categories), focus is on social processes which play out across different social sites. Such processes can be seen as the focus of social constructionism, for example, in Foucault's theory of power/knowledge and demonstration of this process in such diverse contexts as sexuality, madness and imprisonment (Stoddart, 2004). It can be argued that the theory of social constructionism itself and researchers' attempts to demonstrate how various aspects of knowledge and practice are socially-constructed, use this concept of generalizability.

This is, therefore, the model of generalizability used in this research. However, to achieve theoretical consistency with the epistemological position, important qualifications are attached to the concept of generic social processes. Specifically, Stoddart (2004) recommends viewing social processes as metaphors rather than social 'facts' and generalizability cannot be evoked to claim authority over knowledge. Thus, proposed processes provide a lens through which to explore and analyse social interactions but are explicitly acknowledged as tentative and openly contestable.

No alternative set of criteria to reliability and validity has been universally applied to qualitative, social constructionist or NA research (Burr, 2003; Smith, 1996). Smith (1996) suggests criteria for qualitative methods of *internal coherence* (presenting a coherent argument), *presentation of evidence* (allowing the reader to interrogate the interpretation by presenting raw data), *independent audit* (having an 'audit trail' of decisions made while conducting and analysing), *triangulation* and *member validation* (to capture multiple 'voices'). Smith (1996) noted these were neither exhaustive nor all necessary. The appropriateness of criteria will vary depending on one's epistemology and method. Taylor (2001) proposes various criteria to allow readers to judge *coherence* and *rigour* in discourse analysis, demonstrating the logic applied (procedural and interpretative decision-making).

Spencer and Ritchie (2012) suggest that three recurring principles underpin ideas of how to evaluate quality in qualitative research: *contribution*, the value and relevance of the research in enhancing knowledge; *credibility*, the defensibility and plausibility of claims; and *rigour*, demonstrating methodological and theoretical consistency through an audit trail and reflexivity. This research attempts to demonstrate quality in accordance with these principles. Specifically, I hope to show credibility, rigour and coherence through: a) providing in-depth information about the steps in the analytic process in the method of analysis; b) including a worked example of a section of transcript through all stages of analysis; c) reporting results with excerpts with context and an overview of the whole interview/text. I have used Burr's (2003) definition of reflexivity of explicitly acknowledging my personal, political and theoretical values/perspectives informing the research. I have made these explicit in the preface, discussion of the method of analysis and, in more depth, in the appended critical reflection.

3.3 Participants and recruitment

The inclusion criteria for participation were being a professional in England working in 'mainstream' institutions in the 'mental health' system, who self-reported being given a ‘psychosis’ diagnosis. A professional was defined as someone in a role requiring a specific qualification, differentiating them from 'peer workers' (one participant was in a job requiring both qualification and service-user experience, as director of a service-user research department). 'Mainstream' institutions were defined as NHS 'mental health' services for clinicians, or university departments focused on 'mental health' for academics/researchers, or training professionals, for educators.

Individuals publicly known to meet the inclusion criteria (e.g., from speaking in the media about their experiences) were contacted by email, which included an invitation to participate (Appendix II) and an information sheet (Appendix III). In addition, a ‘snowballing’ recruitment method was used (Atkinson & Flint, 2001). Individuals who were contacted were asked to forward the information to others who met the inclusion criteria. Individuals expressing interest were given the research proposal and an opportunity to ask questions. My position as a survivor-researcher was explained, with an opportunity to discuss this further.

Four people participated in this study (see *Data analysis* for discussion on participant numbers); three were female. Participants' professions were: academic/researcher ('Christine'), clinical psychologist ('Laura'), mental health nurse ('Ian'), and occupational therapist ('Bethany'). They had been in their professions for from two to over twenty years. All participants were White British and English was their first language. They worked in East and South-East England, covering urban and rural areas. Two participants reported being diagnosed prior to becoming a professional, one was diagnosed after, and one was diagnosed as they qualified.

3.4 Procedure

Participants were interviewed at a location of their choice and I conducted interviews at a participant's home, participants' workplaces and at a café (with private space). At the interview they were given the information sheet again and consent form (Appendix IV). Participants were informed of their rights, including confidentiality and the right to withdraw. The interview process was explained, the topic list (Appendix V) shared, and participants invited to add topics they thought were relevant. Interviews, lasting 50 – 70 minutes, were audio-recorded and manually transcribed later (see *Data analysis*). At the end, participants were asked about their experience of being interviewed, thanked for participating, reminded of their rights and provided with the researcher's contact details.

3.5 Ethical considerations

3.5.1 Ethical approval

Ethical approval was sought and granted by the School of Psychology, University of East London (Appendix VI). As this research did not seek to access individuals currently using any particular services, nor were participants recruited through the NHS, approval was not needed from an NHS ethics or research and development board.

3.5.2 Benefits and harm

It was not anticipated participants would be harmed. The study did not involve deception and informed consent was sought (e.g., the participants were sent the research proposal). Participants were fully informed of their rights to confidentiality, to not be harmed, to ask questions and to withdraw their participation. They were given contact details to report any concerns/complaints.

As the interviews involved discussing potentially distressing experiences, space was provided at the end of the interview to discuss participants' experience of it. Participants all spoke positively about this, suggesting there had been unexpected benefits to participating. Three spoke of discussing things for the first time or thinking differently because of the interview, three were curious about other participants' responses, and two remarked that they rarely had opportunities to speak with other survivor/service-user professionals.

3.5.3 Maintaining anonymity

Maintaining anonymity and, thus, confidentiality, was particularly challenging when writing up the study. A balance was sought between providing contextual information and interview extracts necessary for understanding the narrative and judging quality, whilst at the same time protecting anonymity. All participants spoke about positions, discourses, etc., related to their specific professions and so professions have been identified for each participant. However, other demographic information (e.g., location, length of time in their profession) is provided as an overview. Names and other identifying information here and in transcripts were changed.

All recordings and consent forms were securely kept (as an encrypted file and in a locked filing cabinet, respectively) and only the researcher had access. Audio recordings will be deleted when the thesis has been approved and other records will be destroyed after three years.

3.6 Data analysis

There is no one method of narrative analysis and various typologies have been suggested (e.g., Langellier, 1989, Mishler, 1995; Riessman, 2005). Riessman (2005) proposes four models of NA: thematic, structural, interactional and performative analysis. Mishler (1995) groups models around similarities and differences in the problems addressed and methods used. Reference models are concerned with representation, correspondence between 'real' temporal sequencing and order in text. Structure models (including structuralist and post-structuralist models) focus on how form constructs meaning and coherence. The function group focus on the purpose of stories, contexts within which stories are produced and the consequences of telling them (Mishler, 1995).

There are similarities between typologies; the categorisation of models is derived from an interplay between epistemological approach, research question and analytic strategy. Different categories/models are variably suited to different research features (e.g., the number of participants). However, boundaries between groups should be considered 'fuzzy' (Mishler, 1995; Riessman, 2005). Moreover, reference, structure and function are simultaneously and necessarily present; we cannot communicate together “unless we are talking about something in ways that fit cultural understandings of how to speak coherently, and what we say has inevitable and inescapable effects” (Mishler, 1995:117).

The model of NA used in this research broadly falls within Riessman's (2005) performative group and Mishler's (1995) *politics of narrative* function subgroup, models which explore how dominant discourses, incorporating the values of dominant groups, define and legitimate rights and duties and may be resisted by counter-narratives constructed from excluded perspectives. The model specifically follows Mishler's (1999) 'narrative as praxis', integrating micro (co-construction and performance) and macro social constructionist concerns (power and resistance to subjectivity) with structural methods.

3.6.1 Narrative as praxis

This model is guided by the assumption that there is a “dialectic interplay between our dual positions as subjects, first as active agents making and transforming the world, which then becomes the 'objective' conditions to which we must then respond, as we adapt, make, and transform both ourselves and these conditions” (Mishler, 1999:18). Personal narratives/life stories are socially situated actions, identity performances and fusions of form and content. Coherence is achieved by participants working together within social and cultural frameworks of interpretation to co-create stories and understanding. Analysis focuses on this dialogic process through which meaning is negotiated.

Mishler (1999) and Emerson and Frosh (2004) adapt Gee's (1991) 'poetic breaks' method to a social constructionist epistemology (what the latter call a 'critical' approach), applying this method to five and one participants, respectively, arguing that the detailed (and time-consuming) nature of integrating multiple aspects of analysis requires studying fewer narratives in greater depth.

3.6.2 A 'critical poetic breaks' method

Gee (1991:16) argues that interpretation is “an amalgam of structural properties of texts and creative inferences drawn on the basis of context and previous experience”. These properties function at a variety of levels to set up a series of interpretative questions (see Table 1). Conceived hierarchically, each level is inclusive of those 'below' and taken into account by those 'above', informed by 'micro' and 'macro' linguistic components or tools, each of which, through contributing interpretative cues/questions, grounds the overall thematic interpretation (Emerson & Frosh, 2004).

Analysis of 'micro' components begins with focus on *pitch glide*, based on the English prosodic system of rises and falls from base level, which “signals the focus of the sentence, the information that the speaker wants the hearer to take as new or asserted” (Gee, 1991:21). Without changing the literal meaning, pitch alters how a sentence fits with surrounding material, the point being made. Any sentence with one pitch glide is an *idea unit* (sentences may have more than one idea unit), often separated by slight pauses/hesitation (Gee, 1991). These are grouped into *lines* around a central idea in their syntactical and intonational organisation.

Table 1. Structural levels of interpretation

Level	Characteristic	Role in interpretation	Interpretative questions
1	Organisation of text (line & stanza structure)	Ideas/perspectives on characters, events, states, information	• How has this text been organised as speech?
2	Syntax & cohesion	Logic & connections	• Why has/have the speaker(s) made this particular connection at this point? • How does this connection make sense within the overall logic of particular narrative sections & the overall interview?
3	Mainline / off-mainline plot	Plot	• What is the main point/significance of this plot? • 'So what'?
4	Psychological subjects	Point of view	• Who/what is the psychological subject of this stanza? • Why does the narrator change subjects / shift positions / points of view? • Are there patterns in these changes?
5	Focusing system (pitch & stress)	Image/theme	• Why is this focus important? • How does it fit with other focused material?

Adapted from Gee (1991) and Emerson and Frosh (2004)

Lines pattern into the 'macro' components of the narrative, stanzas, strophes and parts (Emerson & Frosh, 2004). *Stanzas* organise around a particular perspective on a character, event, etc., and a new stanza involves a shift in this perspective. Whilst a variety of linguistic devices can signal stanza divisions, Gee (1991) suggests that the best grounds to argue for stanza structure is the overall pattern of the text, rather than assuming universal rules. Stanzas are then organised into *strophes*, thematically linked stanzas. Themes in strophes that link around a 'grander' theme, or argument, are organised into *parts*, 'episodes' of the overall narrative (Emerson & Frosh, 2004; Gee, 1991).

Further units of analysis are added with a social constructionist epistemology

(Emerson & Frosh, 2004; Mishler, 1999), aiming to explore how:

> dilemmas and resources are storied and interactional, located neither 'in' nor 'separate' from [individuals], but through those discursive practices by which...[they situate and account for their selves] in relation simultaneously to the real time of the interview and to the canonical as well as personal narrative versions of [their] own lived time, past, present and future and possible identities. (Emerson & Frosh, 2004:123)

This involved examining how discourses and canonical narratives are used and the socio-cultural context in which storytelling occurred. Both participant and interviewer are included in the transcript and co-construction explored, for example, by attending to what openings were pursued or neglected, how questions asked shaped what could be said. Any sense of 'finding' structures is tempered by the reflexive awareness that structuring is an interpretative process (Emerson & Frosh, 2004). Interpretation always involves these kinds of questions and decisions; the benefit of this method is not its 'accuracy' (based on realism) but its systematic approach and the way in which it renders the analytic process more transparent.

3.6.3 Process

The process of analysis involved first producing a raw, verbatim transcript, including false starts, over-lapping speech (denoted by prefixing '<'), non-lexical expressions (in ‘[square brackets]’) and pauses, with '…' representing hesitation less than a second and '(seconds)' longer pauses. Words carrying pitch disruption were capitalised. This transcript was read and re-read, annotating with points the interpretative questions raised. Although levels of interpretation are hierarchical, they “mutually and recursively inform one another across the systematic listening/reading and re-listening/re-reading of a text” (Emerson & Frosh, 2004:65). Based on this, the text was divided through progressive re-transcriptions, into idea units (separated in lines by ' / '), lines, stanzas, strophes and parts. Lines were numbered, stanzas separated by blank, unnumbered lines and all stanzas, strophes and parts were titled (Emerson & Frosh, 2004; Gee, 1991).

One deviation was using 'sub-narratives' as a further level of division/organisation of the text. The narrative was still defined as the whole interview (Gee, 1991; Emerson & Frosh, 2004; Mishler, 1999). Although these could have been organised as the 'parts', I believed this would lose some of the 'richness' and complexity of the stories/arguments in each, and was perhaps influenced by having three 'topics'.

4. RESULTS

In this chapter, each participant has a section devoted to their overall narrative. Grouping their responses by research question would lose the variability and complexity between interviews in co-construction of the meaning of questions and narratives. Complexity is important in attending to subtleties in meaning, and arises from the discontinuities, disjunctions, variability, instability, contradictions and tensions that characterise life stories (Bruner, 2004; Mishler, 1999). Although other participants' narratives and the research questions are referred to, these are addressed in the *Discussion*. As the word limit did not permit reporting all levels of analysis, macro levels are focused on with reference to micro levels where this is essential to interpretation. An example of all stages is appended to allow greater 'interrogation' of interpretative decisions (Appendix VII) and tables of part, strophe and stanza titles are provided for each participant's sub-narratives (Appendices VIII-XI). Participants' words are denoted by quotation marks. Longer extracts include transcription details (pitch disruption is placed in bold for clarity) and abbreviation denoted by '[…]' to distinguish from hesitation.

4.1 Laura: A precarious, chameleon-like position

Laura’s interview followed the topic list, with 'user involvement' added pre-interview. From this, four sub-narratives were derived: (I) *A precarious position: sharing/not sharing when it's 'out there'*; (II) *A chameleon-like position*; (III) S*tigma/discrimination: barriers and reasons for disclosure*; (IV) *Natural to do user involvement*. Throughout the narrative, Laura explains taking different approaches with clients and colleagues regarding sharing her 'mental health' experiences. This is characterised by contrasting arguments and examples being presented around central statements, exploring different contexts and causal explanations, creating an impression of complexity. Laura emphasises not having a *single* way of understanding her position, using language implying camouflage, that she is protectively changing herself (“I don't know if I have […] a way of...situating myself […] of understanding my position I suppose...it's just being quite...chameleon-like and being different with different people” [308-10]).

Early on, Laura positions 'professionals' and 'service-users' on opposing sides, neither of which she *completely* fits into:

> Sub-narrative I, Strophe 13:
>
> 85. it's **HARD** to **BALANCE** kind of.../ **WHERE** you're **AT**...
> 86. **AND** / I suppose I quite **OFTEN** / **FEEL** like.../ I **DON'T** really **FIT** very **EASILY** / in **EITHER** camp
> 87. I'm **NOT** / **COMPLETELY** a psychologist / **BECAUSE** I'm.../ quite ss-...kind of **SYMPATHETIC** / to **WHAT** it **FEELS** like / to **BE** on / the **OTHER** side of the **ROOM**
> 88. but **SERVICE**-users **ALSO**.../ kind of **MIGHT** be.../ **THINKING** that / I **CAN'T** quite sit in **THEIR** camp / 'cos I’ve **DEFECTED** to the other **SIDE**

The military language (“camp”, “defected”) creates an impression of a war-like battle, perhaps explaining the need for camouflage/protection. Service-users are positioned as potentially not allowing her in 'their camp' because she is now a professional (88) but her exclusion from completely being a psychologist is stated as a fact (87); both physically locate her on the professional side. Across the narrative, she presents herself as having a survivor/service-user identity and her experiences of 'madness' as foundational to her work (“I'm a psychologist because of it” [785]). 'Personal' and 'professional' experiences come together to provide knowledge and empathic understanding: “my experience kind of fleshes out...the theory and the facts and stuff and […] makes me feel it more” [347]. They are also used to explain her responsiveness to clients' wishes compared to colleagues (who use a 'professional boundaries' discourse to maintain control). A tension between this identification and the positions she is able to take, seems key to the different approaches she employs.

With clients, Laura does not talk directly about her experiences but lacks control because her media work could lead to clients 'finding out', which has already happened. The construction of her argument presents it as a 'compromise' position, because clients could reject her identification a 'service-user psychologist'. Laura contrasts experiences of being positioned by clients. When knowing her service-user experience/position could not be avoided, it has led to being positioned as a more 'knowledgeable' psychologist, and their gratitude for sharing. A client who looked her up on the internet stated that she felt Laura “had a sense of knowing what she [Laura] was talking about” [28], another service-user anonymously left her a chocolate bar and a 'thank you' note after seeing her on television. In contrast, one client “always […] says oh but you'll never understand because you haven't heard voices” [67], another similarly stated “you'll never know what it's like to be one of us” [609], constructing her as 'other' and precluding her being able to understand because of her professional position.

Laura uses various professional discourses to validate not sharing. However, as demonstrated by the following extract (within which strophe 13 was centred), uncertainty and ambivalence characterise these explanations. Laura rapidly switches between and contests them (including within stanzas), which presents the arguments as not particularly credible/persuasive and exemplifies Laura's conclusion that uncertainty stops her (93):

Strophe 11:

70. but **MY** voices / probably **WEREN'T** / **LIKE HIS**.../ because...**HIS** were quite **MALEVOLENT**.../ **ARE** quite malevolent...
71. **AND**.../ I don't **KNOW** / what his **EMOTIONAL** reaction to them **IS**...
72. **MINE** have **GONE** / I haven't **HEARD** mine for a **VERY** long time...

73. and I think the **PURPOSE** of me **TELLING** him / **WOULD BE** to kind of.../ **DEEPEN** the **RAPPORT** / in **THAT** at that **MOMENT** in the **SESSION**
74. and...I'm **NOT** sure / if **LONG-TERM** / it would **STILL** have.../ a **POSITIVE** effect
75. and **SOMETIMES** / I **WORRY** that.../ if **I DISCLOSE** to clients /

THEY might **WORRY** about **MY** mental health
76. and oh I **CAN'T** tell her anything really **DISTRESSING** / 'cos she **CAN'T** quite **COPE** with it

77. **OR**.../ kind of **MIGHT** / ask me **LOTS** of **PERSONAL** details / **ABOUT** my **EXPERIENCE**
78. which would...kind of **FEEL** / quite **DIFFICULT** to **TALK** about / or would **MAKE** me feel quite **VULNERABLE** (1)

<u>Strophe 12:</u>
79.. um...so **THAT** / that's **ONE** client / that **LOTS** of times / I've **REALLY** had the **URGE** to say / well **ACTUALLY** / I ha- I **HAVE** heard voices and...
80. it just **FEELS** like.../ it would **BE**.../ **JUST** for / to **MAKE** things better **FOR ME** / **RATHER** than / to **ACTUALLY** do something / **THERAPEUTICALLY HELPFUL**...

81. um **BUT** / then I'm **AWARE** that / that's a **BIT** kind of **ALOOF**...
82. like oh **YOU** don't need to know / about **MY** experiences
83. **YOU** just kind of / **SIT** with your **OWN** and.../ kind of **COPE** with it...
[…]
<u>Strophe 14</u>
91. **AND** (1) / I **DON'T** know / **HOW** he'd **RESPOND**
92. he **MIGHT** be really **TAKEN ABACK** / he **MIGHT**...be really **SURPRISED**.../ he **MIGHT** be a bit **SCARED** / or...**MIGHT** be **ANGRY** that I **HADN'T** shared **BEFORE** or...um (1)

93. kind of I **SUPPOSE** / the **UNCERTAINTY** / **STOPS** me from **DOING** it
94. and...kind of...**WHO'S** it **BENEFITTING**
95. and **WHAT** will the **OUTCOME** be
96. and **ONCE** you **SAY** it / you **CAN'T UNSAY** it...
97. but I'm **ALSO** quite aware / that's a bit of a **PRECARIOUS**

POSITION

98. I mean I **HAVEN'T** really / **DONE** any **MEDIA** work / for a **VERY LONG** time
98. but **SOMETIMES** still / **PEOPLE** kind of.../ **KNOW** a bit **ABOUT** it
99. **SO**... / it **KIND** of.../ some...it's it's...kind of **SOMETIMES** always **THERE**

Laura firstly uses a 'representativeness' discourse (70-2) to position herself as *not really*, or, *no longer* 'one of them', perhaps, also an attempt to justify clients' 'othering' of her. Switching from "telling" (73) to "disclose" (75) whilst broadening to all clients (75), Laura then draws upon a 'self-disclosure' discourse to construct it as changing the boundaries of the relationship (implying concern should only be about the client; 75-8), becoming 'non-therapeutic' (80). However, she contests this, reconstructing non-disclosure as an unhelpful distancing, with implications of power (81-3). The vulnerability Laura would feel (77-8), suggests the boundary is to protect her from exposure. Although this seems like an individualising explanation, vulnerability is perhaps conferred by a dominant 'mental illness' discourse which would construct her as incapable (76). Supporting this interpretation, following the second story of clients othering her, Laura justifies not sharing with: "I don't want that bad day to be seen as oh she's ill or she's mad and we can't trust her to cope" [659]. The media work (97-9) perhaps stands as a reminder of the importance of her survivor/service-user experiences to her identity as a psychologist (having chosen to 'speak out'), as well as creating a risk of being 'found out'.

If uncertainty silences her with clients, perhaps the factual way Laura presents herself as not completely being a psychologist (87), enables her 'openness' with colleagues:

Sub-narrative I, Strophe 28:

186. 'cos the **TEAM** actually / the team at **WORK** / **KNOW**
187. I've been **QUITE OPEN** about it / and just given **TINY** little **BITS** of information **AWAY**...um...
188. **LIKE** / kind of just **SAYING**.../ kind of **MATTER**-of-factly / when

> **TALKING** about a client / **BUT**/ **I'M** a service-user as **WELL**/ **SO**.../
> I **THINK** duh-duh-duh-duh-duh.../ and oh **MY** experience **WAS**...

The juxtaposition of the emphasis on being “quite open” and how little she 'gave away' (187), begs the question how 'openness' is constructed. Its position after discussion about her approach with clients, suggests a contrast with that. It is also unclear whether “as well” (188) emphasises being *both* a service-user and professional, or positioning herself *with* the client. Supporting the former, Laura positions having these two identities/experiences as giving her a unique perspective, an additional knowledge that can be a resource to others. For example, when a colleague asked her a question requiring 'experiential knowledge' (taking medication): “that was like a resource and another way of understanding something” [162-3]; “thinking that I've got a different perspective that's valued to add” [168]. Similarly, she stories a colleague asking her to share her experience with a client of the benefits of medication, as ‘someone who actually knows’.

Either way, Laura was seemingly not using 'being both' as the focal point of discussion, but as a position which gives her a credibility and authority from which to speak (188). She later narrates using this to challenge negative assumptions associated with the 'mental illness' discourse: “I've disclosed to try and counter people's discrimination” [516]; “saying that they'll never get anywhere [...] kind of like well I've been mad, so...” [524-6]. The open “so” suggests a direct challenge; presumably her professional position shows she has 'got somewhere', thus, particularly standing as a challenge to other professionals. This use of position to give her authority and credibility, challenge assumptions, and provide a unique perspective/resource, seems key to Laura's approach with colleagues. Although it suggests survivor discourse and/or user involvement legitimise a survivor/service-user position, important, related limitations to this are presented.

Firstly, credibility/authority was not always validated (e.g., she stated that there was no response from interviewers after she disclosed in a job interview). Although Laura attributes 'non-response' to the legacy of known survivor/service-user professionals 'normalising' duality, some invalidation is also implied ("it doesn't really...make too much difference to them […] some of them have said that" [536-9]). One supervisor, to whom she disclosed early on, later stated she should not have "because it made [them...] think about [her] in a different way" [556], instructing Laura to hide her experience and making her responsible for their reaction. When she then delayed telling another supervisor, Laura was told she should have said sooner ("we're psychologists of course we don't mind" [565]). Thus, these supervisors were using their power as qualified, 'complete' and supervising professionals, to define what Laura should do and how others within the discipline would respond (ignoring her experience).

Secondly, Laura positions herself, across sub-narrative **III**, as resisting being constructed within a 'mental illness' discourse, specifically, as incompetent and 'against' professionals, their institutions and practices. In the following extracts, resistance is attempted by actively contradicting these assumptions and, more passively, 'hiding' difficulties. All survivor/service-user professionals are implicated through switching from the first-person to a general 'you'. The first is situated after stating uncertainty about having been discriminated against at work:

Strophe 2:

467. I **SPEND** probably **MORE** time / **SECOND-GUESSING** other **PEOPLE'S** opinions
468. and **TRYING** to.../ trying to **MAKE SURE** / people think it's **COOL** / and it's **OKAY** that...
469. I can **BE** a service-user / and I **DON'T HAVE** to be.../ kind of **COMPLETELY** / ru-...**RUBBISH** at my **JOB**
470. or...**COMPLETELY** / um **ANTI**-medication / or **ANTI**...um **CPNs** or social services or whatever

[...]

474. and I think **SOMETIMES** / you kind of almost **TRY**...quite **HARD** / to **DISPROVE** those assumptions
475. to kind of **BE** like / oh what...um...**HAVE** we thought about **MEDICATION** with this person

The repeated emphasis on “completely” (469, 470) seemingly stresses the all-encompassing subjectivity produced by the discourse, as does emphasis on the effort required (474), raising questions about whether one can challenge or disagree, without this being constructed as because of her 'being a service-user'. Repeated emphasis on “trying” (468, 474), perhaps implies a lack of success, providing a justification for her 'hiding’ (721).

Supporting this interpretation, the intervening parts, between the two strategies of resistance, narrated Laura's previously discussed experiences of disclosing to supervisors. This included a third supervisor normalising a 'bad day' then surreptitiously checking up on Laura's work, implying her ability was questioned. Additionally, Laura narrated that her disclosure, rather than challenging the assumption of incompetence, had led to her being dismissed as 'unrepresentative': “one [colleague] said […] oh I'm quite surprised because you seem so confident” [540-2]. Thus, this second strategy is proposed following the presentation of a number of stories recalling being constructed by an 'incompetence' discourse:

<u>Strophe 38:</u>

715. **IF** / I'm **FEELING** kind of **LOW** / or...**HAVING** a kind of a **DIFFICULT DAY**
716. **THEN**.../ I probably **WOULDN'T**.../ **CONSIDER** talking about it / with **ANYBODY**

<u>Strophe 39:</u>

717. **WHICH** is **WEIRD**
718. 'cos if you **THINK** about it / they're **ALL** mental health **PROFESSIONALS**
719. which **ARE** the kind of / **EXACTLY** the **KIND** of people / that it **SHOULD** be helpful to **TALK** to

720. but **BECAUSE** / you **WANT** them / to **SEE** you / as **PROFESSIONAL** and.../ kind of **IN CHARGE** / and **ON TOP** of

things...

721. you kind of...**HIDE** it a little bit

Laura's use of “difficult day” (715) presents a contrast between a transient (potentially externally caused) problem and permanent, internal dysfunction of ‘illness’, implying a discrimination in the way the latter constructs survivor/service-user professionals' difficulties. This creates a dilemma regarding the role of 'mental health' professionals in helping people with such difficulties (717-9). The 'us-and-them' dichotomy of professionals and service-users seems to merge with a 'mentally ill'–'not ill' dichotomy, precluding having difficulties *and* professional positioning (720), *when* occupying an 'ill' position.

This interpretation (rather than *no* professional can have difficulties and remain in that position) is supported by another barrier Laura narrates to sharing with colleagues – resentment about her access to support and flexibility: “my colleagues who also have their own...problems don't get the same benefits” [181]. Thus, a 'mentally ill' position confers entitlement to support at work that a 'non-ill' position does not but then this can invalidate a 'professional' position.

The 'us-and-them' construction of service-users and professionals interacting with 'mental illness' discourse, would, therefore, appear key to the approaches she takes with clients and colleagues. However, this perhaps enables dilemmas to be restricted to within services (“it's quite hard to be an activist within a service and change it whilst you're...kind of within it” [421]; “if you join a service on some level you kind of endorse it” [426]). This seemingly creates space for Laura to speak from an integrated service-user professional position outside of the service context: “that's the immediate team” [434], “being open in the media [...] that's kind of trying to change a system” [438,440]). Presenting on her experiences in schools and conferences are similarly positioned. Thus, duality can be used to challenge the system in a more direct and critical way than from within.

4.2 Christine: Being *able* to share has changed over time

Much of Christine's interview involved the first sub-narrative, *Being able to share has changed over time* – a chronological account from her becoming a service-user and an academic to the present, interspersed with reflections (see Appendix IX). There was a clear orientation ("being able to share my mental health experience […] has changed over time" [3-5]) and conclusion ("so that's the story" [288]). Each part builds upon the last, creating a progressive narrative, combining her life-story with contemporaneous social and political events to consistently contextualise it. All but the final other sub-narratives follow questions from me expanding on aspects of this story: (II) *1970s era context;* (III) *Life experiences create identity;* (IV) *Civil rights and social structures;* (V) *Challenges and advantages to service-user researchers;* (VI) *Comparison to other participants*.

As this extract shows, Christine's narrative starts from a time when she was silent about her service-user experience, which she tried to keep completely separate from her researcher identity:

> <u>Sub-narrative I, Strophe 2:</u>
> 11. I worked in **RESEARCH**
> 12. and I had a **TEACHING** and lecturing job
> 13. and that was for **FOURTEEN** years um...
>
> 14. and I **DIDN'T**.../ **DISCLOSE** to **ANYBODY**...
> 15. **EVEN THOUGH** / there were **TIMES WHEN**...
> 16. I was turning up at **ACCIDENT** and emergency / every **NIGHT**
> 17. and I'd go to **WORK** / the next **DAY**

The emphasised "even though" in contrasting night and day experiences (15-7) highlights the extent and non-sustainability of the emphasised lengthy separation (13-4) of 'mental health' experiences and the professional role she locates herself in (11-2). Indeed, Christine notes that her colleagues knew she was self-harming as she had visible marks, suggesting she could not completely control the visibility (and thus knowledge) of her 'mental health' experiences at work.

Christine later expands on this as resisting a 'mental health' position in all areas of her life/identity, not only at work: “I was not willing to be positioned as having anything to do with mental health even though it was affecting my day-to-day life” [485-6]. She uses a canonical narrative that prevents 'willingness' being individualised: “you have to remember that we're talking [1970s] here […] you just didn't” [319-22]. The attitudes and social structures of the era demonstrate an environment hostile to 'mental health', with no value given to disclosure and no culture of disclosing. As examples: her colleagues held a “being mentally ill means you’re weak […] kind of stereotype” [306-7]; treatment by nurses in A&E was “you're manipulative, attention-seeking [...] we're going to stitch you up without anaesthetic and then you'll never do it again” [437-9]. Thus, to accept a position related to 'mental health' would mean being constructed by this discourse.

Once the separation of professional–'mental health' could not be maintained and she struggled to teach, this led to Christine losing her job, presenting an impossibility of occupying both positions. The following strophes (straddling Parts 1 and 2 of Sub-narrative I) demonstrate that 'mental illness' is narrated as an all-encompassing state nullifying/precluding any other:

Strophe 4:

30. so I **THOUGHT** I was on the scrap heap
31. and and **THAT** was **IT** as far as.../ any kind of **PROFESSIONAL ACAMEDIC** job was concerned...

Strophe 5:

32. **AND** I suppose...
33. I **SPENT** some **YEARS** / as a...**COMMUNITY MENTAL PATIENT**
34. **DOING** what you **DO**

The language creates an impression of finality about Christine's professional identity (30-1). Invoking a canonical narrative of what *a* “community mental patient” does (33-4) – medication and day hospital – constructs her life as the fulfilment of this generic role, implying a loss of self/objectification. There is also an impression of passivity, of accepting this loss of identity and purpose.

The rise of the survivor movement is then storied as an agent of change:

Sub-narrative I, Strophe 11:
78. **AND** / **SOMETHING** was **HAPPENING**...
79. in the mental health **WORLD** that...
80. well.../ **SEVERAL** things were happening

81. **ONE** / **INSTITUTIONS** were being **CLOSED** and...
82. so people were **ORGANISING** because
83. in a **WAY** that / they **HADN'T** been **ABLE** to / when they were in **HOSPITAL** and...

Strophe 12:
84. I **GOT** involved in the survivor movement / **VERY EARLY** on in the early eighties...
85. **NO** / I got involved in the survivor movement **ALMOST IMMEDIATELY** / I **LOST** my job...
86. so I had **THAT** as **WELL**

Structural changes are clearly positioned as enabling this rise by changing what was possible (81-3). Survivors organising narrates a collective power that, perhaps, challenged the powerlessness of a 'mental patient' position. Furthermore, Christine narrates the development/sharing of alternative discourses from individuals hearing each other's stories: “she's suddenly talking about this being an abuse of her human rights […] and it was like a...epiphany” [440-2]. This discourse enabled a resistance to a 'mental patient' subjectivity, including providing her with an opportunity to use her professional skills when Christine's survivor group did research.

This, perhaps, made reclaiming an academic identity possible. However, conflict is presented through a disconnection between intellectualising in academic research and the material reality of 'being a mental patient', struggling with basic survival needs without 'personhood' or human rights:

> Sub-narrative I, Strophe 6:
>
> 46. I **STILL** had lots of **FRIENDS** / who were **INTELLECTUALS** and **ACADEMICS**...
> 47. and **THEY** were.../ **DOING** very **ABSTRACT** work
> 48. around um **STRUCTURALISM** / and **FOUCAULT**
>
> 49. and I...**WANTED** to be **PART** of it
> 50. but I also thought **WHAT** the **HELL** / does this have to **DO WITH** you know...
> 51. having **NOT ENOUGH MONEY**
> 52. and being given **SO MUCH CHLORPROMAZINE** / that I can't even make it to the **DAY** hospital for nine **O'CLOCK** and...

By motivating Christine to pursue a PhD, this conflict begins a theme that research was not, but should be, relevant to survivors/service-users' experience. Through this, her academic and survivor/service-user identities merge, although not immediately: “I thought I would do something on mental health [...] but not anything too close to home” [72-3]. Again, this distancing is explained contextually not internally. Although survivor discourse provided possibilities for alternative identities, the dominance of 'mental illness' discourse restricted available positions. Thus, 'mental illness' nullified Christine's academic experience; her academic ability had to be proven again: “[the university] knew about my condition and they made me do a...masters first […] it was ridiculous because I was having to study things that I had taught” [56-9].

Difficulty integrating survivor/service-user and researcher identities/experiences within 'the academy', is demonstrated through her career progression outside it. Thus, researching with her survivor group led to Christine networking with people in mental health charities and getting a job researching something 'relevant' (stigma). Both the work of these charities and the survivor movement preceded State interest in 'user involvement', suggesting they influenced the latter: “while I was there […] the Department of Health was getting interested in having service-users […] involved in NHS research" [116,122-4]. By commissioning its own research with UI, State interest in UI performs a role of validating duality *within* the mainstream (rather than 'side-lined' outside of it in the third sector). This is storied as further enabling the integration of Christine's identities by changing the meaning of disclosure, as demonstrated in the following extract from sub-narrative I, strophes 17 and 22:

125. so **THINGS** / so things were **MAKING** / **CERTAIN** things
possible um
126. things that **HADN'T** been possible **BEFORE**
127. big **STRUCTURAL** changes and
128. **OR** / **MINOR** structural changes [laughing]
[…]
158. **BUT** / I guess the **MAIN** point is that
159. **THESE** / **LITTLE** changes in **POLICY**
160. and **WHAT** was **POSSIBLE**
161. **MEANT** that…/ **DISCLOSING** was an **ASSET**

Christine's career progressed, doing increasingly large user-research projects in charities and the NHS, leading to her being "head-hunted" for a job doing service-user research "back in the academy" [183]. This narrates the survivor movement as a 'gateway' to the integration of her professional and survivor/service-user roles, which was completed when the State legitimised service-user input.

However, a third element to this development is also narrated. Disputing and deconstructing her 'epiphany' (442), Christine positions her ability to see the treatment of people with 'mental illness' as a political, human rights struggle, as due to her exposure to left-wing politics and other social movements. As the following extract demonstrates, Christine provides this as an explanation for why others do not engage with survivor discourse:

<u>Sub-narrative III, Strophe 12:</u>

451. I'd **BEEN EXPOSED** / to those **KIND** of **STRUGGLES** / **ALL** my

ADULT LIFE

452. so... […] the **ODDS ON** / was that I **WAS** going to...
453. **SEE** it / **HER WAY**

454. whereas **OTHER** people...
455. **WOULDN'T** see it / **THAT WAY**
456. and would **CONTINUE** to **BELIEVE** the **NURSES** at A&E

Therefore, survivors/service-users need exposure to discourses which *enable* them to use survivor discourse to transform the devalued role from a 'mental illness' discourse. Without this exposure, they will buy into the discourse and be constructed by it. Exposure allows 'personal' experiences to be seen as part of a wider political/social situation: “they're able to...raise their experience to a level of abstraction that fits with...a concern for social justice” [402-4]). One then needs structural changes that validate this position. Thus, Christine narrates all three of these features being necessary for enabling the development of an integrated service-user researcher position:

<u>Sub-narrative III, Strophe: 14:</u>

468. I **ALWAYS POSITION** myself / as a **SERVICE-USER RESEARCHER**
469. um I’m **BOTH**

[…]

<u>Strophe 15:</u>

476. a **SCIENTIST** / **AND** / a **SERVICE-USER**…
477. and you try and **BRING** those **TWO** things **TOGETHER**
478. it’s **NOT ADDITIVE** / it’s **MULTIPLICATIVE** (1)

The meaning of this being multiplicative is clarified through Christine's elaboration:

<u>Strophe 19:</u>

497. people **TURN** to **YOU** / for the **SERVICE-USER PERSPECTIVE** um
498. well **THAT'S** fair enough / because **THAT'S** what I'm **THERE FOR**...

499. **BUT**.../ I don't **WANT** them to **HAVE**.../ **MY PERSONAL** perspective you know

500. um I **WANT** to **TELL** them / something more **GENERAL** / that I've **LEARNED** from my **RESEARCH**

Seeing her as 'both' additively, colleagues can ask her, as their researcher colleague, about her experiences as a service-user. In a multiplicative integration, these experiences combine with Christine's researcher role, creating 'service-user research' (research informed by her lived experience of that being studied) – the findings are what she wants to share from this integrated position. For example, answering a journalist's question about 'stigma', Christine provided examples from her research but her colleague gave an example from Christine's experience. Thus, a multiplicative position distinguishes between speaking of personal experiences as a service-user *and* researcher, and speaking about research conducted from a *service-user researcher* position.

However, 'us-and-them' dichotomies (interacting with institutional practices and demands) mean this integration is rarely accepted: “nevertheless scientists see you as a service-user and service-users see you as a researcher […] so you have a bit of a problem” [479-82]. This is storied with colleagues, the team she manages, research participants, and other survivors/service-users. Colleagues position her as a service-user and take positions of authority over her in doing so. For example, at a social event, a professor of psychiatry quizzed her as if giving her a mental state exam. Her co-director positions Christine as unable to make decisions and as a liability: “she tells me not to do things because I'm going to ruin my reputation and ruin her reputation” [220]. Although Christine challenges this as over-protective and, by implication, discriminatory (“people can be too protective […] and also too worried about their own reputation” [260-1]), she also explains it contextually, as consequential to the competitiveness and demands of the academic environment.

These demands also limit how Christine can respond as a manager, particularly limiting her acting from empathy to colleagues' 'mental health' struggles. Christine stories her team of service-user researchers positioning her as a clinician and expecting greater sympathy from her because of her service-user experience. Although Christine will identify with them to provide hope (e.g., she might share her experience of coming through similar difficulties), her responsibilities as a manager can sometimes preclude this. For example, when one team member “became so psychotic that [they] caused havoc in the office” [743-4], Christine sent them to occupational health. Her duty to ensure the effective functioning of the department seemingly superseded her empathy for an individual: “we have to perform, we have to deliver...otherwise we'll be closed down” [773-4]. Similarly, Christine narrates that, although disclosure changes the 'atmosphere' with survivor/service-user participants, research processes prevent it equalising her power relationship with them: “they know that you're the researcher and you've had them sign a consent form and so there is a power relation there” [691-3].

Finally, Christine spoke about being positioned as a 'collaborator' for going into a mainstream organisation:

<u>Sub-narrative III, Strophe 21:</u>

512. you know **NOT ALL**...**SERVICE**-users / **NOT ALL** service-users / **I'M NOT LIKED** by everybody...
513. I mean the **SERVICE-USER COMMUNITY**...
514. it's it's **SEEN** to **BE** / co-op a **CO-OPERATION** / you know a **COLLABORATION** / in a **BAD** sense...
515. to **COME** and **WORK** here / you know in **SOMEWHERE** like **THIS**

As with Laura, Christine is clearly arguing that survivors/service-users also use 'us-and-them' dichotomies, with language creating an impression of war (514). This questions whether one can be ‘in’ both groups, without being seen as siding with one or other, or doing something treasonous.

Despite these difficulties having her multiplicatively integrated identity accepted, the present is positioned as progressively better than the past: “so I wouldn't say it's particularly...easy but it's certainly easier than being a community mental patient...I hated that” [525-8]. Perhaps in relation to Christine's 'hatred' (and powerlessness) of that position, the present – holding a senior position in a user-research department within academia, which gives her more power – is concluded as “the success part” [270]. Nonetheless, Christine qualifies this success; it took much longer, and being out of the academy, than it would have if she had not experienced 'mental health' problems.

4.3 Bethany: Being believed is key (and paradoxical)

Bethany's narrative centres on a specific “mental health breakdown” [14] and subsequent situation with colleagues, the dilemmas these had created and possible solutions. Interview questions were all discussed in relation to this; 'off-topic' parts were initiated by me with Bethany returning to this focus. There was a shift halfway, initiated by me following a 19 second pause. Therefore, two sub-narratives were identified with parts that largely mirror each other (see Appendix X). The first, *Having to disclose and effects of disclosing*, contextualises the breakdown, describes the subsequent situation and explores consequential dilemmas. These are re-examined in relation to identity/positioning (which I asked about) in the second sub-narrative, *Benefits and disadvantages of, and contesting, diagnosis*, and different solutions are proposed.

Bethany begins by describing the background to her breakdown, which she then narrates as the pivotal point at which her managers finally accepted that something was wrong:

Sub-narrative I, Strophe 11:
78. so **THEN** / I think **THAT'S** when my...
79. by my **MANAGERS** / I think the **ILLNESS** was...
80. **MY** illness / was actually um **ACCEPTED**

81. because **BEFORE** then / I'd been I think I'd been quite **UNWELL**
82. and trying to um...um...**TRYING** to (1) / maybe **ARTICULATE** that things weren't right
83. 'cos there was **ALSO** / this **INVESTIGATION** for a **MISTAKE**

that...I **MADE**
84. that **ADDED** to the...added to the thing

85. and um it was **ONLY** when / I went **COMPLETELY**...**OFF** the road
86. that I think that people **REALISED** that / **ACCEPTED** that / something was **WRONG**
87. and it **WASN'T** just / me being...**NEUROTIC**
88. and trying to get time off **SICK** or whatever

There is a dichotomous construction of 'neurotic' and 'ill' presented in these stanzas. Only illness means something is wrong and provides an entitlement to sick leave (85-8). The colloquialism used by Bethany (85) suggests that illness refers to 'madness', which her breakdown description shows as meaning 'psychosis' ("a full psychosis […] just total psychotic...madness really everything paranoid" [68; 72]). Bethany repeatedly emphasises acceptance, including as a correction to realisation (80, 86), and the line about her attempt to communicate that things were wrong is centred between these emphases (82). This suggests that the turning point is about Bethany's feeling that things were not right being *believed*, rather than her managers realising something was wrong. This interpretation is supported by Bethany's narration of the initial outcome of the acceptance; her managers were questionably sympathetic but it enabled her to have (or justified having) sick leave: "they were quite sympathetic I think (1) um (1) well they allowed me time off um whilst I recovered...and I'm not one to go off sick without...reason" [109-11].

However, there is disconnect between what she presents as the problem and *her illness* (80) being what was accepted. Bethany contextualises the breakdown as being 'set off' by a combination of medication effects (agitation/anxiety from taking a stimulant for recently diagnosed 'attention deficit disorder' and 'hypomania' from then taking an SSRI) and multiple changes and pressures at work and home. Although this could be interpreted as using a 'biopsychosocial' / 'diathesis-stress' discourse, the following extract suggests Bethany is positioning work (not the breakdown) as the problem:

Sub-narrative I, Strophe 7:

45. I'd come back from **MATERNITY** leave...
46. and um...**FOUND** working life very difficult
47. the **DEMANDS** on the job.../ the **EXPECTATIONS** and the...
48. just the **WAY** [senior colleague] **WORKED** / in a really **RESTRICTIVE** way

49. so as an **OCCUPATIONAL THERAPIST** / in that **ENVIRONMENT** / it's really difficult to do **ANYTHING**

Bethany positions *working* life as what she found difficult (46), thus restricting her experience of difficulties to a specific environment. This environment she attributes to the restrictive approach of a more powerful colleague (48). Furthermore, this environment is constructed as preventing someone in her *discipline* from doing their job (49), not Bethany individually.

This disconnect between the situation presented and what is 'believed' by managers, is mirrored in Bethany's narration of the 'subsequent situation'. This situation involves certain colleagues taunting her, trying to test her 'paranoia' by behaving in intrusive ways and talking about her with other colleagues. The following extract follows Bethany describing her managers as now (since the 'breakdown') being helpful, supportive and thoughtful:

Sub-narrative I, Strophe 32:

229. **ACTUALLY** / I'm **ABLE** to be (1)
230. whenever **I FEEL**.../ um people are **GETTING** at me
231. **I CAN TELL** this manager / **NOW**
232. and she's alw- she sort of (1) she's really um she **RESPONDS WELL**

233. and because I've had a couple of **BLIPS** since then
234. I think she uh she **BELIEVES** me
235. which is **REALLY** important and...
236. **USUALLY** / **I HAVE** tried to **REDUCE** the medication (1) um (1)

Strophe 33:

237. and...yeah sh- **SHE** thinks / it's absolute **RUBBISH** (1)
238. and that these people **AREN'T** doing **ANYTHING**...
239. but I **THINK**...
240. I think they **ARE** / there is a **DEGREE**

241. I think it's probably that **I**...**MAGNIFY** it
242. and...get **SENSITIVE** to it when I'm unwell
243. or **GETTING** unwell (1)
244. RW: but there's **SOMETHING THERE** / that you're **RESPONDING** to
B: yeah **DEFINITELY DEFINITELY**

The false starts, pause and hesitation (232), suggest Bethany is ambivalent about defining her manager's response as positive. An incoherency is created by the contradictory statements in the two strophes about whether the manager believes Bethany (234, 237). This incoherence raises questions about what is believed, especially with the emphasised 'are'/'aren't' (238, 240) and repeated 'definitely' (244), which stress opposition between Bethany's perspective and her manager's. The discontinuity between the contradictory statements (236) and later lines in which Bethany uses an illness narrative to discredit her perspective to some extent (241-3), suggest that an illness discourse may explain this contradiction. This is confirmed in Bethany's elucidation, when asked, that her manager "believes that I'm...upset and unwell...but she doesn't believe what is happening" [253-5].

Bethany seems to be implying that her manager uses a 'mental illness' discourse (that constructs 'the mentally ill' as irrational and unable to judge reality) to dismiss Bethany's view that she is experiencing *work-related* problems that are due to colleagues' behaviour. Bethany resists this construction, attempting to present herself as credible, whilst seemingly anticipating that her judgement will be seen as suspect by an audience. Thus, she repeatedly presents a difficulty with judging reality (e.g., “I don't know how much of that is illness and how much is um...reality” [120]), perhaps to demonstrate 'insight' and thus increase her credibility. This is followed by presenting examples of the situation which are framed as logical 'evidence': “that's how I feel what it is, is real” [205]. These examples highlight a specificity to certain colleagues and a difference from her 'paranoid' beliefs when she was ill (e.g., it is only two colleagues behaving in these ways, whereas she thought it was everyone when she was ill).

Bethany also directly challenges the use of this 'mental illness' discourse. By stating 'you know' (which assumes shared, unspoken understanding[6]) and switching from the first-person to a non-specific 'you', Bethany uses a canonical narrative to re-frame the dilemma: “I know that's real but if you say it...people don't believe you…you know...they attribute it all to illness” [299-302]. This implies stigma/discrimination. Furthermore, correcting my summary that others can make her doubt herself, she asserts her conviction of her beliefs: “well others doubt me...I'm convinced that they are...doing that” [520-1].

Perhaps because of this resistance, Bethany tries to present both her and her managers' perspectives as plausible:

Sub-narrative I, Strophe 41:

314. <and they **CAN'T** believe
315. RW: <they they see it as an **ILLNESS** issue
     B: **YES**
316. RW: not a **WORK**...**ISSUE**...between colleagues
     B: yes yes
317. and **THEY'RE**.../ **OH** do you **REALLY** think [colleague] would (2)

318. I **DON'T** know (2)
319. yeah I **DON'T** think **THEY** / I don't think they...**THINK** they're doing **THAT**

---

[6] Having positioned myself as a survivor-researcher, this, perhaps, suggests a survivor/service-user knowledge

This strophe constructs the managers' disbelief as an inability to believe that her colleagues would behave in such a way (314) and then re-frames her colleagues' behaviour as unintentional or unconscious, whilst asserting that it is actually occurring (319). This may not just serve to demonstrate Bethany’s credibility but also to maintain a view of her managers as 'supportive', whilst Bethany can resist the subjectivity of the 'ill' position that is necessary for accessing this support.

This dilemma, or trade-off between the advantages and disadvantages of being positioned as 'ill', continues in Bethany's response to my question, beginning sub-narrative II, about how she identifies/positions herself:

Strophe 3:
538. I suppose there **IS** / a **DIFFERENCE** I mean...
539. having had a diag- **THAT** experience / and...**DIAGNOSIS**
540. **I DO** think um (1) / it's a bit **STRANGE**

541. sometimes...you **WANT**...
542. the **EXPLANATION** / and the **HELP** / that comes with the **DIAGNOSIS** / and being a **SERVICE**-user
543. and **SOMETIMES** you...um...
544. **WANT** to / **DETACH** yourself from it.

Bethany discusses identity in terms of the consequences of adopting different subject positions, which she constructs as canonical to diagnosed service-users through her use of the plural 'you'. These consequences are not expanded upon, presumably because they were discussed in sub-narrative I, and Bethany continues with examples problematizing ‘detachment’ (544).

Firstly, services' systems make a service-user position visible and unavoidable. As examples, Bethany could be found by any professional on the electronic patient record system and her colleagues could know that she had been transferred to a neighbouring 'mental health' team (due to living and working in her Health Authority area). Secondly, detachment is constructed by Bethany as ‘dishonest’. Previously in the interview, and in response to me asking, Bethany firmly positions herself as never telling clients about her service-user experience, although there is a sense of identifying with them:

> Sub-narrative I, Strophe 45:
> 338. no I **DON'T**
> 339. **THAT'S** just um...
> 340. I **FEEL** I have / **MORE** of an **UNDERSTANDING** of / where they're **COMING** from.../ **DEFINITELY**
> 341. through **HAVING** that experience / **PSYCHOTIC** experience
>
> Strophe 46:
> 342. but I **DON'T**
> 343. I don't know **WHY**
> 344. I don't know if it's **APPROPRIATE** really...
> 345. you know I **DON'T** know

The repeated emphasis that Bethany does not share with clients (338, 342) contrasts with the repeated uncertainty about *why* she does not (343, 345), and with the assertion that her experience increases her understanding of clients' perspectives (340). Indeed, Bethany later argues that her lived 'psychotic' experience has contradicted her taught professional knowledge, leading to her changing her practice: "when people are...totally...delusional, I think I...don't try and...fight it so much […] I've done courses and things using CBT for psychosis and […] used to try to put this into practice" [774-6]; "but […] I realised how […] when you're so ill you don't need someone challenging your beliefs" [780-2]. Furthermore, there is an implication of some level of integration of personal and professional selves, in Bethany's following canonical statement about how people are shaped by their experiences: "you are the person you are because of your experiences" [805].

Although Bethany seemingly uses a 'self-disclosure' discourse to suggest sharing is inappropriate (344), she also tentatively challenges it by providing an example of another survivor/service-user OT who is 'open' with clients and colleagues and provides training from a service-user-professional position. This discourse is then directly challenged in sub-narrative II, with Bethany orientating the following extract to this earlier comparison (“you know this friend that I spoke about” [568]):

Sub-narrative II, Strophe 6:

575. in a **WAY** that seems quite um... / **RESPECTABLE** / and even **ADMIRABLE**

576. **WHEREAS**...
577. **I** sort of try to.../ um...maybe **DETACH** myself a bit from it...
578. **BUT** um / you can **SEE** how um.../ being **UPFRONT** and honest and.../ **CAN WORK**
579. because I...can **SEE** how **SHE** is (1)

By shifting from no psychological subject (575), to 'you' (578) and then herself (579), it is unclear whom it is that ‘can see’ that being open can work and is respectable and admirable – Bethany, an audience or me (or perhaps all). Comparing their approaches (576), implies 'detachment' is dishonest (578) and Bethany cannot be respected/admired (575). This judgement is perhaps influenced by the following problem with empathy presented later in the narrative, following me asking about the relationship between Bethany's identity as an OT and her 'mental health' experiences :

Sub-narrative II, Strophe 37:

806. […] I'm **MORE EMPATHIC** / in **SOME** ways...
807. uh **I DON'T** know it's different / it's **DIFFICULT**

808: **SOMETIMES** / I see **YOUNG**.../ uh well **WOMEN**
809. I **DON'T** know / there's **ALMOST** this **REPULSION** sometimes...
810. when **I SEE** people really **UNWELL** / it almost **TRIGGERS** something (1) / um...**DISTASTEFUL**...
811. because **I** can **RELATE** [laughs dryly]

Strophe 38:

812. oh that it **SOUNDS** aw-

813. and I've...**HOPEFULLY** over-**COME** it and...um...
814. I **HOPE** it doesn't ever affect my **PRACTICE**
[…]
<u>Strophe 40:</u>
822. um (4) so I **HADN'T** really **THOUGHT** about **THAT**
823. but that's **DEFINITELY TRUE**
824. it's a sort of...you know...maybe still **ASSOCIATIONS THERE**
825. of **NOT** wanting to be.../ this **PSYCHOTIC**...you know...**PERSON**

The distance tacit in 'repulsion' (809) perhaps implies that the detachment from an 'ill' position which Bethany wants, potentially interferes with her professional work. Bethany anticipates this judgement, interrupting her statement of how it sounds to defend her 'professionalism' (812-4). Despite ending with “person”, Bethany’s hesitation and use of “this” (825) create an impression of a dehumanised 'thing'. This is perhaps suggesting that, within the dominant 'psychosis' discourse, empathising with 'psychotic' clients involves experiencing a devalued, discredited and all-encompassing identity.

Bethany resists the subjectivity of both an objectified 'psychotic' and someone who 'dishonestly' detaches, by questioning whether she was/is 'genuinely' ill: “I wonder if I really am ill” [591]; “there's a […] degree of me maybe...questions that...whole diagnosis” [605-6]. Revisiting the background to her breakdown, the investigation into the mistake that she made is reconstructed from being an additional influence (83-4) to being the cause of the whole situation: “actually that was a catalyst for the whole thing” [636]; “it was a nightmare […] there was a lot of scrutiny on me” [640-1]. Bethany's employers' responses to her ADD diagnosis (which she disclosed during the investigation) give a hostile quality to the scrutiny she was under: “people were terrified” [645]; “it was like I'd done something terribly wrong […] I had to have supervision with two people […] it was really aggressive” [675-7].

This hostile response is then constructed as discrimination, primed by me asking Bethany what she would define as discrimination, in the context of having previously stated that she had not experienced it ("I probably did [experience discrimination] in the early stages with the ADD...yes I probably did" [699-700]). This prompted further contextualisation of the investigation and a more firm positioning of the 'breakdown' as being consequential to systemic work problems. There is an implication in this of having been made a scapegoat: "a lot of it was related to...I didn't just take the...investigation...lying down" [701-2]; "it was...related to that and fear because policies weren't in the right place" [713-4]; "I had to get witness statements from other members of staff […] it just got...quite nasty and maybe that was why...there was such...antagonism towards me" [724-6]. This contextualisation, in which there was a lot of antagonism from colleagues and Bethany was put under scrutiny, perhaps functions to legitimise or vindicate her 'paranoia' about colleagues (i.e. her 'psychotic' breakdown).

Bethany concludes with an attempt to create a new identity and start a new 'chapter' that can nullify the preceding narrative: "now I feel I'm trying to forge a new identity" [826], "create a new era of um(2) being well and forget this ever happened" [831-2]. This attempt involves proposing two resolutions to the dilemma focused on in the narrative:

<u>Strophe 42:</u>
836. **MAYBE** / I almost feel **CLEANSED** by not **TAKING** that [stimulant]
837. and **NOW** / if I can **REDUCE**.../ **SUCCESSFULLY** reduce the... [antipsychotic]
838. **THEN** I'm hoping.../ **MAYBE** I'll **BE**.../ a person **WITHOUT** a mental **ILLNESS**.../ in a **WAY** (8)
839. but I'll **HAVE** to wait and **SEE** (4)

<u>Strophe 43:</u>
840. and I **ALSO** think / **WITHOUT WORK**
[…]
<u>Strophe 45:</u>
854. 'cos I **CAN'T** imagine.../ **BEING**...**ILL**...

855. **AND**.../ **NOT** at **WORK**
856. it almo- they seem **SO RELATED**...

857. **WORK** is / **SUCH** a...a **PRESSURE**
858. it's **WHERE** / the **PEOPLE** that...**PRESS** my **BUTTONS**.../ **ARE**
859. it's...**WHERE** my.../ **HISTORY**...of mental illness **LIES**
860. and the...**HUMILIATION**...lies

861. I think well if **THAT'S** not **IN** my life [laughs]
862. it will be really **INTERESTING**...to **SEE**...
863. **WHAT** sort of **PERSON I AM**

Bethany's first solution removes her from a 'mentally ill' position by using (rather than contesting) a dominant 'mental illness' discourse. Specifically, she uses the construction of 'psychosis' as a biological disorder requiring medication. Her emphasis on "*successfully"* coming off medication (836-7), within an "if… then..." clause (837-8), demonstrates that the solution involves evidencing that she does not need medication and, therefore, according to that discourse, is not actually ill. In contrast, the solution proposed in the subsequent strophes contests this biological discourse and seemingly confirms Bethany's construction of her 'illness' as a response to work problems. Perhaps her first solution is to prevent other people positioning her as 'mentally ill' (and restore her credibility), whilst both this and the second provide her with a 'not ill' subjectivity/identity. Moreover, as neither position ('ill' or 'not ill') led to Bethany's managers believing her and addressing the work problems, perhaps the only way to resolve these problems, considering the dominance of this dichotomy, is for Bethany to remove herself from the work environment.

4.4 Ian: 'Crossed-roles', power and safety

Ian's interview was quite 'disjointed', frequently switching between, and then returning to, the prompt questions (see Appendix X). This was mostly led by Ian stating that he needed to think more about the questions. These discontinuities formed the basis for identifying five sub-narratives: (I) *Is he open, does he want to be?* (II) *Uncertainty about discrimination;* (III) *Unsafe to share: Discourses, boundaries & power;* (IV) *Not just colleagues;* (V) *Differences with service-users, colleagues and students.* One 'thread' ran throughout; some of his colleagues had previously been involved in his 'mental health' care, which created 'crossed-roles'. Each sub-narrative contributed to weaving a narrative of the importance/influence of these crossed-roles, including an integral interaction between crossed-roles and us-and-them, 'mental illness' and 'professional boundaries' discourses.

Ian started by identifying crossed-roles as an issue in talking about his 'mental health' experience:

Sub-narrative I, Strophe 2:

14, I was **SAT** within.../ what's called the [service **NAME]** [...]
15. **AND** / because I'd moved **INTO** that **ENVIRONMENT**
16. I had **LOADS** of sort of **FACE-TO-FACE** contact with / people who'd been **DIRECTLY** involved in my **CARE**...

17. which I found **REALLY COMPLICATED**
18. 'cos I'd had a **CONSULTANT** that... / I **HADN'T** got **ON** with
19. and I had a...care-**COORDINATOR** that I.../ I **HAD** got on with
20. but **HE** had he.../ in **THIS** context / he was my...**MANAGER** [...]
21. and **THEN** / I had **ANOTHER** care-co-ordinator **DOWNSTAIRS** so...

Strophe 3:

22. I **DIDN'T** really **WANT** to / **SHARE** it with...**COLLEAGUES** um...
23. it's **NOT** that I'm **GUARDED**
24. I just **DON'T** want to be / **DEFINED** by my mental **HEALTH**...
25. **SO** / [...] I felt I...**HAD** to **IDENTITIFY** it

By physically situating himself and others (14, 16), Ian creates an image of moving into a space in which he is surrounded by colleagues who were previously involved in his care. In highlighting the difficulties he had in one of these relationships (18), Ian is seemingly positioning this as an *additional* complication, as the following lines imply that the crossed-roles *per se* are sufficient for creating an issue (19-20). In using 'guarded' (23) – a term used by professionals with pejorative and pathologizing connotations – Ian is perhaps anticipating an audience constructing his reluctance to talk within a 'mental illness' discourse. That colleagues could construct his silence as 'guardedness', perhaps created the imperative for Ian to identify it himself (25). However, as Ian implies that sharing his 'mental health' experience with colleagues also risks him being defined by 'illness' (22-4), this suggests a dilemma or double-bind in which both sharing and not sharing these experiences can lead to the same undesirable outcome (mediated by having the crossed-roles). The *way* Ian talks about his 'mental health' experiences is perhaps an attempt to undermine this dilemma: “I talk about it in a very sort of joking way...and you think actually it's quite serious” [79-80].

The following extract, in which Ian identifies an exception with a 'non-involved' manager, supports an interpretation that his reluctance to talk relates to the crossed-roles issue, not an irrelevance or lack of need:

<u>Sub-narrative I, Strophe 13:</u>

86. she was **REALLY** / really **INSIGHTFUL** into...
87. **I'D**...**HAD** um.../ a a sort of a **REAL**...um **DIFFICULTY** / when I was in the **TEAM** [...]
88. and I **DISCHARGED** myself.../ because I...**HAD** a **RELATIONSHIP** that / with someone that was **INVOLVED** in my **CARE**
89. and it was **ALL** just / really...**HORRIBLY MESSY** / because...I...you know it **DIDN'T** end **WELL** and um...you know um

90. **BUT**...
91. so **SHE**.../ **THOSE** sorts of **THINGS** / I I started talking to **HER** about
92. and...I suppose **BEHIND** a **CLOSED DOOR**
93. I was...sort of **ABLE** to just **SAY**.../ I **DON'T** want **THIS** to.../

AFFECT...my **JOB**

Strophe 14:

94. **SO**...
95. even **WITHOUT** that relationship.../ that I **HAD**...
96. I **THINK**.../ it it there's an **EFFECT** in **HOW** you.../ sort of **PERCEIVE** yourself in certain **ROLES**...
97. um so **SHE** was very **HELPFUL** / and sort of **HELPED** identify some **PRACTICAL** stuff...

The positioning of Ian's statement about the difficulty/relationship (87-9) in between descriptions of his manager as insightful (86) and someone he could talk with (91), suggests that her helpfulness (97) came from recognising this difficulty and providing a space in which Ian could discuss it with her. An image is created of this space being private / a refuge (92), maybe from the 'surrounded' location previously described. Ian does not specify how his job might be affected by having had the relationship (93). However, a sexual relationship (as is insinuated) between clinicians and clients is unethical in 'professional boundaries' discourse, and is grounds for dismissal and de-registration. Although Ian occupied the service-user role in that relationship, the seriousness of this violation and the fact that he also held a professional position outside of the relationship, perhaps meant that his 'professionalism' could be questioned. However, Ian situates this relationship as a *further* complication, switching psychological subject to present a canonical argument implicating survivor/ service-user professionals generally (95-6).

Seemingly elucidating this, Ian progresses by narrating the effects of a derogatory/dehumanising discourse that professionals use, within a context of him straddling the 'us-and-them' dichotomy: “it's really difficult as well because […] there's loads of […] real subtle negative...things […] terms they use [like] revolving door […] I always have a sort of foot...in the other side” [98-104]. If Ian were to identify himself as a survivor/service-user, he would be objectified within this derogatory discourse (“that changes...how I identify myself as a...user of services" [112]). Ian explicitly prevents this by refusing to use services: "I refuse to access services...because I've kind of...seen that" [106-7]. Resistance is also implied by his choice to work in dementia: "the majority of why I work in dementia is probably because I just can't...deal with that side of […] negative...comments" [114-5]. It is unclear whether he is not exposed to such comments when working in dementia services or he is but they do not implicate him.

Ian relates the objectification of service-users to constructions of their incompetence within a 'mental illness' discourse and the 'totalising' effect of this discourse: "I just...stop people putting me in that...mad box" [130]; "I didn't want people to sort of go...tch well...he's good at that because...but he's not good at that because he's...you know a bit mental […] I don't know...I've got to think about that" [152-5]. This implies a stigma/discrimination in how he is treated due to having a 'mental illness' diagnosis. However, in the second (brief) sub-narrative, Ian questions whether he has been discriminated against and suggests he discriminates more 'against himself': "I've just...grown into a very sort of protective...sort of penalising myself (1) so that I can perform at work at a level that I should...I think I should...I'm not sure that's quite right" [194-6]. There appears to be a contradiction between 'protecting' and 'penalising' himself – perhaps why Ian questions his answer. However, there is a coherence; it could be 'penalising' to hold himself to (unrealistic) standards but also protective by preventing colleagues from constructing him as incapable due to 'mental illness'.

The uncertainty presented would seem to prevent an audience accepting these explanations as Ian's view. This uncertainty can also be seen in the conclusion to sub-narrative I:

> <u>Strophe 23:</u>
>
> 156. I've never **THOUGHT** about.../ well I **HAVE** thought about um / **WHY** I **DON'T** talk about **IT**
> 157. and I suppose I **USED TO**
> 158. but then when I **DISCHARGED** myself from the **TEAM** […]
> 159. I just had this **HUGE HATRED** for...**MENTAL** health **SERVICES** /

which **CONFLICTED** with...**MY**...um.../ sort of **WORKING** [laughing] in **MENTAL** health **SERVICES**

160. and **MAYBE**.../ 'cos there was a **DISTINCT SHIFT** in.../ **HOW** I would **TALK** about it
161. **WHEN**.../ **ALL** of this....**PALAVER** happened...
162. and maybe I just **FELT** that / I wanted to **DISTANCE** myself from.../ **MENTAL** health **SERVICES** / so I **WASN'T** sort of...I don't know...
163. yeah I think I'll have a **MOVE** on / **THAT** might **OCCUR** to me later...

The conflict (159) is not elaborated on or questioned by me; taking the meaning of it for granted would seem to co-construct a hatred for services and working in them as a fundamental contradiction. Positioning this experience as *changing* whether/how he talks (157, 160) implies that 'mental illness' and us-and-them discourses did not prevent Ian talking about his 'mental health' experiences previous to his need for distance (162). The emphasised “maybe” (160) tentatively constructs this distance as being from 'mental health' services (162), however, there is an uncertainty about the purpose of it (162-3).

There are, therefore, numerous uncertainties which characterise sub-narratives I and II and which render the conclusions or statements in the narratives incomplete, tentative or ambivalent. In particular, questions are left regarding how he presents himself at work, why he presents himself in these ways, what it is he is seeking distance from and for what purpose.

In contrast to this uncertainty, Ian then confidently turns to what prevents him sharing with clients: “that's an easy one […] all to do with um...quite clearly being told actually at university […] if you've got mental health problems don't talk about that” [199-201]”. Ian explicitly positions this within (and contests) dominant discourses and resultant unequal power relationships between professionals and service-users and between educators and students. This is perhaps a consequence of the university's explicitness, suggesting that implicit discourse is harder to speak about and challenge.

Sub-narrative III, Strophe 3:

204. I think...from **THAT** / there's quite a...**STRONG**.../ sort of **DISCOURSE** / in **THAT**...
205. in **TERMS** of.../ you know it it's a **LEARNING** period / and you're being **TOLD** that.../ **THAT'S** not **RELEVANT** information (1)

206. and I think (2) I can **UNDERSTAND** / their **REASONING** of
207. you know the **INTERACTION** / between **YOU** and the client / **ISN'T**.../ it's it's **ABOUT THEM**
208. but I suppose...by **HOLDING BACK** on it.../ you you sort of...you **DO** / you just sort of...**CREATE** this kind of.../ um...**BARRIER** almost
209. and it it just **MAINTAINS** that kind of.../ **I'M** the.../ **I'M** in the **POSITION** of **POWER**.../ and **YOU'RE** the **ILL** person...

A 'professional boundaries' discourse endows the university with the authority/power to define the irrelevance of Ian's experiences and prohibit sharing them (205). By reconstructing 'not talking' as “holding back” and using “create” (208), Ian contests this, repositioning it within an (unhelpful and unnatural) 'us-and-them' dichotomy which functions to maintain professional power over a powerless 'ill' person (209). Nonetheless, the legitimacy of the dominant 'professional boundaries' discourse (e.g., being incorporated in professional codes of conduct) renders sharing unsafe: “I might not qualify […] overstepping […] a professional boundary” [222-3]. By inhibiting sharing, this discourse prevents an opportunity to challenge the negative subjectivity that a 'mental illness' discourse gives service-users: “it might give them a sort of hope that you can […] work...quite...well with um...mental health difficulties” [211-2].

The variation in safety between Ian's two experiences of sharing (which both took place while a student), narrates an interaction between medicalised and 'professional boundaries' discourses. The 'safe' experience occurred in a demedicalised context:

Strophe 8:

237. he was in […] an **OPEN FACILITY** um / it was **RUN** by a **CHARITY**
238. and I'd been...sort of **ENCOURAGED** to spend **TIME** with him
239. **HE** was the **PERSON** / I'd **TAKEN** to the hearing **VOICES** group...

240. um and I had the **LUXURY** of **TIME**
241. so we were able to **GO** / you know we went [green-space **PLACE]** / and **WALKED** around [place] **LAKE**
242. […] you know **NICE** sort of **THERAPEUTIC** things

Ian's role in this context is to *be with* a *person* (238) and this role ascribes him freedom to engage in 'normalised' and helpful activities (241-2). Sharing his experience of 'mental health' problems is appropriate within this context. The outcome of his sharing supports Ian's challenge of 'professional boundaries': “it wasn't like he was sort of...saying well what do you experience […] it was just like a […] shared sort of experience” [266-7]). The third-sector institution and non-medicalised roles and aims, constitute a person-centred, normalisation discourse which constructs sharing as positive and helpful.

In contrast, Ian's 'unsafe' experience of sharing his 'mental health' experience with a client was within a medicalised environment in a statutory service:

Strophe 14:

277. I was um...on a **WARD**...
278. and there was a...a **GENTLEMAN** [...]
279. he **HE** was.../ **ALCOHOL**...**DEPENDENT**

[…]

281. **AND** / it was **VERY**...**MEDICAL**
282. everyone was say- you know his **WIFE** didn't want him **HOME** / because...**HE**.../ hadn't **EVIDENCED** that he would **COMMIT** to anything and...
283. um the **MDT** meetings were **VERY MUCH**.../ um...uh...a sort of **RIGHT** you need to.../ **TELEPHONE** [community service] / and **DO**

this and this and this

284. and it there was **NO** real sort of / **LONG-TERM** um **PICTURE** / of **HOW** he'd....**REALLY** sort of..../ **ENGAGE** with some sort of **TREATMENT** programme

Situating *himself* on the ward (277) focuses attention on Ian's (restricted) position in this context. The patient is largely depersonalised, defined by a diagnosis (279) and others' demands of him (282). Control and objectification characterise the discourse; 'treatment' is prescriptive without considering the individual (284) and Ian's role is similarly to follow 'orders' – to *do to* the patient (283). In this context, sharing is constructed as outside Ian's authorised role: "if he tells someone that I've told him […] that would be overstepping professional boundaries" [299-300]. Furthermore, what Ian shared was his experience of attending a peer-support group. This could be seen as encouraging use of alternatives to the professional-led service 'prescribed', which would be particularly threatening to professional power and, thus, more risky.

The parallels between Ian and his clients in these examples suggest that the discourses these contexts constitute, oppress (a 'medicalisation' discourse) or empower (a 'normalisation' discourse) survivors/service-users, regardless of whether they occupy a clinician or client role. However, Ian positions his qualified status as something which enables resistance to 'professional boundaries' discourse by reducing his vulnerability and giving more power to defend his clinical decision-making (e.g., a decision to share with clients). Indeed, Ian states that he would now share his 'mental health' experience with clients, if he had not decided to work in dementia. This carries an implication that his experiences are irrelevant in this area. However, Ian immediately contests this ("actually...I think there is a parallel" [326]), which creates confusion about why he does not share with clients.

Talking about dominant discourses and unequal power relationships in this sub-narrative, seems to enable Ian to then explicitly narrate a relationship between these discourses and 'crossed-roles', when this subject is revisited in sub-narrative IV. His university's explicit instructions not to share, in conjunction with the evidence he presented to refute this, may have established a credibility to Ian's perspective. A similar way of asserting credibility seems to be used in the fourth sub-narrative, to discuss us-and-them positioning in relation to crossed-roles. Specifically, Ian presents an explicit example of this in between two more subtle ones. In the first, Ian sought reassurance from qualified colleagues (when he was a student) that his service-user experience – including the relationship he had with someone involved in his care – would not affect how colleagues treated him. However, Ian's perspective was that his disclosure resulted in exactly this: “I really distinctly remember one person saying oh yeah I know...that person […] and I remember...[laughs] you know just a massive change in her” [352-4]. The second example, involving a 'blind-date' who turned out to be another mental health professional, provides the evidence that confirms Ian's perspective that his colleagues discuss / judge him and that his service-user experience affects how they view him:

Strophe 5:
371. she **STARTED** saying / oh I don't **BELIEVE**...**SERVICE**-users should **BE**...**NURSES** um...
372. and I I'm **REALLY** unassertive / **SO** / in...**SOME** situations
373. and she **SHE** had quite a lot of sort of **POWER** over me / in a **WAY**
374. because she was **TALKING** about **LOADS** of people / that had **BEEN**...in **INVOLVED** in.../ the **INVESTIGATION** into my **RELATIONSHIP** with **THIS** [professional] blah blah blah

375. and **THEN** she um...
376. and she started **SAYING** / oh yeah we were **TALKING** about this **OVER**.../ we have **POKER** nights
377. and she says **DON'T** worry / **MOST** people think that.../ **YOU** were in the **RIGHT**

In both examples, the other person invokes power relations by aligning themselves with a colleague who had occupied *the* professional role in a relationship in which Ian was *the* service-user. This places them in a professional position, with associated professional power, and 'others' Ian to a less powerful service-user position (373-4). In the second story, this power is then used to reject Ian's professional identity (371) and to claim the right to discuss and judge him. In Ian's narration of the encounter, his date implies, through the emphasis on “most”, that some of his colleagues considered him to be blameworthy (377). Although Ian initially uses an internalising explanation for why he did not challenge her, adding a contextual qualification and raising the issue of power relations (372-3) seemingly constructs an inability for him to challenge which is attributed to the powerlessness of a service-user position. Supporting this interpretation, his resistance was enabled by another group of professionals positioning him as 'us', professional and competent: “[I] eventually came to a conclusion...of... you know...fuck you [...] I don't really care but that […] took […] me building up my...clique of people [...] in dementia who thought I was...worth-while and doing a good job” [401-5]”.

However, even within this team, Ian continues to be affected by crossed roles as his manager had been involved in his care: “there's no way I could speak to [manager] about a mental health difficulty...because […] I see [them]...partly as a manager but partly as a […] person that was involved in my care” [454-5]; “I've no doubt that [manager]...sees me...in the inverse of the way I see [them]” [479]. The importance of crossed-roles is demonstrated through Ian's comparison with a non-involved manager who had regularly asked about his well-being, which he found helpful. This suggests that *a* service-user position does not necessarily preclude a professional one or collegial relationship. That Ian's current (previously 'involved') manager does not raise it with him directly, is constructed as evidence of them communicating that it is both prohibited/taboo and relevant to how they position him: “[my manager] obviously had...thought about it because [their] senior manager sort of...pulled me aside and said look […] this [person] has...spoken to me about...” [473-4].

These three stories demonstrate that Ian's colleagues position him as *that* service-user (rather than as an equal colleague), which positions them as *the* professionals. This creates an unequal power relation in which his colleagues claim a professional power to discuss and judge his service-user experiences, whilst prohibiting Ian from discussing these experiences with them. The social contexts (e.g., the date; colleagues' poker nights) and past and present situations, create a greater sense of Ian being 'surrounded' by people who had previously been involved in his care, either directly or indirectly. Concluding sub-narrative IV, there is an impression that the crossed-roles issue has become ridiculous and unhealthy, with a sense of Ian's despair or powerlessness: “will I ever be able to be just a bloody [laughing] practitioner [...] it's getting so sort of perverse that maybe it's therapeutic ultimately 'cos I'm laughing about it...but...I know it's not” [498-501].

These explicit discussions in sub-narratives III and IV about dominant 'professional boundaries' and 'mental illness' discourses, 'us-and-them' positioning and power relations, seemingly enable conclusions to be drawn in the final sub-narrative. These statements clarify the questions which were raised in the first two sub-narratives.

I suggest an apparent difference in these discussions, in how Ian spoke about clients and colleagues. Ian then confirms and expands upon this difference:

<u>Strophe 3:</u>
516. […] and I I sort of **FEEL**.../ at **WORK** / all **CORPORATE**
517. and **THEN** I / 'cos I work in [**AREA**] / I have at **LEAST** an **HOURS** drive / to **WHICHEVER** person it **IS**...
518. and I just have **THIS** sort of um (1) / I don't know it's **LIKE** this / sort of **FEELING**.../ **OF** (1) of...
519. I **SEEM** to sort of / **AS** I come out of the **OFFICE** / I seem to just **ADJUST**

520. and **THEN** / I'm sort of **THINKING** about the **PERSON**...
521. and I’m thinking **HOW** can I **GET THEM**.../ sort of like the **BEST DEAL** [laughing] / **HOW** can I
522. I think **ALSO** / I **START** to sort of think / **HOW** can I.../

MANIPULATE the **SYSTEM** / to sort of **GET** them...**ALL** that they **NEED** and...

Strophe 4:

523. so I **THINK**.../ it and I I think that's **BORNE** out of
524. **WHEN** I'm **THERE** / and I'm **WITH** them / in a one-to-one **SITUATION** (1)
525. I am **COMPLETELY** different to / **HOW** I am with **COLLEAGUES**

Ian perhaps presents an image of 'corporatism' (prioritising cost-efficiency, *service* needs) to assert his professional role/identity and resist the service-user positioning he is subjected to. In contrast to this 'corporatism', Ian's repeated use of “person” (517, 520) and his emphasis on being *with* clients (524), constructs a 'partnership' with a human being whose needs are paramount (521-2). Indeed, Ian then positions himself as identifying with his clients, particularly with their powerlessness and frustration. This shapes his work one-to-one with them, seemingly without the conflict previously mentioned between his hatred of services and professional identity; they come together to make him a knowledgeable and empathic nurse. Ian's language suggests that he feels relief when getting physical distance from his colleagues by leaving the office (517-9), although the false starts and pauses suggest that this feeling is difficult to define. This creates an impression of having a freedom to integrate his 'mental health' and professional experiences/identities in his work with clients, which the crossed-roles issue prevents when he is with colleagues.

The powerlessness and frustration that Ian identifies with is extended to all survivors/service-users (“that insight is universal to service-users regardless of the diagnosis” [529]) and this canonical statement leads Ian to reconstruct dementia:

Strophe 8:

547. I see **DEMENTIA** / as **SEPARATE** from...**EVERYTHING** else
548. but **ACTUALLY** / that's **ONLY** that I see it as **SEPARATE**.../ **AS SEPARATE** as I can **GET** / from the **PEOPLE** that I were

INVOLVED...in my **CARE**

[…]

Strophe 13:

588. it's **NOT** that I **WOULDN'T** [share with clients]...um (1)
589. **IT'S** (2) I think **THAT** is purely **JUST** because.../ I **SEE** have...**UNTIL** sort of...**TODAY** [laughs] / I I **I'VE SEEN** dementia as **SEPARATE** from mental **HEALTH**

Positioning this change as consequential to the interview (589) is perhaps related to having been able to construct the importance of the crossed-roles situation across the interview. It may also be a consequence of recognising the uncertainty and incoherence in the earlier sub-narratives about why he does not now share with clients. Furthermore, it may function to defend Ian against an anticipated judgement (perhaps by me as a survivor-researcher) for not sharing (588). Whatever the reason/function, these strophes conclude that the "distance" Ian wants is from colleagues who were involved in his care (548). Constructing 'mental health' and 'dementia' to exclude himself from a service-user position in his current work (548), which then prevents him from sharing with clients, is consequential to this.

Finally, this clarification leads to a further conclusion that the crossed-roles issue is fundamental to Ian's narrative: "that for me is probably...the main (1) issue...and probably the main thing that influences...sort of how I speak with colleagues" [627-8]. Across the sub-narratives, these crossed-roles are shown to be important in determining the positions/identities available to Ian and, therefore, to sharing his 'mental health' experiences with colleagues and clients. An interaction is narrated between these crossed-roles and dominant 'mental illness', 'professional boundaries' and us-and-them' discourses. Furthermore, through the use of numerous canonical arguments, other survivor/service-user professionals are implicated in the effects of these discourses on identity/ positioning and ability to share 'mental health' experiences.

5. DISCUSSION

This study set out to understand the function(s) of 'user involvement', as it interacts with other dominant discourses in the 'mental health' system. It aimed to do this by exploring how survivor/service-user professionals negotiate these often conflicting discourses for constructing the use of 'lived experience', through asking *how and why 'mental health' professionals who have experienced ‘psychosis’ share their personal experiences in their work*. This chapter provides a brief overview of this question before then exploring it in more detail whilst examining its contribution, in relation to the background literature, to meeting the aim. The critical review then discusses limitations and reflexivity. The chapter concludes by setting out implications and recommendations for research, education/training, policy and practice.

5.1 How and why survivor/service-user professionals share

Supporting previous research with survivor/service-user professionals and 'self-disclosure' research (e.g., Adame, 2011; Henretty & Levitt, 2010; Knox & Hill, 2003), it was rare for participants to talk about their 'mental health' experiences with service-users. This extended to others that they worked with, e.g., colleagues and students. Participants' narratives also addressed why and when they did *not* share; reasons for not sharing delineated the boundaries of reasons for sharing. Furthermore, participants often constructed the question as whether they were (categorically) 'open', despite their narratives demonstrating that sharing was context-bound. This suggests that there is a dominant 'openness' discourse. Christine's 'service-user researcher' role, which identified her as a survivor/service-user, presented an exception as it meant that she *was* categorically 'open', to some extent. This had important implications, which are discussed.

As with previous research and first-person accounts (e.g., Adame, 2011; Schiff, 2004), all participants narrated that they used their experience in their work (without necessarily sharing), positioning it as a *unique knowledge* and *resource* used for making their practice more beneficial for survivors/service-users. This was constructed as having empathy – a direct understanding of 'what it is like' to be a survivor/service-user in the system (rather than experiencing 'mental health' problems *per se*) and particularly of damaging, ineffective or irrelevant professional practices.

A seemingly overriding reason for sharing in all but Bethany's narrative, was to *assert a position of credibility and authority* from which to speak. By 'mentioning' that they had survivor/service-user experience, participants positioned themselves as survivor/service-user professionals and used this position to *provide a different perspective.* This position was used in job interviews (Laura and Christine), team discussions about clients (Laura) and one-to-one work with clients (Ian). Christine's service-user researcher role meant that this position was already established and her narrative focused on using her experiences to inform her research. The knowledge this produced was the 'service-user perspective' that she then wanted to share with colleagues. Asserting this position, or sharing a limited specific experience, had three related uses in the narratives: to *provide hope, contest 'us-and-them' dichotomies* and *disprove negative assumptions* (particularly incompetence). These are the same uses which dominate the literature (e.g., Bassman, 2000; Frese & Davis, 1997; Lindow & Rooke-Matthews, 1998).

The final reason for choosing to share was to *access support options* (e.g., time off, flexibility, reassurance, etc.), which particularly occurred in management/ supervisory relationships. This was narrated by Laura and Bethany. It was the only reason Bethany gave for sharing and, moreover, was positioned as something she had, but did not want, to do. Ian also claimed that support was restricted to those occupying an 'ill' position but narrated this as a reason for not sharing.

Whilst contesting us-and-them dichotomies and challenging negative assumptions were given as reasons for sharing, conversely, these dichotomies and assumptions were central to the reasons given for not sharing. These reasons included: identification with clients potentially could be rejected due to being a professional (Laura); difficulties might be constructed as 'illness' (Laura, Bethany, Ian); being constructed as 'mentally ill' involved a loss of credibility (Laura, Bethany, Ian) and being subject to control (Bethany, Ian). Christine narrated her reasons for not sharing as consequential to dominant discourses about 'mental illness' within an historical context. 'Professional boundaries' discourse was a reason for not sharing, used to construct both 'disclosure' as inappropriate (Laura, Bethany) and sharing as unsafe (Ian).

Finally, all participants spoke about *difficulties controlling/knowing 'who knows what'*, given by all but Christine as a reason for not sharing. This was largely within a canonical narrative of 'people talk' (i.e. after telling one person), with an implication of 'gossiping', but also it being unavoidable that some indicators were 'seen' (e.g., self-harm marks, sick leave, referrals, etc.). This difficulty was particularly applied to colleagues, perhaps as those most likely to 'see' something and with opportunities to talk together, which service-users are unlikely to have. This issue problematized the research question, challenging its implications of choice, control and agency, and indicating that 'sharing' should not be constructed as a single event within a fixed context but becomes knowledge that is then 'out there' and can be used. Related to this, the only reason all four participants gave for having shared was *because they had to*. This included having difficulties at work *(being 'seen*'; Christine, Bethany, Ian), previous relationships in service-user roles (*being 'known*'; Laura, Ian), and others learning from public and professional records, for example the media or patient records (*being 'found out*'; Laura, Bethany). However, 'being known' was also constructed as reason for not sharing (Ian).

Although distinctions in the self-disclosure literature between intentional, unintentional and unavoidable disclosure (Barnett, 2011) resonate with these issues, they lack the qualities of coercion / pressure / having limited options and the application to colleagues, which characterise the issues in the narratives. For example, being 'found out' is similar to discussions concerning the internet/social media and unintentional disclosure (e.g., Zur *et al.*, 2009). In Laura's narrative, speaking in the media was a deliberate attempt to use her experiences/duality to change a system. Her media work created a risk of being 'found out' in a service context, which made her position of 'non-disclosure' precarious. However, it also represented a tension created by taking, in one context, a service-user professional position and wanting to share her experiences to change the system, whilst, in another context, adopting a “chameleon-like” position in order to 'fit in' and not wanting and/or feeling able to share.

5.2 Systems of power/resistance: Voice, user involvement and survivor/ service-user professionals

There is a striking mirroring of participants' narratives and the user involvement literature, regarding reasons for sharing / benefits of UI (e.g., Craig *et al.*, 2004; Repper & Breeze, 2007; Rush, 2008; Truman & Raine, 2002), reasons for not sharing / barriers/limitations to UI (e.g., Crawford *et* al., 2002; Gates & Akabas, 2007; Felton & Stickley, 2004; Tait & Lester, 2004; Truman & Raine, 2002), and the relationship between the two, in which discourses and assumptions contested by sharing/UI are, conversely, the main reasons for not sharing/barriers.

This mirroring arguably supports the assumption that survivor/service-user professionals represent a 'site' from which the discursive conditions of UI can be explored, suggesting the findings of this study are applicable to UI. As these were not voices 'brought in' through UI but people occupying 'normal' professional positions, this mirroring indicates that limitations of UI are due to relationships between the ideas underpinning it (valuing survivor/service-user voices and experiential knowledge as legitimate and authoritative) and other dominant professional discourses, which subjugate survivor/service-user voices.

Foucault (2003) argues that not just is there always resistance to dominant discourses but that resistance must be possible for actions to be considered an exercise of power. He argues for analysing forms of resistance – and the strategies employed against this resistance – to understand forms of power; “analysing power relations through the antagonism of strategies” (Foucault, 2003:129). This research suggests two key findings that can contribute to understanding the dynamics between UI and other dominant discourses: 1) the form of resistance that is 'sharing' sheds light on how these dynamics operate as an effective 'strategy' to maintain power in this struggle ('systems of power strategy'; Foucault, 2003); and 2) how alternative forms of resistance are employed against this.

5.2.1 Systems of Power

As discussed in the literature, the right of professionals to control and define survivors'/service-users' reality is dependent on constructing them as ‘mentally ill’ – as irrational, unable to judge ‘reality’ or govern their selves, dangerous and dependent (Crowe, 2000; Roberts, 2005; Stickley, 2006). Survivor/service-user workers, whether employed through UI or in 'usual' professions, represent a threat to this by demonstrating competence through working. They also represent a threat to the process of 'objectifying through dividing practices' (Foucault, 2003), which maintains the power relations. For example, survivors'/service-users' duality disrupts practices that dichotomously construct a categorically different 'normal'/'sane' and 'abnormal'/'mad' and which require professionals to be placed in the former group and service-users in the latter. In addition, if objectification attenuates the dilemma of professionals encroaching on service-users' human rights (Hamilton & Manias, 2006), then there is also a threat to this.

The similarities in these areas of contention, between the UI literature and the narratives in this study, suggest that these threats are being countered by a number of common strategies – “mechanisms brought into play in power relations” (Foucault, 2003:142). These strategies are explored within three dominant discourses that they relate to: 'mental illness', 'professional boundaries', and 'us-and-them'.

5.2.1.1 'Mental illness'

Participants reported a myriad of situations in which they were constructed in derogatory and objectifying ways by a ‘mental illness’ discourse, in and outside of work (e.g., the way clients were discussed in team meetings in Ian's narrative; Christine's experiences at A&E). As in previous research (e.g., Doherty *et al.*, 2004; Lindow & Rooke-Matthews; 1998), participants experienced being treated as vulnerable, incompetent and unable to judge 'reality' by colleagues/managers. This could be explicit (e.g., Christine being told not to do things due to her 'mental state') and implied (Bethany’s work-related complaints responded to as ‘illness’ symptoms). Laura's story of being reassured that her difficulties were 'normal' but then having her work 'checked', shows that it could also be implied in a duplicitous way. These constructions possibly explain why a common way of sharing was to 'drop it in' casually or make jokes, which may serve to minimise or undermine it. Unlike Adame (2011), no participant reported experiencing other survivors/service-users constructing them in this way once their survivor/service-user position was known. Only Laura's narrative considered this as a possibility, which she positioned as a reason for not sharing with clients in case they constructed her as 'mad'/incapable on 'bad days'.

Laura, Ian and Bethany highlighted the 'totalising' effect of a 'mental illness' discourse by narrating that, once positioned as 'mentally ill', all their problems and ‘deficiencies’ could be constructed as 'mental illness'. Thus, this discourse could be used to preclude the possibility that they experience 'normal' difficulties that are not due to 'illness'. All the narratives demonstrated that being positioned as 'mentally ill' authorised paternalistic and controlling responses from managers/supervisors and that their difficulties were constructed as leading to a complete inability to function. In Laura's narrative, these negative constructions were also used to position her as 'unrepresentative' when she shared, e.g., a colleague's surprise that Laura seemed “so confident”, which implied survivors/service-users would/should not be confident. By constructing survivor/service-user workers abilities as 'unrepresentative', they are being excluding from being a legitimate object of 'mental illness' discourse (McHoul & Grace, 1993), and, therefore, neutralizing the threat that their competence represents.

There were differences between participants in whether these negative assumptions motivated them to share or inhibiting them from sharing their 'mental health' experiences. Laura positioned sharing as something she did with colleagues to contest their negative construction of service-users (with whom she did not deliberately share), using her identification as the denigrated ‘other’. Ian reversed this; these negative constructions were a reason for not sharing with colleagues but a reason for sharing with service-users, positioning himself alongside them. Christine similarly narrated that she shared with service-user colleagues to identify with them and provide hope. When directly constructed as incompetent by non-service-user colleagues (e.g., being told not to do things by her co-director), Christine contested this by ignoring such commands and demonstrating her ability. For Bethany, negative constructions seemingly underlay her wanting to detach herself from a 'mentally ill' position and the 'repulsion' she narrated when empathising with service-users.

Furthermore, Laura and Ian positioned these negative constructions as preventing sharing or asserting a survivor/service-user position specifically when having a ‘bad day’, and creating a need to present themselves as always 'strong' and 'capable’. The potential for managers to use this discourse to coerce him into 'mental health' services again, was positioned by Ian as a barrier to asking for (needed) support/flexibility. The prior establishment of Christine’s service-user position would preclude the options taken by Laura and Ian. However, her ability to 'ignore' attempts to control her were perhaps enabled by this, to some extent, as well as by the power of her senior post.

These narratives suggest that the 'too incompetent-or-unrepresentative' catch-22 which prevents there being a 'suitable' service-user to involve (Felton & Stickley, 2004), is not just a mechanism for resisting involving survivors/service-users but a strategy to prevent survivor/service-user workers constituting evidence that challenges dominant discourse and power relations. This can be seen to operate through disciplinary power (Foucault, 2003; 1997). Specifically, the structures that enforce what is endorsed as 'professional practice' or 'fitness to practice', particularly supervisory/management systems, provide 'surveillance' (McHoul &

Grace, 1993) and sometimes direct control. In order to prevent this control and their fitness to practice being challenged, participants narrated that they monitored and governed their behaviour to present an image of ‘wellness’.

The ability of survivor/service-user workers to act as a 'model of hope' by sharing their 'mental health' experiences with service-users, must surely be limited by presenting an unrealistic (and, therefore, unattainable) image of 'wellness'. Thus, this also prevents dominant 'mental illness' discourse being contested with those subjugated in an 'ill' position, for whom such contention could offer an alternative, more positive subjectivity. Furthermore, Bethany's 'repulsion' challenges assumptions that 'empathy' is necessarily a positive influence in survivor/service-user workers' relationship with service-users (e.g., Frese and Davis, 1997). Finally, professional responsibilities and other institutional demands (e.g., Christine’s duty to ensure her team performed) limited participants' ability to act from an empathic position, similarly to how these demands limited UI (e.g., Basset *et al.*, 2007).

5.2.1.2 'Professional boundaries'

The ability to act as a 'model of hope' is further limited by a 'professional boundaries' discourse (which subsumes 'self-disclosure') that inhibits survivor/service-user workers from sharing their experience with service-users. This discourse was used by Laura and Bethany to question the 'appropriateness' of sharing with clients, although both also contested it. Ian presented it as something which made sharing 'unsafe' and which had been used by his university to prohibit students from disclosing their 'mental health' experiences with service-users.

Laura presented numerous considerations from the self-disclosure literature to justify not sharing, such as her motivation/intention, who it would benefit and therapeutic effect (Henretty & Levitt, 2010; Knox & Hill, 2003). However, the conclusion that these considerations should lead to non-disclosure was presented ambivalently and contested. To some extent, this contention was part of a dominant self-disclosure discourse as it involved arguments which are made in favour of a limited use of disclosure, such as needing to respond to clients' questions in a 'human way', 'normalise' clients' experiences, and promote 'therapeutic alliance' (Barnett, 2011; Knox & Hill, 2003). However, Laura also directly contested it by drawing on an alternative critical discourse focused on power relations and 'othering' processes. This discourse reconstructs 'disclosure' as 'sharing' or 'talking to' and the switch in discourses is highlighted through a differential use of these terms. This critical discourse was used to challenge the function of dominant boundaries discourse by turning its arguments 'on their heads'.

Thus, Ian and Laura both reconstructed non-disclosure as creating/reinforcing power of the professional over the client, whereas a self-disclosure discourse constructs boundaries as *protecting* clients from the power differential (Barnett, 2011). An exclusive focus on clients was associated with establishing an unhelpful us-and-them position using a 'mental illness' discourse (i.e., conveying to the client that they are categorically different to the clinician, as 'the ill one' with problems). Dominant professional boundaries' discourse argues that it is in service-users' interests to not disclose to them *because* they are 'mentally ill' (Henretty & Levitt, 2010). In contrast, sharing was constructed as 'therapeutic', as helpfully challenging negative 'mental illness' constructions and breaking down us-and-them dichotomies. Although Bethany did not directly contest 'professional boundaries, like Ian and Laura, she used an example of an 'open' survivor/service-user clinician to construct ‘openness’ with clients as workable and more honourable and honest than non-disclosure. Using a 'professional boundaries' discourse to justify not sharing, was reconstructed by all three participants as protecting survivor/service-user workers from vulnerable exposure or from identification with a denigrated subjectivity.

Implied in this contention (and explicitly argued by Ian) is that the dominance of 'professional boundaries' discourse renders sharing 'unsafe', as it authorises accusations of being 'unprofessional' or 'crossing boundaries' – already a risk from being known as a survivor/service-user worker (Gates & Akabas, 2007; Lindow & Rook-Matthews, 1998). Since 'professional boundaries' discourse includes the regulation of what is endorsed as ‘professional’ practice, such accusation have potential material consequences (including loss of registration). Perhaps by initially using this discourse, Laura and Bethany were performing their 'professionalism', which then enabled them to contest it. Ian did not make this demonstration before contesting the discourse, other than stating he recognised that therapeutic work was about the client not the clinician. This was seemingly enabled by his university explicitly prohibiting disclosure. Dominant 'self-disclosure' discourse does not directly prohibit disclosure but implies this through conservatism and ambivalence (i.e. problematizing it and constructing it as dangerous). Thus, this suggests that an explicit prohibition is easier to challenge without risking a questioning of one's 'professionalism'.

Disciplinary power can again be seen to operate in the participants' narratives, as they monitor and govern their behaviour to prevent their 'professionalism' being challenged. The institutional structures which enforce what is considered to be 'professional practice' (Crowe, 2000) are particularly important in the operation of this power, as is the ambiguity in dominant 'self-disclosure' discourse.

To some extent, a 'professional boundaries' discourse was also used to explain reasons for not sharing with colleagues. Bethany and Laura questioned whether 'mental health' experiences were something that busy professionals (who hear these things from clients) would want to hear from their colleagues. Laura narrated an experience of her colleagues saying that her 'mental health' experience, or survivor/service-user position, made little difference to them, which implies it is irrelevant. This questioning suggests that colleagues sharing such experiences is 'inappropriate' to that relationship and that this interaction belongs to a service-user–professional dynamic. This reinforces an us-and-them dichotomy.

Finally, there is a clear relationship between 'professional boundaries' and 'mental illness' discourses, in Ian and Laura's narratives of the relative safety/'appropriateness' of sharing/disclosure in different contexts. Medicalised contexts constructed 'disclosure' (inappropriate, unsafe), while non-medicalised contexts constructed 'sharing' (appropriate, safe); ‘positive’ experiences of talking with clients, in Laura’s narrative, involved them 'finding out' from media (sharing outside of the service context). Therefore, the problematizing of 'disclosure', would seem to relate to the type of roles constructed by a 'mental illness' discourse (i.e. a 'well' professional who 'treats' an ill patient) and the need, within this discourse, for a categorical distance between the two. Dominant 'professional boundaries' discourse can be seen as ensuring that this distance and these roles are maintained. Thus, 'rules of correlation' (McHoul & Grace, 1993) are suggested between the two discourses. A 'mental illness' discourse constructs, through the roles and practices it produces, a 'professional boundaries' discourse and the latter then maintains the dominance of the former by inhibiting contention of it.

5.2.1.3 'Us-and-them'

In narrating that they needed to adopt an 'ill' position in order to access support, participants did not present their need for that support as due to 'illness'. Laura constructed these needs as “emotional problems we all have”, Bethany as the cumulative effect of restrictive work practices, hostility from managers (itself consequential to a lack of appropriate policies) and medication effects. That this 'ill' position also authorises a controlling response, was narrated by Ian as a reason for not talking with managers about his well-being/needs. Contrarily, both 'privileged' and subjugated aspects were problematic. Laura and Ian constructed tensions/animosity between colleagues arising from a perceived unfairness that 'ill' professionals receive 'special treatment'. In Bethany's narrative, as previously reported (Lindow & Rooke-Matthews, 1998), 'mental illness' discourse was used to dismiss her work-related complaints as 'symptoms'. Before an 'ill' position was sanctioned, her distress/complaints were dismissed as ‘neuroticism’ and being ‘work-shy’.

This situation is, arguably, created by a construction of ‘abnormal’/’ill’ which is *categorically* different to 'normal'/'well' and where the latter is constructed in opposition to the former (Crowe, 2000). If ‘normal’, one can cope with work/life without needing (or having a right to) any additional supports or 'flexibility' in the workplace, except in particular socially-sanctioned situations. For example, Laura and Ian narrated support being given for child-care and physical health needs, without having to adopt a 'mentally ill' position. Outside of these situations, the experience of difficulties and need for additional support, without a legitimised 'mentally ill' position, is constructed as 'weakness'. This seemingly functions to mask the impact of social conditions upon people, by internalising the consequential distress and need for help either as individual 'weakness' or symptoms of 'illness'. This can silence workers' concerns about services, which is particularly concerning in the light of the recent attention on difficulties professionals experience in speaking up about poor/dangerous practices in health services (Francis, 2013). It also reifies the dichotomous construction of 'the mentally ill', who are vulnerable, have problems coping and need help, and 'normal' people, who are 'mentally strong' and capable of managing their selves.

A dichotomous construction of normal'/'well'–'abnormal'/'ill' is one way that us-and-them positioning is created. In participants’ narratives, this is distinguished from a 'professional'–'service-user' dichotomy, although the two are related as the former constructs the roles of the latter. Their narratives further distinguish between 'professional'–'service-user' *experiences/identities* and *roles* enacted within a particular relationship (e.g., researcher–participant, clinician–client). This distinction is rarely made in claims that UI 'breaks down' us-and-them barriers (e.g., Rush, 2008; Truman & Raine, 2002). However, the two meanings have different implications for the ability to occupy a dual/'both' position and how they can be brought into play in systems of power strategy.

Thus, in traditional/dominant approaches to research, services, etc., it is not possible to occupy *both* roles (e.g., researcher *and* participant, clinician *and* service-user). As Christine's narrative showed, this is not even possible when explicitly in an integrated survivor/service-user worker position. Christine narrated that the activities she performs as a researcher mark her in this role and distinguish her from participants. This created a power imbalance that sharing her survivor/service-user position could not equalise. The rigidity of these roles, and power imbalance between them, is perhaps influences the ways that an us-and-them discourse is used to strip 'duality', as an *identity*, of its power, or to undermine its potential for resistance. Importantly, it was seemingly people able to assert a 'single' position (professional or survivor/service-user) who could exercise power through using this discourse, perhaps as a single position can claim a legitimacy which a 'both' position cannot.

Firstly, an us-and-them discourse was used to construct duality as neither one or the other (“neither properly”). Central to Laura’s narrative about (not) sharing with clients, was that her identification with them could be rejected and her position constructed as 'defection' (although the examples she presented, of clients knowing, contained more acceptance). Christine similarly described being positioned by survivors/service-users as a ‘collaborator’ for working in a ‘mainstream’ institution, as in Adame (2011). This use of war-like language constructs a 'battle' between professionals and service-users. This supports an interpretation that they are 'set against' each other by the controlling powers ascribed to a professional role (Vassilev & Pilgrim, 2007). Ian’s and Bethany's narratives did not contain such concerns about survivors/service-users. They positioned their not sharing with clients as consequential to distancing themselves from a subjugated 'mentally ill' identity (Bethany) or 'service-user' position (Ian). Both their narratives focused more on how colleagues positioned them. Perhaps particular difficulties for occupying a professional position were created by having been in an 'ill' position at work – Ian through the 'crossed-roles', Bethany through the 'breakdown'.

Secondly, professional and survivor/service-user positions could be constructed as separate aspects of self, although, as in Adame (2011), participants' narratives constructed these as integrated. This integration underpinned their presentation of personal experience as a resource. Christine particularly emphasised having an integrated identity, presenting a “multiplicative” integration of professional and survivor/service-user positions (enabled by her exposure to other human rights struggles and discourses) which created a “service-user researcher” identity. Laura and Bethany similarly employed a canonical narrative of being the person one is (including at work) *because* of one's experiences. Laura extended this to being a psychologist because of being 'mad' (influenced by her route into the profession through UI) and frequently refers to herself as a “mad psychologist” or “service-user psychologist”. In contrast, Bethany presented a desire to separate her occupational therapist identity from a 'mentally ill' subjectivity. Ian's narrative also constructed an attempt to distance himself from a 'service-user' position with colleagues. However, with clients, there is a coming together of his experiences, which shapes his way of working as a nurse in a similar way to Laura.

By separating participants' professional and survivor/service-user identities, their expressions/actions could be ascribed by others to one or other position. By governing, in this way, what could be said from what position (and, thus, with what amount of power), the contention of dominant discourses could be minimised. In particular, participants' challenging of dominant discourses or use of alternative discourses, could be denigrated as coming from a survivor/service-user position. For example, by constructing survivors/service-users as 'anti' services, medication, etc., or ‘always on patients' side', questioning of professional practices could be attributed to ‘being a service-user’, precluding it from being spoken from a professional position.

To avoid this, Laura actively presented herself as 'pro-medication' with colleagues, Ian as 'corporate' (prioritising service needs). Christine narrated a disconnect between the service-user research/knowledge that she wanted to provide from an integrated position and the 'personal' experience that colleagues sought as her service-user perspective in research. Arguably, this reinforces the dichotomous, hierarchical construction of 'professional'–'experiential' knowledge (Rose *et al.*, 2006), preventing survivor/service-user workers presenting integrated knowledge, even where explicitly in an integrated role. This would seem to be a further way of maintaining the discursive inequality, noted by Hodge (2005), between who can provide 'professional' or 'experiential' and alternative knowledge.

This separation of professional and survivor/service-user identities and attribution of expressions/actions to one or other position, can be seen as strategies that again partly operate through a disciplinary power. As with the ambiguity in 'self-disclosure' discourse, variability in legitimate responses to survivor/service-user workers' duality, seemingly played an important role in the operation of this power. In the narratives, responses from other professionals included outright invalidation (e.g., Ian's date saying service-users should not be nurses, Laura's supervisor stating she should not have disclosed) as well as a more subtle invalidation (e.g., not responding to their disclosures, dismissing the relevance of it). In contrast, participants' survivor/service-user knowledge was also sought as a resource.

Participants did not explicitly relate this variability to the subject of their survivor/service-user knowledge. However, in Laura's and Christine's examples of being used as a resource, their knowledge was used in support of dominant discourses (e.g., the helpfulness of medication; stigmatising/discrimination by the general public). The subtle invalidation has similarities with Hodge's (2005) finding that ‘involved’ service-users *could* assert different types of knowledge but these assertions would not be meaningfully incorporated if they were challenging to dominant discourses. This previous research, along with the observation in this study that a survivor/service-user perspective was apparently only validated when it supported dominant discourses, supports an argument that UI only reinforces the power/knowledge of dominant discourses (Stickley, 2006). However, a survivor/service-user perspective could also be *directly* invalidated with survivor/service-user professionals. This suggests that their conceptual exclusion from UI enables a further strategy to be used in maintaining dominant discourse.

5.2.2 Strategies of resistance

Although 'sharing' was taken as the starting point of the research, resistance in participants’ narratives largely took other forms. These alternative strategies of resistance seemed to work from a recognition that 'sharing' is rendered ineffective by relationships between UI, 'mental illness' and 'professional boundaries' discourses (i.e. the effectiveness of the strategies discussed above). Instead, participants resisted the subjugation and subjectivity produced by dominant discourses, and used alternative discourses to construct a more empowering subjectivity. This subjectivity formed a basis for subverting (and, under some conditions, directly acting upon) dominant power relations, through the possibilities for different actions that these alternatives constructed (Burr, 2003). Survivor discourse, with its focus on power, voice and human rights (Beresford, 2002), played an important role. Although alternative discourses were important, participants also exercised power through the way they used dominant discourses (Burr, 2003).

5.2.2.1 Reconstructing 'professional boundaries'

Participants' reconstruction of 'professional boundaries' made salient a number of conditions that enabled resistance. As well as having less medicalised contexts (as previously discussed), Laura and Ian narrated their ability to resist as being enhanced by having a qualified status (compared to being a student/trainee). This suggests that disciplinary power does not produce the same subjection with qualified professionals as with students. This is perhaps because professionals have attained their 'professional credentials' and, thus, greater freedom for unobserved working, whereas students are subject to constant observation and evaluation. This has particular implications for survivor/service-user workers brought in through UI, who may not have this professional credibility to draw power from to resist a 'role boundaries' discourse (Gates & Akabas, 2007).

Secondly, participants employed the same aims in support of sharing – to be professional and help service-users – as are used to discourage disclosure in a 'professional boundaries' discourse. They also focused on the overlap between alternative discourses and a dominant discourse promoting (limited) disclosure. These strategies seemed to exercises power from a 'professional boundaries' discourse that could be used to then contesting it. Finally, Laura and Bethany storied visible examples of 'open' survivor/service-user professionals as enabling resistance, supporting the idea that a culture of resistance can be created and empowered by survivor/service-user voices coming together (Campbell, 2009).

5.2.2.2 Resisting a subjugated subjectivity

Various strategies were used to resist the subjugation and subjectivity produced by a ‘mental illness’ discourse. These included using a dominant discourse to remove themselves as a legitimate object of it (e.g., Bethany's use of successfully managing without medication to mean never really being 'ill') and to claim credibility (e.g., Ian and Bethany demonstrating 'insight' into their potential impaired judgement). All participants used a survivor movement discourse to contest a 'mental illness' discourse and claim a subjectivity with greater power, to a claim 'personhood' (Campbell, 2009). For example, they constructed their difficulties as transient and contextual and as anyone may experience (Laura, Bethany) and 'mental health' problems were constructed as retaining one's ability to make decisions, judge reality and work (all participants). It was, perhaps, this access to an alternative subjectivity which enabled other strategies of resistance at work, such as 'hiding' difficulties to prevent themselves being positioned as 'ill' and subject to control (Laura, Ian) or ignoring attempts to control them (Christine).

This resistance implicitly constructed actions which objectify survivors/service-users through a 'totalising' concept of illness and which use paternalism/control, as discriminatory, placing it within a human rights framework (Beresford, 2002). It is, therefore, noteworthy that Laura, Bethany and Ian all stated that they did not think, or were unsure, they had been discriminated against at work. Instead, they discussed their experiences of stigma/discrimination using a 'self-stigma' discourse with internalising accounts (e.g., Laura stating her concerns were “one of my issues”, Ian suggesting he discriminated against himself). However, these accounts were inconsistent and often disjunctive with accounts of structural and discursive influences. Although Christine consistently positioned her ability to disclose as context-dependent, her examples of discrimination were also outside of work or constructed as belonging to a different era. A similar ambivalence is seen in the literature. For example, certain practices (especially involuntary hospitalisation) are named as a civil rights issue but then unhelpful professional attitudes are constructed as being a result of the 'stigma' associated with mental illness (e.g., Frese & Davis, 1997; Schiff, 2004).

An uncertainty about 'who knows what' underlay some of the problems in the narratives in constructing interactions as discrimination. Furthermore, in the context of the interviews, participants were positioned as survivor/service-user professionals by me and, therefore, by an audience. This created the potential for a 'mental illness' discourse to be used to construct their interpretations as suspect or lacking credibility. This potential may also have made it difficult for them to name discrimination.

In narrating their 'lived experience' as a resource which shaped their professional practice, participants resisted the dominance of 'professional knowledge'. To some extent, this resistance drew power from a UI discourse, as it gave currency to their 'user perspective'. This was despite survivor/service-user professionals' being excluded from UI policy and the ambivalence in it towards the value of a user perspective (Hui & Stickley, 2007). Christine explicitly constructed an ability to assert a position of authority/credibility through having survivor/service-user experiences (even if not always then validated), that was not possible before a UI discourse became dominant. Christine and Laura also narrated a process of accessing their professional positions through their involvement in UI. However, Christine positioned the survivor movement as impelling the State induction of UI. Furthermore, by narrating the use of their 'experiential knowledge' to contest professional knowledge/practice, participants would seem to be drawing on a democratic approach to UI (which has its roots in the survivor movement), rather than a consumerist approach (Beresford, 2002; 2005; Tait & Lester, 2009).

Some authors (e.g., Frese & Davis, 1997; Schiff, 2004) have argued that, by using 'experiential knowledge' to shape their practice, survivor/service-user professionals can model to their colleagues a more hopeful and collaborative way of working. However, in the narratives, being able to work in such ways was often positioned as only possible away from other professionals (e.g., one-to-one with clients). Each strategy of resistance outlined above, seemingly 'came together' to enable participants to act from an alternative professional position with service-users (i.e. ‘doing things differently’). Thus, by resisting the subjectivity produced by a 'mental illness' discourse and the positions constructed by a 'professional boundaries' discourse, participants were able to use alternative discourses which construct a more empowering subjectivity and enable professional knowledge/practices to be contested by their 'lived experience'. This then created alternative subject positions and practices in their work with survivors/service-users. These particularly involved listening, ‘being with’ (not ‘doing to’), seeing a person (not seeing a diagnosis), and being responsive to service-users’ preferences, rather than being controlling and prescriptive – all things that survivors/service-users have prioritised (Barnes *et al.*, 2000; Repper & Breeze, 2007). By working in this way, a different subjectivity is perhaps offered to the people that survivor/service-user workers engage with, one that is more humanised and agentive.

Finally, having access to these alternatives also enabled some of the participants to contest dominant discourses outside of the immediate mental health system. For example, sharing in the media or doing presentations in schools from an integrated survivor/service-user professional position. A more direct resistance and use of their duality seemed to be possible in these settings, whilst such resistance can also be seen as promoting alternative discourses among the general public and potential service-users.

5.2.3 Conclusions

User involvement can be seen as subordinate to other dominant discourses in the 'mental health' system and as operating in the same field/space, without recognition or acknowledgement of contradictions between them. This seems to enable these other dominant discourses, especially ‘mental illness’ and ‘professional boundaries’ (which both create/maintain ‘us-and-them’ dichotomies), to be used to govern what can be said, by whom and from what position. The present study suggests that this functions to manage the potential threat to dominant power relations, which is created by an endorsement of UI and its underlying ideas. UI itself can be seen as an attempt to counter the threat represented by the rise of the survivor movement, human rights and other discourses in society which contested the dominant construction and treatment of the ‘mentally ill’ (Beresford, 2002; Crossley, 2006). Therefore, it could be argued that there is a symbiotic relationship between UI and dominant 'mental illness' and 'professional boundaries' discourses, which functions to maintain the status quo.

However, this study also demonstrated strategies of resistance that could challenge this relationship and work to effect change. Specifically, critical and survivor discourses were used to resist the subjectivity constructed by a 'mental illness' discourse and to claim a more empowering subjectivity. A survivor discourse was used in conjunction with a UI discourse, to give credibility to 'experiential knowledge' and to enable this knowledge to be used to contest professional knowledge and practices. Finally, by employing a critical discourse and selectively appropriating a 'professional boundaries' discourse, 'disclosure' (which is problematized and implicitly discouraged) was reconstructed as 'sharing' (appropriate and helpful). These alternative discourses produced different legitimate professional (and service-user) subject positions, roles and practices. These could also be taken out of the immediate service context and applied to interactions with the general public.

Arguably, these can be seen as ways of 'subversively' changing the system, enabling further survivor/service-user resistance and rejection of the legitimacy of professional expertise and control over their subjectivity and lives. If survivors/service-users and the general public (and, therefore, potential survivors/service-users) can use alternative discourses to construct experiences currently framed by a 'mental illness' discourse, they will hold different responses to them as legitimate. This will impact on 'help-seeking' and the power that the public and survivor/service-users invest in professionals, which will therefore affect power relations.

5.3 Critical review

5.3.1 Limitations

A limitation of this study was the small number of participants. The epistemological stance precludes the possibility of achieving a 'representative sample'. However, people have different personal-social histories (Cromby & Standen, 1999) which provide a unique mix of discourses they are exposed to and act within. This influences the positions available to them and their ability to adopt or reject them (Davies & Harré, 1999). As different aspects of identity intersect to create positions of power and subjectivity in different contexts, the perspectives and knowledge of a number of 'groups' can be considered to be neglected in this research. Recruitment depended on survivor-service-user professionals having shared their position/experiences publicly in some way. Therefore, which 'groups' are neglected may indicate something about their ability to 'share'. Indeed, the issues experienced with recruitment, and the small number recruited, may indicate that sharing these experiences is challenging for professionals in general and/or it is difficult to find shared stories due to the lack of common language.

All participants were of a White British ethnic background and therefore, in this respect, held a privileged position. A lack of BME voices is particularly important considering the racism in the 'mental health' system. For example, it has an ethnocentric ‘knowledge'-base (Patel, 2003; Patel and Fatimilehim, 1999); clinicians interpret the behaviour of Black service-users as more aggressive and paranoid (Loring and Powell, 1988; Spector, 2001); and certain BME groups are over-represented in overt incidents of coercion (Audini and Lelliott, 2002; Watters, 1996). Not all professional groups or areas of the system were included and only one participant occupied a non-clinical role. Different roles/areas of work carry different responsibilities, focus and types of encounters or relationships with survivors/service-users and other professionals, which influences the availability and accessibility of different subject positions. Psychiatrists, who arguably have the greatest investment in 'mental illness' discourse (as a medical discipline) would have been a particularly important group to include.

However, having a greater number of participants would have made it difficult to use the time-consuming analytic method employed, which privileges breadth and complexity within a few narratives over a less in-depth analysis of more stories.

Even with four participants, the word limit restricted the ability to report the multiple levels of analysis conducted and how they recursively informed each other. This is especially limiting as the approach was used to demonstrate decision-making, enabling readers to judge the rigour and coherence of claims made. Furthermore, by largely reporting the overall narrative, the complexities, subtleties and multiple stories within each have been diminished, although an attempt to preserve them has been made by appending tables of strophe and part structure. Similarly, the epistemological and value base demanded a reflexive use of self throughout the design, interview (including co-production of the text) and analysis. Reporting this was also largely restricted to the appendix.

Finally, it can be questioned as to what extent my attempt to enter a 'language game' (Wittgenstein, 1963), where dominant terminology is used but contested, has successfully altered its meaning to challenge the discourse it is part of. As much of the language is constituent of medicalised and dichotomised constructions, these constructions have perhaps been reified through the use of this language. The research question was worded to achieve brevity and coherence across a wide audience with various perspectives but this risks reifying 'personal' and 'professional' experience as dichotomous and the construction of certain experiences as 'psychosis'.

Dominant discourses were perhaps better challenged in the interviews, where discussion occurred about different ways of understanding 'mental health' experiences. However, it was difficult to discuss the impact of what is dichotomously constructed as 'mental health'–'not mental health' without reifying this dichotomy, or speech becoming more 'clumsy'. This was partly due to the lack of a shared alternative language which would maintain coherence. However, it is probably also a reflection of the difficulty of trying to speak outside of discourses that have been dominant in constructing my/our world 'reality'.

5.3.2 Reflections on reflexivity

As Wintrip (2012) notes, it is difficult to know where to place one's own narrative and performance of self, when it has a fundamental relationship to all aspects of the research process and production. Although the preface attempted to situate my researcher position and approach within a survivor discourse, and co-construction was included in the method of analysis, word limitation (and anticipation of expected academic convention) has constricted the telling of the stories that provide an essential reference for the interpretative decisions and claims made. These stories include those I tell about my 'self' and my experience of conducting the research.

Within the epistemological stance adopted, there is no one 'true' story but various stories I can tell; which ones I tell and how I tell them changes depending on the performative context. Having conversations about where to place my stories, and examining how other people have done this, has been very important. To separate my narrative from the narratives of my participants, risks presenting them as independent and separate from each other, whilst putting them together or entwining them would perhaps suggest that the process of telling my own stories is the same as re-producing another’s story, which is equally erroneous. Mentioning my position as a survivor and my role in co-producing the text solely in the appendix would fail to convey the fundamental importance of this to my approach. Therefore, I have used a preface and method of analysis to explicitly incorporate myself as the researcher, whilst telling my stories in more depth in reflexive research notes (Appendix XII), to provide that 'missing link'.

In addition, I hope to 're-humanise' and show respect to participants' narratives by providing an account of my emotional reactions. The expressions of hope, striving, suffering, injustice, outrage, etc., in these stories, were deeply moving and deserve to be recognised as such. ‘Mental health’ services often show a lack of humanity, both in the way service-users are objectified and in professionals not acknowledging their own personhood, emotional reactions and human connections with the people they work with. The intellectualising process of interpretation and reproduction of participants’ narratives similarly strips their stories, and ourselves as researchers, of this humanity, reproducing an unhelpful dynamic.

Key reflexive themes are summarised here, focusing on the journey of conducting the research, lessons I have learned from it and what I might do differently if I were to do the research again. Five themes are discussed: parallel journeys between participants' narratives and my life beyond the research; an interactivity of contexts influencing the research produced; changes in the importance of similarities and differences between myself, the participants and other survivor/service-user professionals; re-evaluating the role of 'sharing' in changing systems; and rethinking the complexity of the research design.

(1) Parallel journeys

Towards the end of the research process, I became very aware of seemingly parallel journeys between the stories told in the research and those I had connected with throughout this period, which were particularly influenced by services I had been working in. Before developing the study, I had been working in a 'psychosis' service where I felt able to share my experiences in a helpful way with clients but unable to (and unsafe) with most colleagues. I was trying to work out how to be the kind of survivor professional I wanted to be (and what that would look like) and on some level, through my research, seeking guidance and a better understanding of how to do this. Thus, I started the journey from a position of 'being' a survivor-professional, focused on negotiating this identity and on my varying ability to use the position in different contexts. These concerns shared similarities with Laura's narrative.

I later 'returned to the beginning', whilst working in CAMHS, which had parallels with Christine's chronological account. Being around children and families had made me focus on the path that had brought me to services, firstly as a service-user and then as a professional wanting to use my experiences to help others. I had felt more able to talk about my experiences with my colleagues in that service, which had me reflecting on the importance of context, which Christine spoke about, in enabling sharing. It was partly due to being in this space, where I was reflecting on history and context, that made me connect to Christine's account of being primed by other life experiences to see a human rights struggle, and for this to make me think more about my own family background and the socio-political values I was taught.

Between the interviews with Christine and Bethany I worked in a difficult service, which had a lasting impact on the way I related to the research. Initially, it shifted my focus from negotiating being a survivor professional and sharing experiences, to how people in distress are treated, particularly in relation to the 'ill-not ill' dichotomy, which paralleled Bethany's dilemma-focused narrative. My feelings of frustration and anger during this time resonated with the emotional content of both Bethany's and Ian's stories and I felt a conflict between these feelings and working in services that connected strongly with Ian's narrative.

The processes of analysis and write-up were part of a larger reflective time, in which I was making sense of both my recent experiences and the research. How to effect change in the system and barriers to change, were key themes in this reflection, connecting with the systems of power and strategies of resistance I was writing about. In addition, as I was coming to the end of training and preparing to embark on a new stage in my professional journey as a qualified psychologist, I was thinking a lot about my place in the system and my role as a professional. These reflections reconnected me with my reasons for wanting to become a 'mental health' worker and brought me back to the question of how to be the kind of survivor professional I want to be.

(2) Interactivity of contexts

Reflecting on the parallel journeys led me to consider the complex interaction of stories and contexts, which all influenced what has been produced through the research. Particularly important have been the participants' narratives (at interview, analysis and write-up stages), my personal-social history and the contexts I have been working in as a survivor-clinician (including service and client stories). All of these influence and are influenced by each other, creating the context for this research (Figure 1). Thus, my clinical and personal experiences have undoubtedly influenced what I have connected with in participants' stories at different times and shaped how I understand them. Those stories are also likely to have influenced my experience of clinical work and what

I have connected with from my personal-social history. These, in turn, affected my engagement with the research, and so on.

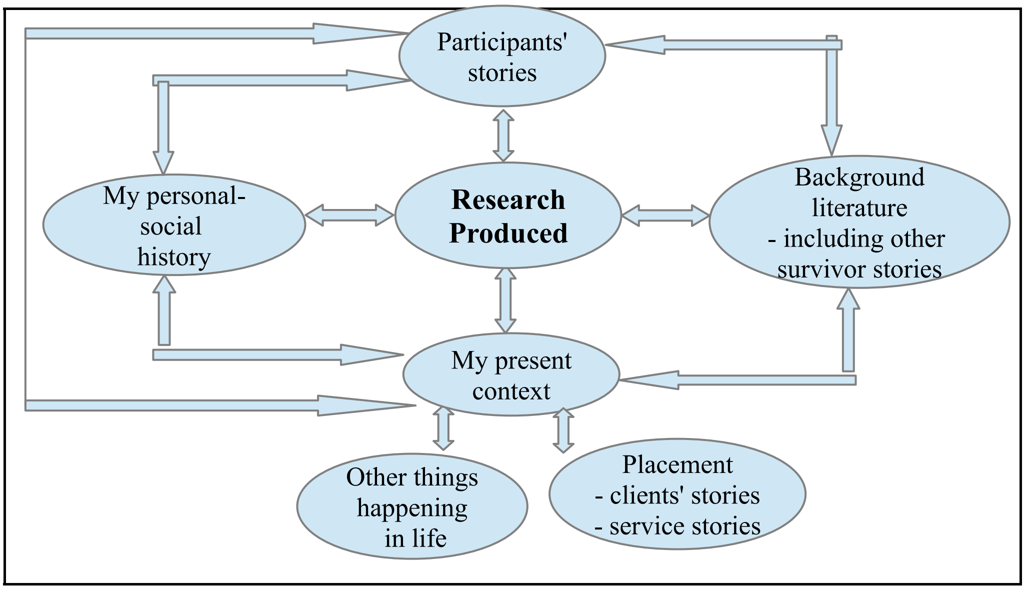

Figure 1. Interactivity of contexts

(3) Similarities and differences

I recognised early on that I had started this research (subconsciously) looking for and expecting similarities between my perspective and experiences, and those of other survivor/service-user professionals. When reading accounts by other survivor/service-user professionals, and in the first interview, I noticed that I was surprised by differences. Furthermore, some of these differences aroused feelings of envy (e.g., Laura's ability to 'be open' with her colleagues) while others felt rather threatening.

Exploring my response to these differences was what led me to recognise that part of my motivation for the research was to look for guidance on how to be a survivor professional and to seek companionship in this sometimes lonely position. A desire to change the system and improve the treatment of those considered 'mad' was another key aspect of my motivation. I realised that I had been thinking that survivors/services-users needed to present a 'united front' to effect this change, at least on issues I feel to be key to the perpetuation of poor treatment. For example, one author stated that they knew, from their own experience of 'mental illness', that the most important steps in recovery are accepting one is ill and one's experiences are not real, and taking medication. I believe that insisting on defining our distress as 'illness', discounting the truth and validity of our experiences, and forcing medication upon us, are damaging practices that desperately need changing. The above statement from a survivor/service-user felt like a reinforcement of these practices and a barrier to changing them. This felt particularly threatening as the author was using their position as a survivor/service user professional to claim authority and credibility.

Accepting these differences was helped by remembering the quite significant changes that had occurred in my own perspective and the positions, or identities, I had adopted at different times. 'Letting go' of my desire to find similarities, I believe, helped me notice and attend to subtleties and nuances in participants' positions/perspectives, for example, the way that Christine associated herself with the survivor movement but not the survivor label.

Furthermore, the study became less 'personal' through attending to complexity and nuance in the similarities and differences of the many different survivor/service-user professional perspectives included in the research (i.e. accounts in the literature, participants' narratives and mine). The following extract from the reflexive research journal demonstrates the change in my relationship with the research:

> [The research] connects with my experiences but it is not so personal...I feel more like a 'researcher' – not detached and objective, but interested in what is coming from it...for what it can teach us and what can be used in the field, rather than for something for me. Perhaps because it is so real now, because there are stories that have been told that have so many similarities and differences with my own and with each other that my story is just one story 'out there' amongst many?

(4) Re-evaluating 'sharing'

I started this research with a clear idea that survivor/service-user professionals sharing their experiences in their work was important for challenging dominant, unhelpful ideas and relationships. I sought to understand what enabled and inhibited sharing, in order to find ways to promote it. However, doing the research has changed my view. The biggest lesson I have learned is that sharing *per se* is not key, that there are mechanisms in place to counter the challenge that sharing might present. Initially, this led to a feeling of hopelessness, as this extract from Appendix XI expresses: “I started this research wondering how survivor professionals negotiate their position...and how change can be effected. I thought it was important that professionals were able to share their 'mental health' experiences in their work, to help bring about this change. But now change seems impossible and sharing seems unimportant, an impotent tool.”

However, by exploring resistance, through revisiting both Foucauldian theory and the participants' narratives, I came to appreciate the importance of subjectivity, as I reflected on in the journal: “resistance is in the ways they talk in the interviews, in the way a difference is presented between how they construct things and how others do. They don't accept a damaging subjectivity as true, they resist it.” The ways in which an alternative subjectivity is constructed, and how this subjectivity then enables more subversive actions, are, I believe, the main lessons I have taken from this research.

(5) Rethinking the design

Finally, I consider one of the strengths of the research to be the complexity of its design – looking at various interacting discourses, using a number of related research questions, having multiple levels of analysis, and synthesising macro and micro social constructionist concerns. However, it was difficult to capture this complexity within the word limit. This is particularly problematic for the analysis, as the purpose of the chosen method was primarily to demonstrate interpretative decision-making to enable the reader to judge credibility, rigour and coherence. Thus, there is a trade-off between breadth and depth in the research and being able to demonstrate its quality.

Therefore, if I were to conduct the research again, I would consider reducing the complexity in order to report more of the findings and enable better evaluation of its quality. Some ways of reducing the complexity could include: having a narrower focus (e.g., looking at specific discourses, such as user involvement and self-disclosure); having fewer participants; or using a less in-depth method of analysis. However, each of these has drawbacks.

Narrowing the focus would have artificially isolated certain discourses from the others that they are connected to. It would not have been possible to see how the interaction between 'mental illness', 'professional boundaries' and UI discourses (with their associated us-and-them dichotomies) functions to maintain dominant power relations. I consider this process to be a very important finding of the research. Having fewer participants would have made it difficult to suggest that this process occurred across different 'groups' / contexts. It would have also reduced the ability to explore the interaction between this process and different positions (e.g., Christine's senior role, Ian's 'crossed-roles'). This would be particularly problematic as the study already has relatively few participants. Lastly, the method of analysis helped make my interpretative decision-making more systematic and grounded the macro (thematic) levels of interpretation in the structure of the text. However, as it was difficult to demonstrate this decision-making process, changing the method of analysis would seem to be the best way to reduce complexity and improve the demonstration of quality.

5.4 Implications and recommendations

The findings of this research have a number of implications for clinical psychology and the 'mental health' field as a whole. However, the recommendations leading from these depend on the aims trying to be achieved. Therefore, it is important to clarify that the goals pursued in making the following recommendations are in keeping with the aims of the survivor movement; specifically, to encourage the development of discourse and practices, around experiences constructed as 'mental health' problems, which recognise and respect people as conscious human beings rather than disease entities (Basset &

Stickley, 2010; Campbell, 2009), without encroachment on human rights, discrimination or domination by professionals and professional knowledge (Beresford, 2002).

This research, in the context of the literature, suggests that quite radical changes are required to realise these aims, changes that are not going to happen immediately and which are likely to meet considerable resistance. This study does, however, also suggest things that can be done to pave the way for more radical change. Therefore, recommendations are made which can be implemented in the short-term but which, in and of themselves, do not fully address the problems; they are likely to constitute 'stepping stones' to the long-term recommendations made. These include recommendations for further research, policy development, service planning and delivery, and education and training. These recommendations are organised by implication / key finding.

(1) Neglected voices

As discussed in the critical review, the small number of participants in this study means that a number of important voices have been neglected. In order to address this, future research should pursue the same research aim and questions with these neglected groups, including professionals from BME backgrounds, other professional disciplines (e.g., psychiatrists, social workers), and those working in other areas of the system (e.g., education, policy development). Furthermore, it would be important to compare the narratives and experiences of those working in statutory and non-statutory contexts, particularly as a previous study found similarities between them (Lindow & Rooke-Matthews, 1998), whilst this study suggests that third-sector organisations can operate within a less medicalised discourse and promote resistance.

Thus, academic researchers, trainees and students, clinicians (as practitioner-researchers) and third-sector organisations, are encouraged to pursue this in their research. It is recommended that supervisors and educators highlight these areas and encourage their trainees and students to research them.

(2) 'Subversively' changing the system

Further examination is required of the suggestion in this study that, although directly sharing their survivor/service-user position or 'mental health' experiences was rare (supporting previous research, e.g., Adame, 2011; Henretty & Levitt, 2010; Lindow & Rooke-Matthews, 1998), by using their experiences to inform their work and contest professional knowledge/practice, survivor/service-user workers are subversively acting to change the system. It would be helpful to explore service-users' perspectives on working with professionals who have these experiences, compared with professionals who do not. Specifically, future research should be conducted to explore whether survivor/service-user workers and those they work with co-produce a subjectivity from an alternative discourse. This could also include a comparison of when survivor/service-user workers directly share or only use their experiences.

Similarly, this research suggests that survivor/service-user workers can more easily use their duality outside the direct 'mental health' system (e.g., in schools or the media). It would, therefore, be beneficial to have research examining the effects of this on the public's constructions of 'mental illness' and appropriate 'treatment', and the actions people take after exposure to this. In particular, it would be important to compare these effects to the outcomes of dominant 'anti-stigma' and public education campaigns which promote an 'illness' model, as these have been shown to increase stigma/discrimination (e.g., Angermeyer & Matschinger, 2005; Read, 2007). Again, these recommendations apply to those with opportunities for conducting research and those with responsibility for supervising or commissioning research.

Furthermore, supervisors and educators should highlight these other ways of using a dual position. This would particularly apply to informing survivor/service-user colleagues when issues of disclosure are raised but would also relate to teaching trainees/students, in general, about system change and self-disclosure. In addition, and particularly if the further research recommended supports a conclusion that subversive actions enable people to construct a more positive subjectivity, survivor/service-user professionals are encouraged to use their duality in activities outside the immediate 'mental health' system. Managers, supervisors and educators also have a role in supporting such activity, for example, by educational establishments developing links with schools and other platforms for survivor/service-user professionals to give talks, and by providing teaching that develops skills in this.

If further research suggests that it is important that professionals directly share their survivor/service-user experiences with clients, this would be a recommendation for survivor/service-user professionals. Managers and supervisors should support clinicians in this (e.g., through providing space to discuss it) and place therapeutic value upon sharing. Educators should help students/trainees develop their skills in sharing.

(3) The importance of the survivor movement

In this study, a survivor movement discourse played an key role in enabling resistance to dominant discourses and the construction of a more empowering subjectivity and position. Therefore, it is important to promote it. Education/ training on UI should include its roots in the survivor movement. Teaching should make explicit the differences between consumerist and democratic approaches (Beresford, 2002) and the inconsistencies between UI policy and other dominant discourses. This would hopefully support a recognition of the limitations and agenda of a consumerist UI, and knowledge and use of alternatives (e.g., democratic UI).

Educators can both ensure that this is included in the curriculum for training 'mental health' professionals and work with survivor organisations in developing and delivering teaching on the survivor movement. Similarly, clinicians, researchers, etc., involved in UI, should aim to work within a democratic approach, use higher levels of involvement (Sweeney & Morgan, 2009). If this is not possible, due to institutional demands, they should make explicit their use of a consumerist approach and the lack of decision-making power being shared.

The importance, in this study, of having examples of other survivor/service-user workers, suggests that it would be helpful to develop visible networks (e.g., as started with the survivor worker conference; Snow, 2002) across all areas of the system. These networks could then be used to develop relationships between survivor/service-user workers and schools, media organisations, etc., for promoting change outside of the immediate system. Whilst survivor/service-user professionals (as those who will need to identify themselves) are essential to developing these networks, educational, research and clinical institutions can also play an important role in supporting them, for example, by providing resources and promoting awareness of them among professionals and students.

(4) Legitimising 'experiential knowledge'

Participants were able to use a UI discourse and 'experiential knowledge' to claim legitimacy and credibility from a survivor/service-user position. This implies that this position may have greater power (and there would be less room for invalidation of it) if professionals were explicitly included in UI policy, research and literature, as having survivor/service-user perspectives to contribute. Furthermore, recognising that survivors/service-users have professional knowledge to add may help reduce the inherent discursive inequality between professionals and service-users (Hodge, 2005). The inclusion of survivor/service-user professionals in UI may also give greater legitimacy and power to them using their duality outside the immediate system. Therefore, professionals with responsibility for developing local and national UI policies and initiatives should change these policies/initiatives to explicitly include survivor/service-user professionals. Other professionals and trainees/students can put forward these arguments for the inclusion of professionals to policy developers

Seemingly there was a greater ability to directly contest dominant discourse and practice for the participant in an integrated service-user–professional role. Therefore, one possible recommendation is for services, and other areas of the system, to develop and commission specific roles requiring both a professional qualification and survivor/service-user experience. Moreover, this study suggests it is important that these are senior roles. However, further research is needed with people in such roles, as this research only included one person in one area of the system (research), who was also older than other participants and seemingly had the greatest involvement in the survivor movement and exposure to other civil rights discourses. This is not to claim that further research would demonstrate *systematic* differences that can be naively generalised to others. However, the more stories that are heard, the greater one's understanding of the multiple, complex ways that interacting discourses and positions can be negotiated and can influence resistance.

(5) The function of 'professional boundaries' discourse

This study demonstrates a clear relationship between 'professional boundaries' and 'mental illness' discourses in maintaining dominant power relations between both professionals and service-users, and 'the mentally ill' and the 'sane'. This relationship should be made explicit in teaching about professional boundaries, and training should include alternative professional actions and relationships which are appropriate within subjugated discourses (e.g., 'disclosure' versus 'sharing'). Teaching should also include survivor/service-user perspectives on sharing. This is something which can be done by educators training student/trainee mental health professionals and clinicians (often psychologists) delivery teaching on 'professional boundaries' to colleagues from other disciplines. In addition, supervisors should discuss this function of 'professional boundaries' with those they supervise, particular when issues are raised in relations to 'self-disclosure'. They should give 'permission' to share (considering the implicit prohibition of disclosure) and provide an alternative framework from which to understand professional–service-user relationships.

The relationship between those discourses also implies that working in non-medicalised contexts enables professionals to work from positions constructed by alternative discourses. Thus, psychologists (including researchers, educators and clinicians) should develop community psychology projects and knowledge and skills about community psychology, which policy makers and commissioners should support. Service developers should design services to enable practitioners to see clients outside of 'professional' settings (e.g., meeting people in parks). Individual clinicians can change their practices to do this, whilst supervisors can encourage and support those they supervise to practice in this way. Clinicians can also seek to work with and within third-sector organisations.

This study suggests that there were important differences between student/trainee and qualified positions in the ability to exercise power to resist and contest 'professional boundaries' discourse. However, all participants were qualified and it would, therefore, be beneficial for future research to explore student/trainee experiences, perhaps including longitudinal studies to help understand change over time.

Survivor movement and UI discourses were also important tools in resisting dominant 'professional boundaries' discourse. Therefore, researchers, policy makers and educators should explicitly include these discourses in their self-disclosure policies, research and teaching. This should aim to demonstrate the contradictions between the ideas, underpinning UI, about the benefits of sharing and the problematizing of 'disclosure' implied in 'professional boundaries' discourse, as well as raise awareness of alternative professional positions. This would be particularly helpful in combination with the recommendation to include survivor/service-user professionals in UI.

(6) The function of 'mental illness' discourse

Ultimately, what this research shows is that any initiatives will fail to meaningfully alter power relations whilst 'mental illness' discourse is dominant, as it plays a key role in strategies to counter resistance. The differing rights and responsibilities (e.g., claims to 'truth', defining 'reality', decision-making, etc.) attached to the roles constructed by dominant 'mental illness' and 'professional boundaries' discourses, create a power imbalance between professionals and service-users. It would seem that this can only be altered by approaches stemming from alternative discourses which construct radically different roles, such as participatory action research (Whyte, 1991) or peer-to-peer reciprocal support services (Brown, 2009). Thus, the long-term recommendation is for the critical and survivor discourses discussed, to replace 'mental illness' as the discourse from which roles, positions and practices are constructed in policy, education, research and practice.

This disparity of power is arguably most extreme within services, where 'mental health' legislation conflates care and control, ascribing powers to professionals to forcibly detain and 'treat' the 'mentally ill'. Without changes in legislation, it is difficult to see how the inclusion of survivor/service-user workers can help to equalise this power imbalance. Thus, mental health legislation must be changed to end legitimised discrimination, violation of civil rights and the resultant inherent untrustworthiness of professionals and service-users to each other (Vassilev & Pilgrim, 2007).

Therefore, this research recommends that legislators change 'mental health' legislation and that all professionals campaign for this change. Academics, clinicians and educators have a role to play in raising awareness among the general public, survivors/service-users and 'mental health' professionals about the lack of scientific evidence for 'mental illness' discourse. They should also speak out against policies and practices which constitute human rights abuses, including the role 'mental illness' discourse plays in legitimating these. Awareness particularly needs to be raised in relation to the way this discourse creates the ill-not ill dichotomy which seemingly affords certain 'rights' / 'privileges' to those in an ill position. Thus, in highlight the lack of scientific evidence, professionals need to highlight that it is this discourse itself which constructs 'not ill' people as not having real problems / needs. Finally, managers and supervisors can ensure they do not reinforce this dichotomy, by asking about and responding to all professionals' emotional well-being and needs without dividing them into 'ill'-'not ill' groups and making additional support and flexibility dependent on the adoption of an ill position.

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APPENDICES

Appendix I - Levels and areas of involvement

Table 2. Literature review results – levels and areas of involvement

		Research *(%)*	**UI Project** *(%)*	**Commentary** *(%)*	**Total** *(%)*
Levels of Involvement *	User-led	3 *(2)*	4 *(10)*	17 *(22)*	24 *(8)*
	Collaboration	16 *(9)*	11 *(27)*	14 *(18)*	41 *(14)*
	Contribution	32 *(18)*	15 *(37)*	3 *(4)*	48 *(16)*
	Consultation	15 *(8)*	8 *(19)*	1 *(1)*	24 *(8)*
	(participants only)	53 *(30)*	1 *(2)*	-	54 *(18)*
Areas of Involvement **	Own care	63 *(36)*	6 *(15)*	19 *(25)*	88 *(30)*
	Service evaluation & development	48 *(27)*	14 *(34)*	17 *(22)*	79 *(27)*
	Research	23 *(13)*	15 *(37)*	25 *(33)*	63 *(21)*
	Education & training	32 *(18)*	15 *(37)*	8 *(10)*	55 *(19)*
	Policy development	16 *(9)*	10 *(24)*	12 *(16)*	38 *(13)*
	Service provision	6 *(3)*	3 *(7)*	10 *(13)*	19 *(6)*

* Level of involvement could not be identified in all abstracts

** Some papers included more than one area

Appendix II – Recruitment letter

Invitation Letter

Dear Sir / Madam,

My name is Rowena Wasyliw and I am a Trainee Clinical Psychologist enrolled at the University of East London. I am also a user/survivor worker.

I am writing to invite you to participate in my doctoral research, exploring the experiences of mental health professionals who self-report having been labelled/diagnosed with ‘psychosis’. In particular, I am interested in how and why such user/survivor professionals share their personal experiences with colleagues and service users in their work.

Participation will involve an unstructured interview at a location of your choice within England. Travel expenses will be reimbursed, upon presentation of a receipt.

For more information, please see the attached information sheet and research proposal. If you are aware of any other persons who meet the inclusion criteria for this research, please could you pass on this invitation and accompanying documents to them.

If you are interested in participating, or wish to ask any questions, please contact me before 31/11/2012 using the following details:

Email: u1037649@uel.ac.uk or rwasyliw@googlemail.com
Phone: 07896581854

Thank you for reading this letter.

Yours sincerely,
Rowena Wasyliw

Researcher: Rowena Wasyliw – Trainee Clinical Psychologist
Supervisor: Dr. Maria Castro – Clinical Psychologist

Appendix III – Information sheet

Information Sheet

Study title
A narrative study exploring user/survivor professionals' accounts of sharing personal experiences in relation to their work in mainstream mental health services.

Who is doing this research?
The principal investigator of this research is Rowena Wasyliw, a Trainee Clinical Psychologist and survivor worker. This research is supervised by Dr. Maria Castro, Clinical Psychologist.

Consent to participate in a research study
The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London.

Project description
Service user involvement is a priority within the National Health Service and Department of Health (e.g., DH, 2001; 2005; 2011). Greater involvement is also a priority of service users/survivors (Rose, Fleischman & Wykes, 2008; Thornicroft, *et al.*, 2002). However, these two groups appear to be using two different models of involvement, the former a 'consumer' approach, in which the unequal power relationship between services and users/survivors is silent and maintained, and the latter a 'democratic' approach, in which raising awareness of and redressing this power is the foundation of the approach (Beresford, 2002). User/survivor workers (Snow, 2002) can be seen as a form of 'involvement', although one which has received less attention, particularly where these workers are in 'professional' roles. A number of advantages to this form of involvement have been suggested, including the opportunity to challenge stigmatising attitudes and practices, which are particularly strong within mental health services (e.g., Hamilton & Manias, 2006; Reidy, 1993; Roberts, 2005). One way of doing this may be through user/survivor professionals sharing their personal experiences with colleagues and service users.

The main aim of this research is to explore the following question: *How and why do mental health professionals who have experienced 'psychosis', share their personal experiences in their work?*

Participation will involve an unstructured interview in which three topics will be explored: 1) experiences of sharing personal experiences with colleagues and users; 2) identity and positioning; 3) experiences of stigma/discrimination.

It is not anticipated you will be harmed during this research and space will be given after the interviews to discuss how you have experienced taking part. If you become upset, this space will be used to discuss what to do next (e.g., call a friend).

Confidentiality of the Data
Names and contact details will be kept securely electronically with access restricted to the researcher. All recordings and consent forms will be kept securely (electronically and in a locked cabinet, respectively) and only the researcher will have access to them, whilst identifying information will be removed from transcripts, to ensure confidentiality. Names, contact details and recordings will be deleted at completion of the research.

Disclaimer
You are not obliged to take part in this study and should not feel coerced. You are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

Please feel free to ask me any questions. If you are happy to continue you will be asked to sign a consent form prior to your participation. Please retain this invitation letter for reference.

Thank you.
Rowena Wasyliw

Contact: Rowena Wasyliw – u1037649@uel.ac.uk; Dr Maria Castro– maria2@uel.ac.uk

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor Dr. Maria Castro, School of Psychology, University of East London, Water Lane, London E15 4LZ. 020 8223 4422. maria2@uel.ac.uk
or
Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

References

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Appendix IV – Consent form

Consent Form

Study title:
A narrative study exploring user/survivor professionals' accounts of sharing personal experiences in relation to their work in mainstream mental health services.

Please read the 'Information Sheet' for this research thoroughly before completing this form and ask any questions you may have.

	Please tick
I have read the 'Information Sheet' which outlines the reasons for and the nature of this research and understand this.	☐
I understand the purpose and procedure of the research and what my participation will involve.	☐
I understand my rights as a participant, including my right to withdraw my participation or my data (until three months before submission), to confidentiality and to not be harmed.	☐
I understand that I do not have to participate and that withdrawal of my participation will not affect my rights.	☐
I have been given an opportunity to ask questions and discuss this research.	☐
I consent to participate in this research	☐

Participant name: Date:
Signed:

Researcher name: Date:
Signed:

Appendix V – Interview topic list

Interview Topic List

- **Examples of sharing experiences with colleagues / clients / students / research participants**

- Can you describe the context?
- Why did you share that then?
- How did others respond (colleagues / clients, etc.)?
- What have you found facilitates / prevents sharing?

- **Identity / positioning as user/survivor – professional**

- How do you identify / position yourself?
- Why do you take this position?
- Have you felt other people position you?

- **Experiences of stigma / discrimination**

- Can you describe the context?
- How did you respond?
- Have you experienced stigmatising attitudes or practices change?

Appendix VI – Letters of ethical approval and confirmation of title change

ETHICAL PRACTICE CHECKLIST (Professional Doctorates)

SUPERVISOR: Ken Gannon **ASSESSOR:** Mark Holloway

STUDENT: Rowena Wasyliw **DATE (sent to assessor):** 24/02/2012

Proposed research topic: A narrative study exploring user/survivor professionals' accounts of sharing personal experiences in relation to their work in mainstream mental health services.

Course: Professional Doctorate in Clinical Psychology

1. Will free and informed consent of participants be obtained? **YES** / NO
2. If there is any deception is it justified? YES / NO / **N/A**
3. Will information obtained remain confidential? **YES** / NO
4. Will participants be made aware of their right to withdraw at any time? **YES** / NO
5. Will participants be adequately debriefed? **YES** / NO
6. If this study involves observation does it respect participants' privacy? YES / NO / **NA**
7. If the proposal involves participants whose free and informed consent may be in question (e.g. for reasons of age, mental or emotional incapacity), are they treated ethically? **YES** / NO / NA
8. Is procedure that might cause distress to participants ethical? YES / NO / **NA**
9. If there are inducements to take part in the project is this ethical? YES / NO / **NA**
10. If there are any other ethical issues involved, are they a problem? **YES** / NO / NA

APPROVED

YES	**YES, PENDING MINOR CONDITIONS**	NO

MINOR CONDITIONS: There are two areas of uncertainty for me:

1. My understanding of narrative analysis as a method is that it deals with the stories that emerge from participants and looks at how these stories evolve. This means that narrative analysis should be conducted over time rather than simply providing a snapshot view. I don't see any evidence that this research will be carried out over time ie participants look as though they will only be interviewed once
2. Although the student is quite clear that she does not need ethical approval from the NHS I question this. All participants will be working for the NHS and the research is all about how these professionals who have experienced psychosis share their personal experiences in their work. On this basis I would have thought, therefore, that this research would need to get ethical approval from the NHS.

REASONS FOR NON APPROVAL:

Assessor initials: MH Date: 1.3.12

RESEARCHER RISK ASSESSMENT CHECKLIST (BSc/MSc/MA)

SUPERVISOR: Ken Gannon **ASSESSOR:** Mark Holloway

STUDENT: Rowena Wasyliw **DATE (sent to assessor):** 24/02/2012

Proposed research topic: A narrative study exploring user/survivor professionals' accounts of sharing personal experiences in relation to their work in mainstream mental health services.

Course: Professional Doctorate in Clinical Psychology

Would the proposed project expose the <u>researcher</u> to any of the following kinds of hazard?

1 Emotional YES / **NO**

2. Physical YES / **NO**

3. Other YES / **NO**
(e.g. health & safety issues)

If you’ve answered YES to any of the above please estimate the chance of the researcher being harmed as: HIGH / MED / LOW

APPROVED

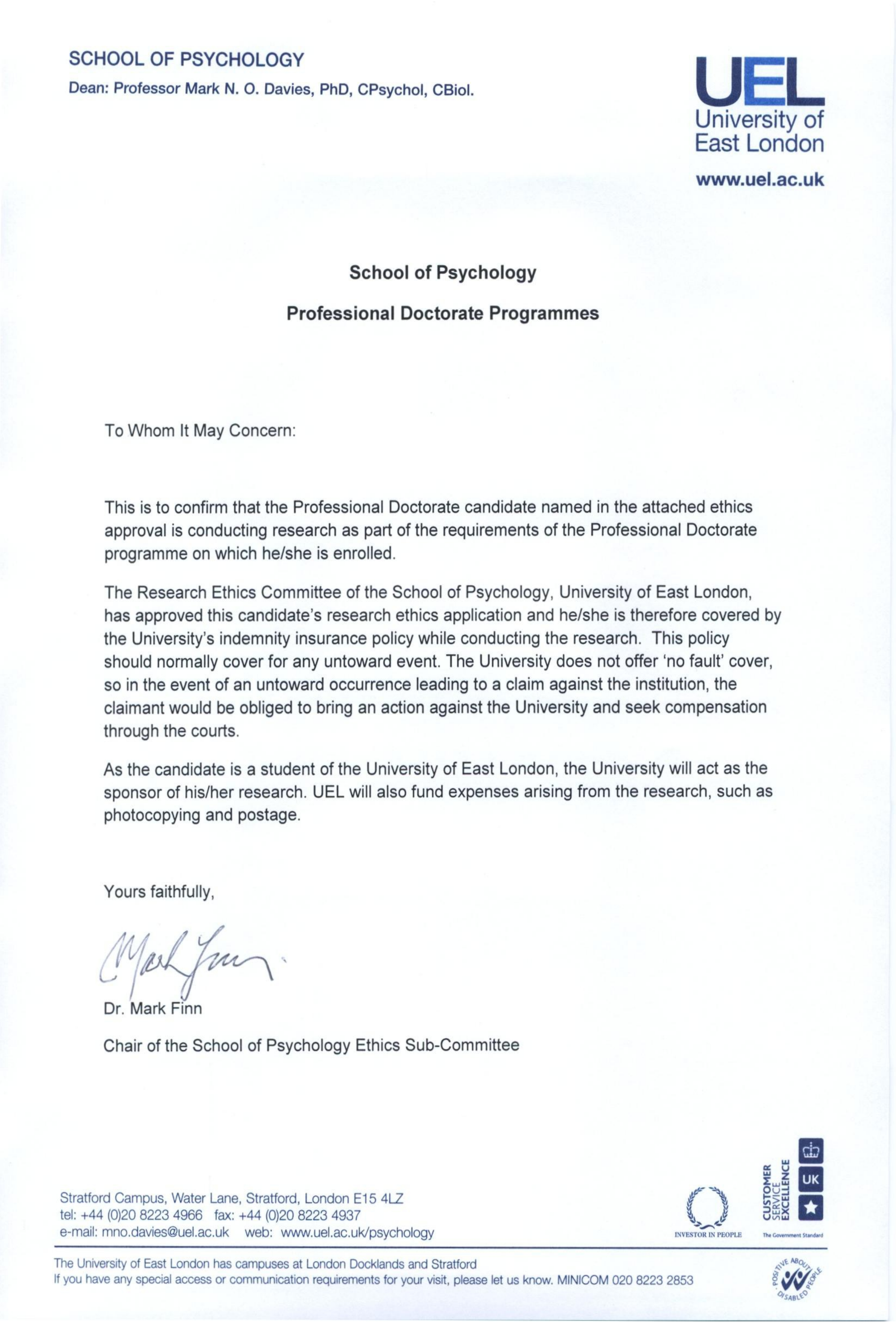
YES	YES, PENDING MINOR CONDITIONS	NO

MINOR CONDITIONS:

REASONS FOR NON APPROVAL:

Assessor initials: MH Date: 1.3.12

Please return the completed checklists by e-mail to the Helpdesk within 1 week.



SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.

UEL
University of
East London
www.uel.ac.uk

School of Psychology

Professional Doctorate Programmes

To Whom It May Concern:

This is to confirm that the Professional Doctorate candidate named in the attached ethics approval is conducting research as part of the requirements of the Professional Doctorate programme on which he/she is enrolled.

The Research Ethics Committee of the School of Psychology, University of East London, has approved this candidate's research ethics application and he/she is therefore covered by the University's indemnity insurance policy while conducting the research. This policy should normally cover for any untoward event. The University does not offer 'no fault' cover, so in the event of an untoward occurrence leading to a claim against the institution, the claimant would be obliged to bring an action against the University and seek compensation through the courts.

As the candidate is a student of the University of East London, the University will act as the sponsor of his/her research. UEL will also fund expenses arising from the research, such as photocopying and postage.

Yours faithfully,

Dr. Mark Finn

Chair of the School of Psychology Ethics Sub-Committee

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The University of East London has campuses at London Docklands and Stratford
If you have any special access or communication requirements for your visit, please let us know. MINICOM 020 8223 2853

SCHOOL OF PSYCHOLOGY
Dean: Professor Mark N. O. Davies, PhD, CPsychol, CBiol.
uel.ac.uk/psychology

UEL
University of
East London

Rowena Wasyliw
6 High Street
Hauxton
Cambs
CB22 5HW

13 June 2014

Student number: 1037649

Dear Rowena

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: A Narrative Study Exploring User/Survivor Professionals' Accounts of Sharing Personal Experiences in Relation to Their Work in Mainstream Mental Health Servies.

New thesis title: A narrative study exploring survivor/service-user professionals' accounts of sharing personal experiences at work.

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

James J. Walsh.

Dr James J Walsh
School Research Degrees Leader
Direct line: 020 8223 4471
Email: j.j.walsh@uel.ac.uk

cc. Maria Castro

Stratford Campus, Water Lane, Stratford, London E15 4LZ
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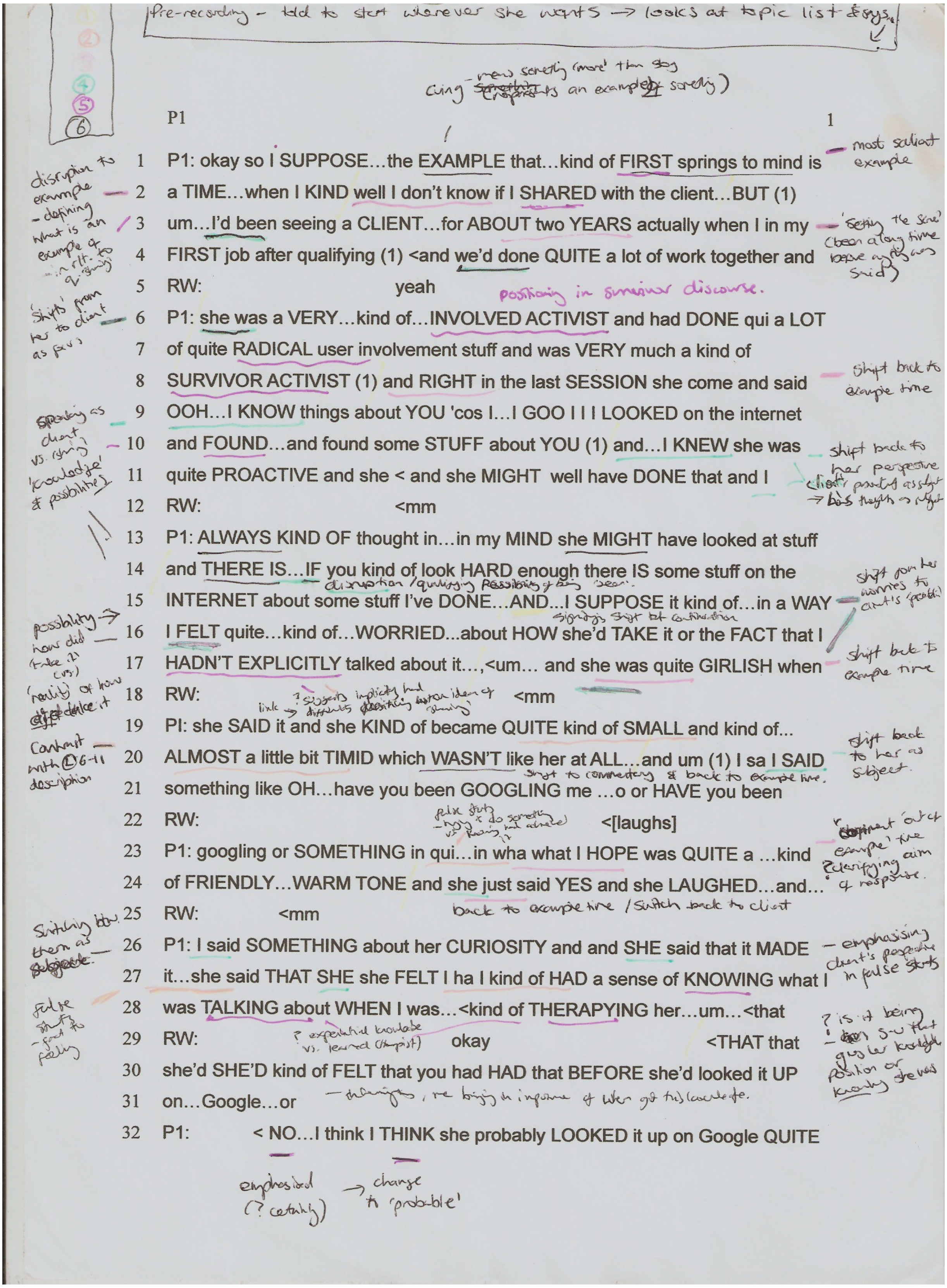
Email: mno.davies@uel.ac.uk

Appendix VII – A worked example of analysis (Laura - sub-narrative I, part I)

Raw transcript



① ② ③ ④ ⑤ ⑥

Pre-recording - told to start wherever she wants → looks at topic list & says

(using ~~something~~ - new something (more than story) (represents an example of something)

P1

1

P1: okay so I SUPPOSE…the EXAMPLE that…kind of FIRST springs to mind is a TIME…when I KIND well I don't know if I SHARED with the client…BUT (1) um…I'd been seeing a CLIENT…for ABOUT two YEARS actually when I in my FIRST job after qualifying (1) <and we'd done QUITE a lot of work together and

RW: yeah

P1: she was a VERY…kind of…INVOLVED ACTIVIST and had DONE qui a LOT of quite RADICAL user involvement stuff and was VERY much a kind of SURVIVOR ACTIVIST (1) and RIGHT in the last SESSION she come and said OOH…I KNOW things about YOU 'cos I…I GOO I I I LOOKED on the internet and FOUND…and found some STUFF about YOU (1) and…I KNEW she was quite PROACTIVE and she < and she MIGHT well have DONE that and I

RW: <mm

P1: ALWAYS KIND OF thought in…in my MIND she MIGHT have looked at stuff and THERE IS…IF you kind of look HARD enough there IS some stuff on the INTERNET about some stuff I've DONE…AND…I SUPPOSE it kind of…in a WAY I FELT quite…kind of…WORRIED...about HOW she'd TAKE it or the FACT that I HADN'T EXPLICITLY talked about it…,<um… and she was quite GIRLISH when

RW: <mm

PI: she SAID it and she KIND of became QUITE kind of SMALL and kind of... ALMOST a little bit TIMID which WASN'T like her at ALL…and um (1) I sa I SAID something like OH…have you been GOOGLING me …o or HAVE you been

RW: <[laughs]

P1: googling or SOMETHING in qui…in wha what I HOPE was QUITE a …kind of FRIENDLY…WARM TONE and she just said YES and she LAUGHED…and…

RW: <mm

P1: I said SOMETHING about her CURIOSITY and and SHE said that it MADE it…she said THAT SHE she FELT I ha I kind of HAD a sense of KNOWING what I was TALKING about WHEN I was…<kind of THERAPYING her…um…<that

RW: okay <THAT that she'd SHE'D kind of FELT that you had HAD that BEFORE she'd looked it UP on…Google…or

P1: < NO…I think I THINK she probably LOOKED it up on Google QUITE

most saliant example

disruption to example - defining what is an example of in rlt. to q. shrg

'Setting the scene' (been a long time before anything was said)

positioning in survivor discourse.

'Shifts' from her to client as focus

Shift back to example time

Speaking as client vs. rshig 'knowledge' & possibilities

shift back to her perspective client's positioning as shift → bias thoughts as reflect

disruption / qualifying Possibility of being 'seen'.

signifying shift but continuation

shift from her worries to client's (possib.)

possibility → how did take it (vs.) 'reality' of how did take it

shift back to example time

link → ? suggests implicitly had difficulties positioning herself around idea of 'sharing'

Contrast with Ⓛ 6-11 description

shift to commentary & back to example time.

shift back to her as subject.

false starts - trying to do something vs. knowing had achieved ??

'comment' 'out of example' time ? clarifying aim of response.

back to example time / switch back to client

Switching btw. them as ~~subject~~

- emphasising client's perspective in false starts

False starts - fact to feeling

? experiential knowledge vs. learned (therapist)

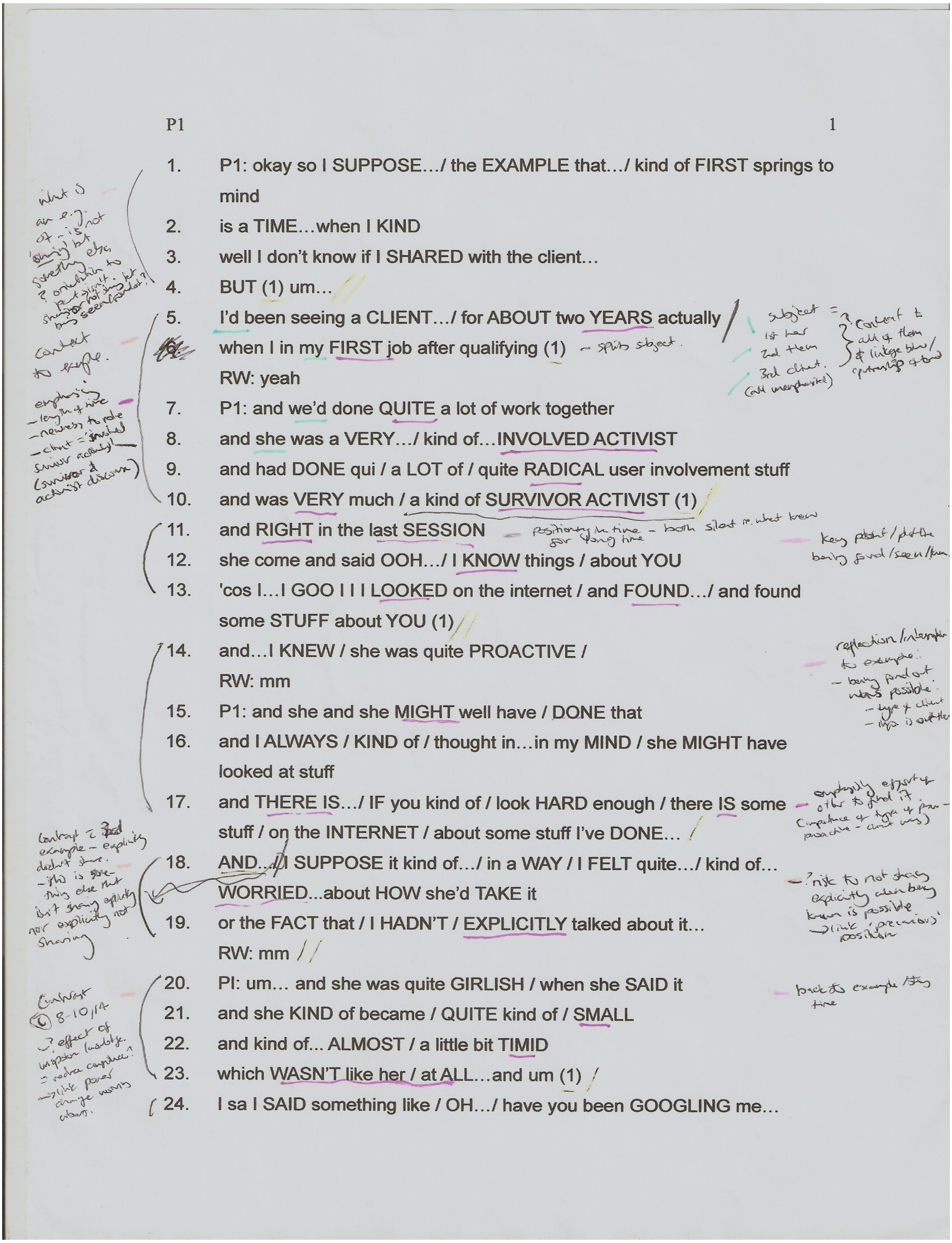
? is it being - seen s-u that gives her knowledge position or knowing she was

- changing, re bringing in importance of when got this knowledge.

emphasised (? certainty) → change to 'probable'

soon on…PROBABLY even BEFORE she came to the FIRST APPOINTMENT to
with ① 3-4 impression of long time keeping & not saying
RW: <oh okay [laughs]
~~[illegible]~~ returning to before interruption
false starts
P1: be honest…um…but YEAH I think it had BEEN kinda and she'd BEEN too
WORRIED about SAYING it and…it was KIND of like…quite a HUMBLING
juxtaposition of perspectives - both worrying re 'it'
RW: <mm
switch to general from specific e.g.
P1: experience 'cos I've ALWAYS...WORRIED about TELLING service users…
contrast hypothetical & 'real'
and it's WEIRD it's a kind of like ACTUALLY it's like…a bit HARD to AVOID 'cos I
evaluation
? links 'working' with inability to avoid
DID MEDIA work so SOMETIMES there was stuff on TELLY …AND WHEN I was
link with ① 14-15 & pattern (implying 'things' for vast idea.
no object back to her as object.
RW: <mm
visibility
new but continued.
P1: DOING that I was WORKING in a ROLE at…MOST of the time when I was
finished context
↓
new example/story
doing that I was working at [MH TRUST] and THERE'S…TIMES…when I was
actually on TELLY one EVENING and then seeing CLIENTS the next DAY…
RW: <yeah
slightly new e.g.
contrast evening & night - visibility & 'hiding' ? - s-u & professionals.
P1: <and there was ONE time where someone just LEFT a…it was a…uh…a
- anonymous subject unemphasized.
Kitkat CHUNKY at RECEPTION for me and said THANK YOU…um WHICH was
switch to evaluation
gratitude / ⊕ emphasised.
REALLY NICE…but the WHOLE kind of BUYING PRESENTS thing was a BIT…
RW: <yeah
? ~~professional~~ professional boundaries discourse - an 'ask'
'general' 'people' are subject - their views on what she's done
P1: kind of AWKWARD…um… so it was KIND of NICE that kind of PEOPLE have
repetition ✱ ? coda to examples of 'feeling ok'
RECOGNISED… that I've DONE STUFF and BEEN PLEASED about it and
RW: <mm
P1: HAVE said THANK you and THAT'S really great that you've DONE that I'm
really GLAD you DID it…um (1) but I've NEVER really kinda TALKED to a client
switch to her as object ✱
qualifying previous statement
link to ① 17 - now is 'hidden' to 'real'
DIRECTLY about my PERSONAL experience of mental HEALTH problems….and
- ? new part (although still linked. → switch from being asked of to being asked / not sharing)
positioning within q - repeats words of q. / study title
SOMETIMES people have kind of ASKED and….and not NOT in TOO MUCH
disruption & false start
switching subjects - generic other / generic e.g.?
detail…because I THINK I probably GIVE OFF quite BRISTLY VIBES about…
contrast with ① 24
RW: <mm <[laughs]
P1: FEELING quite uncomfortable TALKING about it…AND…the MOST I've HAD
switch back to generic e.g. 'when people ask'
to say is something like about OH…we're HERE to talk about YOU and…um…
RW: <yeah
- ? prof-boundary again - taught response.
switch ~~back~~ evaluation of generic example.
P1: that ALWAYS FEELS quite PATRONISING it KIND of like kind of
? contests 'goodness' of her response.
SWITCHING the wha…the FOCUS of the session AROUND and...kind of um…
- ? contesting/resisting prof-boundaries discourse - argument used for not answering q's used here against them. (for answering).
NOT...RESPONDING to someone's QUESTION properly but…I SUPPOSE I kind
? uncertainty
evaluation = no subject, then back to her

Transcribed into idea units and lines



P1 1

1. P1: okay so I SUPPOSE…/ the EXAMPLE that…/ kind of FIRST springs to mind
2. is a TIME…when I KIND
3. well I don't know if I SHARED with the client…
4. BUT (1) um… //
5. I'd been seeing a CLIENT…/ for ABOUT two YEARS actually /
6. when I in my FIRST job after qualifying (1) ~ splits subject.

RW: yeah

7. P1: and we'd done QUITE a lot of work together
8. and she was a VERY…/ kind of…INVOLVED ACTIVIST
9. and had DONE qui / a LOT of / quite RADICAL user involvement stuff
10. and was VERY much / a kind of SURVIVOR ACTIVIST (1) /
11. and RIGHT in the last SESSION
12. she come and said OOH…/ I KNOW things / about YOU
13. 'cos I…I GOO I I I LOOKED on the internet / and FOUND…/ and found some STUFF about YOU (1) //
14. and…I KNEW / she was quite PROACTIVE /

RW: mm

15. P1: and she and she MIGHT well have / DONE that
16. and I ALWAYS / KIND of / thought in…in my MIND / she MIGHT have looked at stuff
17. and THERE IS…/ IF you kind of / look HARD enough / there IS some stuff / on the INTERNET / about some stuff I've DONE… /
18. AND…/ I SUPPOSE it kind of…/ in a WAY / I FELT quite…/ kind of… WORRIED...about HOW she'd TAKE it
19. or the FACT that / I HADN'T / EXPLICITLY talked about it…

RW: mm //

20. PI: um… and she was quite GIRLISH / when she SAID it
21. and she KIND of became / QUITE kind of / SMALL
22. and kind of... ALMOST / a little bit TIMID
23. which WASN'T like her / at ALL…and um (1) /
24. I sa I SAID something like / OH…/ have you been GOOGLING me…

what is an e.g. of - is not 'sharing' but something else ? orientation to part significant sharing or not sharing but being seen/found?

Context to example.

emphasising
- length of time
- newness to role
- client = 'involved survivor activist'!
(survivor & activist discourse)

subject = 1st her 2nd them 3rd client. (all unemphasised)

?Content to all of them & linkage btw / partnership of two

positioning in time - both silent re. what knew for long time

Key point / plot the being found / seen / known.

reflection / interpretation to example:
- being found out was possible.
- type of client
- info is out there

emphasising effort of other to find it (importance of type of person - proactive - client was)

Contrast c̄ 3rd example - explicitly didn't share.
- this is something else that isn't sharing explicitly nor explicitly not sharing

?risk to not sharing explicitly when being known is possible
→ (link 'precarious' position

back to example / story time

Contrast © 8-10, 14
→ ? effect of impression knowledge = reduce confidence?
→ shift power change worry about.

Contrast c 'bigity vibes' Ⓛ 57

~~?~~ – contrast c 'prof. boundaries' response Ⓛ 59

assumptions to ? rectifying effect of not ~~following~~ explicitly.

RW: [laughs]
25. P1: o' or HAVE you been googling / or SOMETHING
26. in qui…in wha what I HOPE was / QUITE a …/ kind of FRIENDLY…/
RW: mm
P1: WARM TONE
27. and she just said YES / and she LAUGHED…
28. and…I said SOMETHING about / her CURIOSITY //
29. and and SHE said / that it MADE it…/ she said THAT / SHE / she FELT
30. I ha I kind of HAD a sense of / KNOWING what I was TALKING about
RW: okay
31. P1: WHEN / I was…kind of THERAPYING her…um/…that
32. RW: THAT / that she'd SHE'D / kind of FELT that / you had HAD that /
BEFORE / she'd looked it UP on…Google…or
33. P1: NO…/ I think I THINK / she probably LOOKED it up on Google /
QUITE soon on…/
RW: oh okay [laughs]
34. P1: PROBABLY / even BEFORE she came / to the FIRST APPOINTMENT
to be honest…um…
35. but YEAH / I think it had BEEN kinda / and she'd BEEN / too WORRIED
about SAYING it and… //

first emphasised subject – client's belief being S-U makes more knowledgeable – ? backs up own views ~~[illegible]~~ later – ? only one with – authority to position in this way = client.

– experiential knowledge largely giving expert status vs. training

– 'doing to.'
– ? separate things, knowledge ~~[illegible]~~ process / S-U & prof. role.

length of time both silent re. this.

impact of knowledge who an S-U or having been an S-U?

? power – unable to say what knew until end of formal rel.

36. it was KIND of like…/
RW: mm
P1: quite a HUMBLING experience
37. 'cos I've ALWAYS…/ WORRIED about / TELLING service users…
38. and it's WEIRD / it's a kind of like ACTUALLY it's like…/ a bit HARD to
AVOID
39. 'cos I DID MEDIA work
RW: mm
40. P1: so SOMETIMES / there was stuff on TELLY … //

both worried re. it. – ? unspoken knowledge/other creates problem

statement of difficulty/issue

visibility – lack control over 'sharing'

emphasised action – ? choosing to share publicly vs not in prof. role

41. AND / WHEN / I was DOING that I was WORKING / in a ROLE at…
42. MOST of the time when I was doing that / I was working at [MH TRUST]
43. and THERE'S…/ TIMES…when / I was actually on TELLY / one EVENING

setting up for 2nd example / story

– emphasising prof. work as a role ? (vs. S-U/person in media work)

generic 'times' to specific 'one time' Ⓛ 45

– contrast evening visibility/sharing publicly vs. day role when not talk (S-U & prof.)

44. and then seeing CLIENTS / the next DAY…

RW: yeah /

2nd example/story (especially here) with anonymous subject

? backs up (+)ive response — to sharing publicly

45. P1: and there was ONE time

46. where someone just LEFT a…/ it was a…uh…a Kitkat CHUNKY / at RECEPTION for me

47. and said THANK YOU…

48. um WHICH / was REALLY NICE…/

similarity to structure of (L)534 — ? not talking due to boundary discourse.

RW: yeah

49. P1: but the WHOLE kind of / BUYING PRESENTS thing /

— prof. boundary discourse. as qualifier to milieu of gratitude (but unemphasised)

~~50.~~ was a BIT…/ kind of AWKWARD…um… //

summing up & starting here — (+) experience disclosure but doesn't talk directly — segue into explaining why doesn't talk directly

51. so it was KIND of / NICE that kind of / PEOPLE have RECOGNISED… /

— qualifier to intents / contrast to 'really nice'

that I've DONE STUFF / — activeness (vs. inactive / not talking directly to clients)

52. and BEEN PLEASED about it /

RW: mm

53. P1: and HAVE said / THANK you / and THAT'S really great / that you've DONE that / I'm really GLAD you DID it…um (1)

difficulty managing gratitude / effect with not talking directly (not sig. new stance).

54. but I've NEVER really kinda / TALKED to a client / DIRECTLY about / my PERSONAL experience / of mental HEALTH problems…. ///

Connects as qualifier

another way not talking is precarious / ineffectual / troublesome.

55. and SOMETIMES / people have kind of ASKED and….

56. and not NOT / in TOO MUCH detail…

orientation to second part — is unhappy with not talking position

RW: mm

57. P1: because I THINK I probably / GIVE OFF / quite BRISTLY VIBES about…/

? not talking due to own discomfort vs. 'inappropriateness' on daily job

RW: [laughs]

P1: FEELING quite uncomfortable / TALKING about it… /

self-disclosure discourse — uses but contests (turning research on its head) — tougher response

58. AND…/ the MOST I've / HAD to say — power of this statement / roles — both parties recog. as stopping the question.

59. is something like about OH…/ we're HERE to talk about YOU and…um…

RW: yeah

60. P1: that ALWAYS / FEELS quite PATRONISING — power.

61. it KIND of like kind of / SWITCHING the wha…/ the FOCUS of the session AROUND and...

62. kind of um…NOT…/ RESPONDING to / someone's QUESTION properly

Transcribed into stanzas, strophes and parts

SUB-NARRATIVE I – A PRECARIOUS POSITION: SHARING / NOT SHARING WHEN IT'S 'OUT THERE'

Part 1 – Worries about sharing with clients (although being 'found' has been positive)

Strophe 1: orientation to part 1 – isn't sharing or not sharing

Stanza 1:- most salient example

1. P1: okay so I SUPPOSE…/ the EXAMPLE that…/ kind of FIRST springs to mind
2. is a TIME…when I KIND
3. well I don’t know if I SHARED with the client…
4. BUT (1) um…

Strophe 2: example – 'survivor activist' client 'found out'

Stanza 2:- positioning self, client and length of time working together

5. I’d been seeing a CLIENT…/ for ABOUT two YEARS actually / when I in my FIRST job after qualifying (1)
   RW: yeah
6. P1: and we’d done QUITE a lot of work together
7. and she was a VERY…/ kind of…INVOLVED ACTIVIST
8. and had DONE qui / a LOT of / quite RADICAL user involvement stuff
9. and was VERY much / a kind of SURVIVOR ACTIVIST (1)

Stanza 3:- client states knowledge of her from internet

10. and RIGHT in the last SESSION
11. she come and said OOH…/ I KNOW things / about YOU
12. 'cos I…I GOO I I I LOOKED on the internet / and FOUND…/ and found some STUFF about YOU (1)

Strophe 3: worries this will happen

Stanza 4:- always a possibility (client 'type' & it's there)

13. and…I KNEW / she was quite PROACTIVE /
RW: mm
14. P1: and she and she MIGHT well have / DONE that
15. and I ALWAYS / KIND of / thought in…in my MIND / she MIGHT have looked at stuff
16. and THERE IS…/ IF you kind of / look HARD enough / there IS some stuff / on the INTERNET / about some stuff I've DONE…

Stanza 5:- worried re response ?to 'deception'

17. AND...
18. I SUPPOSE it kind of…/ in a WAY / I FELT quite…/ kind of… WORRIED...about HOW she'd TAKE it
19. or the FACT that / I HADN'T / EXPLICITLY talked about it…
RW: mm

Strophe 4: trying to respond 'warmly' ? to rectify

Stanza 6:- changed client's assertiveness

20. PI: um… and she was quite GIRLISH / when she SAID it
21. and she KIND of became / QUITE kind of / SMALL
22. and kind of... ALMOST / a little bit TIMID
23. which WASN'T like her / at ALL…and um (1)

Stanza 7:- ? trying to rectify through friendliness

24. I sa I SAID something like / OH…/ have you been GOOGLING me…
RW: [laughs]
P1: o' or HAVE you been googling / or SOMETHING
25. in qui…in wha what I HOPE was / QUITE a …/ kind of FRIENDLY…/
RW: mm
P1: WARM TONE

26. and she just said YES / and she LAUGHED…
27. and…I said SOMETHING about / her CURIOSITY

Strophe 5: knowledge/expertise through s-u position/experience

Stanza 8:- client positioning her as 'knowledgeable'

28. and and SHE said / that it MADE it…/ she said THAT / SHE / she FELT / I ha I kind of HAD a sense of / KNOWING what I was TALKING about
    RW: okay
29. P1: WHEN / I was…kind of THERAPYING her…um…that

Stanza 9:- length of time knowing but not saying

30. RW: THAT / that she'd SHE'D / kind of FELT that / you had HAD that / BEFORE / she'd looked it UP on…Google…or
31. P1: NO…/ I think I THINK / she probably LOOKED it up on Google / QUITE soon on…
    RW: oh okay [laughs]
32. P1: PROBABLY / even BEFORE she came / to the FIRST APPOINTMENT to be honest…um…
33. but YEAH / I think it had BEEN kinda / and she'd BEEN / too WORRIED about SAYING it and…

Strophe 6: media work makes it hard to avoid

Stanza 10:- statement of difficulty

34. it was KIND of like…/
    RW: mm
    P1: quite a HUMBLING experience
35. 'cos I've ALWAYS.../ WORRIED about / TELLING service users…
36. and it's WEIRD / it's a kind of like ACTUALLY it's like…/ a bit HARD to AVOID
37. 'cos I DID MEDIA work /
    RW: mm
    P1: so SOMETIMES / there was stuff on TELLY …

Strophe 7: example – being thanked for media appearance

Stanza 11:- juxtaposition - on telly (visible SU) & with clients (not 'explicit')

38. AND / WHEN / I was DOING that I was WORKING / in a ROLE at…
39. MOST of the time when I was doing that / I was working at [MH TRUST]
40. and THERE'S…/ TIMES…when / I was actually on TELLY / one EVENING
41. and then seeing CLIENTS / the next DAY…
    RW: yeah

Stanza 12:- was nice (but awkward) when left present saying thank you

42. P1: and there was ONE time / where someone just LEFT a…/ it was a…
    uh…a Kitkat CHUNKY / at RECEPTION for me
43. and said THANK YOU…
44. um WHICH / was REALLY NICE…
    RW: yeah
45. P1: but the WHOLE kind of / BUYING PRESENTS thing / was a BIT…/
    kind of AWKWARD…um…

Strophe 8: segue between parts 1 and 2

Stanza 13:- clients/SUs are pleased but she 'never talks directly' (?issue)

46. so it was KIND of / NICE that kind of / PEOPLE have RECOGNISED… /
    that I've DONE STUFF /
47. and BEEN PLEASED about it /
    RW: mm
48. P1: and HAVE said / THANK you / and THAT'S really great / that you've
    DONE that / I'm really GLAD you DID it…um (1)
49. but I've NEVER really kinda / TALKED to a client / DIRECTLY about / my
    PERSONAL experience / of mental HEALTH problems….

<u>Part 2 – Reasons for not sharing with clients</u>

Strophe 9: orientation – unhappiness with position of not talking

Appendix VIII – Sub-narratives, parts and strophes: Laura

Table 3. Sub-narrative I: A precarious position; sharing / not sharing when it's 'out there'

	Parts						
	Part 1: Worries about sharing with clients, (although 'being found' has been positive)	***Part 2:*** Reasons for not sharing with clients (& conflict in position)	***Part 3:*** Disclosing to colleagues to impress (doesn't always work)	***Part 4:*** Value to colleagues as a resource	***Part 5:*** Worries colleagues treat her differently	***Part 6:*** 'Being out' as a trainee	***Part 7:*** Difficulties having SU and professional 'parts' equally
Strophes	*Strophe 1:* Orientation to part 1 – isn't 'sharing' or 'not sharing'	*Strophe 9:* Orientation - unhappiness with position of not talking	*Strophe 16:* Orientation – 'sharing with colleagues'	*Strophe 23:* Orientation – colleagues ask questions 'only know being a SU'	*Strophe 26:* Orientation – worry 'go more easily' on her as have been flexible	*Strophe 31:* Orientation – (R asks about previous roles) 'disclosing' at beginning of training	*Strophe 40:* (R suggests 'trade-off') hard to 'have them both equally', 'lose-lose'
	Strophe 2: Example – 'survivor activist' client 'found out'	*Strophe 10:* Example – a client 'specifically haven't shared with'	*Strophe 17:* Example – 'disclosing' to colleague (? knew from others)	*Strophe 24:* Example – asked how medication can help	*Strophe 27:* Is it unfair? (is the worry colleagues will think it is?)	*Strophe 32:* Example – 'justifying' being on the course after disclosed	*Strophe 41:* Contradictory example – thanked for talking as psych and SU
	Strophe 3: Worries this will happen	*Strophe 11:* Reasons for not sharing	*Strophe 18:* Not planned, 'hoping to impress'	*Strophe 25:* Nice to be a resource / different perspective that's valued	*Strophe 28:* The team know / is 'quite open'	*Strophe 33:* Always felt different as first involved with course through UI	*Strophe 42:* Contrasting example – contacted by psych unable to reveal SU position
	Strophe 4: Trying to respond 'warmly' *? to* rectify	*Strophe 12:* Unhappiness with sharing & with not sharing	*Strophe 19:* Countering view of her as 'psychologist not accepting referrals		*Strophe 29:* Is lucky are supportive but also honest	*Strophe 34:* Was open about this and always/often 'carried sense of tokenism'	*Strophe 43:* Should be able to be more confident in NHS colleagues
	Strophe 5: Knowledge/expertise through s-u position/experience	*Strophe 13* Not fitting into either camp	*Strophe 20 :* Wanted to make impact but didn't really respond		*Strophe 30:* Did get 'annoyed' had flexibility for 'non-MH' needs	*Strophe 35:* (R probes) also influenced by 'imposter syndrome' & difficult cohort dynamics	
	Strophe 6: Media work makes it hard to avoid	*Strophe 14:* Coda – uncertainties stop her sharing but media work makes this precarious	*Strophe 21:* Non-response maybe a legacy of UI work			*Strophe 36:* Always feeling 'out on the edge' due to 'own stuff' & context	
	Strophe 7: Example – being thanked for media appearance	*Strophe 15:* Segue – example being recognised by colleague (? due to media work)	*Strophe 22:* Awareness of interview / feels discontinuous ('jumping round a lot')			*Strophe 37:* Actually didn't 'walk into it' (but feeling remained)	
	Strophe 8: Segue – clients/SUs are pleased but she 'never talks directly' (?issue)					*Strophe 38:* Contrasting example – 'quite out' by end / encouraged to talk more after presented	
						Strophe 39: Worries others then think she isn't a 'proper psychologist'	

Table 4. Sub-narrative II: A chameleon-like position

	Parts			
	Part 1: A chameleon-like position (not a poster girl)	***Part 2:*** Oscillating between intuition & theory	***Part 3:*** A campaigner (vs. activist) in 'changing systems'	***Part 4:*** 'Being open' in the media is trying to change a system
Strophes	*Strophe 1:* R (ref. S-n 1,str. 21) asks about hearing other SU professionals talk re their experiences	*Strophe 8:* Experience 'fleshes out' what taught, gives confidence	*Strophe 13:* R (ref. different terminology L. used), asks re thoughts on 'different labels / names'	*Strophe 23:* Being open' in the media was a way of trying to change a system – how MH is reported
	Strophe 2: Good to hear but 'intimidating' – pressure to be a 'maverick' / 'poster girl'	*Strophe 9:* Overcompensate using intuition with overly 'logical & planned' - oscillate	*Strophe 14:* Leans towards 'SU' – influence of first service worked in	*Strophe 24:* Example – pejorative reporting, no rights once it's written
	Strophe 3: doesn't have 'way of situating' herself, is being 'chameleon-like'	*Strophe 10:* R clumsily probes origins of idea 'intuition is bad'' – introduces 'completely intuitive'	*Strophe 15:* Critiquing 'patient' ('last thing you feel') and 'illness' (vs. 'state of being')	*Strophe 25:* Normality of getting a variety of responses
	Strophe 4: 'Theme' among SU professional friends 'have more to prove'	*Strophe 11:* Example – 'very anti' MH services friend thinks 'just tell stories about myself and they'll feel better'	*Strophe 16:* Comical analogy – woodlice consumers of Rent-A-Kill (services quite toxic)	
	Strophe 5: Having a consistent position would alienate half social & work circle	*Strophe 12:* Wanting to avoid 'whole intuitive end that I'll just tell them about me-me-me' (?conflated in interview)	*Strophe 17:* Hatred of 'case' & 'that approach to thinking about people'	
	Strophe 6: Example – avoiding being positioned by others (bring extra stress and strain)		*Strophe 18:* 'Survivor' is 'brave and fighty' but what of those 'who fall by the wayside'	
	Strophe 7: Particularly difficult taking SU role with 'expert' practitioners & academics		*Strophe 19:* 'SU' is ‘popular’ & 'clients' is 'more respectful'	
			Strophe 20: Positions self as a 'campaigner' - not 'confident enough' to 'fully be an activist'	
			Strophe 21: Difficulties being activist / changing system from within	
			Strophe 22: Segue – that's just the immediate team, there are wider systems	

Table 5. Sub-narrative III: Stigma/discrimination: Barriers and reasons for disclosure

	Parts						
	Part 1: Being positioned as both	***Part 2:*** Disclosing to counter stigma/ discrimination	***Part 3:*** Responses of supervisors during training	***Part 4:*** Service-users: 'you're not one of us'	***Part 5:*** Not want 'bad day' = 'she's ill'/'can't cope'	***Part 6:*** Improvements and current issues	***Part 7:*** Context impacts on sharing
Strophes	*Strophe 1:* Orientation – never had 'outright discrimination' (as a professional)	*Strophe 9:* Orientation – sometimes 'disclosed' to try to 'counter people's discrimination'	*Strophe 15:* Example – disclosing to first supervisor who said she 'shouldn't' as 'made him think about her differently	*Strophe 22:* Orientation – can be difficult with SUs / doesn't want to act like 'owns the place'	*Strophe 27:* Example – colleague 'quite open' with clients	*Strophe 30:* Orientation – experiencing stigmatising attitudes / practices change	*Strophe 36:* Orientation – what facilitates and prevents sharing (should benefit both)
	Strophe 2: Working hard to disprove incompetence / anti-meds assumptions	*Strophe 10:* Example – how friend does it (when being derogatory - 'in your face'/silencing)	*Strophe 16:* Contests this – sup. should be more thoughtful how situates people	*Strophe 23:* Example – SU directing anger at her, saying 'never know what is like to be one of us'	*Strophe 28:* Is more 'open'/ 'permissive' than colleagues and share only what have coped with	*Strophe 31:* Example – UI job – from 'scepticism' to 'commonplace' over 6 years	*Strophe 37:* Seeing it as 'non-damning feature', disclosing 'off-hand' / 'jokey'
	Strophe 3: Does have 'bit to contribute' to 'medication debate' as been on them a long time	*Strophe 11:* Contrasting example – L does it 'subtly' & humorously, to raise hope	*Strophe 17:* Example – made her not tell second supervisor for longer – told should have said sooner 'of course psychs wouldn't mind'	*Strophe 24:* Dynamic as others 'knew she kind of did' but didn't want to say / let SU 'discharge'	*Strophe 29:* Not want 'bad days' seen as ill / always wanting to seem in control	*Strophe 32:* Challenging accepted notions of 'us-&-them' makes people uncomfortable	*Strophe 38:* Can go wrong – 'difficult day' wouldn't talk about it
	Strophe 4: Example – sharing experience of taking meds with client whose job was threatened by not taking them	*Strophe 12:* 'Weird' (dilemma) – is psych because of experience 'being mad' but 'often last thing will talk about with anybody'	*Strophe 18:* Is no 'evidence-based disclosure policy' so brings up 'personal opinion' / 'expert vs. SU power differentials'	*Strophe 25:* Questions whether she is 'representative' of clients (more privileged / less unwell)		*Strophe 33:* Example – colleague 'politically right on' but not in other ways	*Strophe 39:* Dilemma (“weird”)- supposed helpfulness of talking to MH profs vs. hiding it to 'seem professional'
	Strophe 5: Only experience 'talking directly' & thinking 'helped me, might help you'	*Strophe 13* Team says it's “really good” to have “psych SU” but not want to hear details / not make difference to them	*Strophe 19 :* Final placement 'disclosed soon-on' but was having problems / life events happening & medication change	*Strophe 26:* (R asks) was tempted to say but not helpful		*Strophe 34:* 'Odd' as were also colleagues - struggling to 'position' employed SUs	*Strophe 40:* Example – impact of psych seated outside MDT - 'banter'
	Strophe 6: Doesn't know what decision client made, ended up doing well and remembering conversation later	*Strophe 14:* Example – colleague expressed 'surprise', because she ‘seemed so confident'	*Strophe 20:* Example – having 'bad day', supervisor 'reassured' then 'checked up' on work			*Strophe 35:* Helpful us-&-them boundaries blurring (conflict – prof training needed)	*Strophe 41:* Example – 'bad feeling' as psych has more autonomy
	Strophe 7: Example – being thanked for media appearance		*Strophe 21:* Would 'you' question someone's ability if having bad day from ‘non-MH’				*Strophe 42:* Being psych & SU, not know which causes it
	Strophe 8: 'Sense of' other people positioning her as 'being in both camps'						*Strophe 43:* 'Pointing to' emotional effect can get barriers removed
							Strophe 44: Coda

Table 6. Sub-narrative IV: Natural to do user involvement

	Parts	
	Part 1: Own experience makes UI essential	***Part 2:*** This is just the start
Strophes	*Strophe 1:* Orientation – user involvement (UI)	*Strophe 5:* Is psychologist because of being SU but that's different to UI
	Strophe 2: Personal experience makes impossible not to do UI – 'just where she's come from'	*Strophe 9:* Makes it 'natural' to do UI, but is 'just the start' of involving people
	Strophe 3: Gives more focus / confidence doing UI – colleagues see her as 'expert' in UI	*Strophe 10:* End of interview
	Strophe 4: 'Doesn't make sense not to' do UI, is not 'a luxury'	

Appendix IX – Sub-narratives, parts and strophes: Christine

Table 7. Sub-narrative I: Being able to share has changed over time

	Parts					
	Part 1: Becoming an academic & service-user	***Part 2:*** Being 'a community mental patient'	***Part 3:*** Getting a PhD	***Part 4:*** The survivor movement / UI leads back to the academy	***Part 5:*** Returning to 'the academy'	***Part 6:*** Conclusion – present day
Strophes	*Strophe 1:* Orientation – an 'historical' account; being able to share has changed	*Strophe 6:* Orientation – spent years as 'community mental patient'	*Strophe 9:* 'Nervousness' of her, made do Masters – studying things had taught	*Strophe 12:* Orientation: institutions closing enabled SUs to organise	*Strophe 27:* A dream come true (almost didn't due to SUs) being 'back in the academy'	*Strophe 36:* Promotions have brought 'a lot more power'
	Strophe 2: Became academic and SU 'at same time'	*Strophe 7:* Struggled with becoming 'anti-intellectual' / seeing relevance to real-life	*Strophe 10:* Supervisor 'thought she'd never get a job' but did – funded her PhD	*Strophe 13:* Became involved in survivor movement at beginning	*Strophe 28:* Boss is supportive but it's a tough environment – have to perform	*Strophe 37:* A longer-taking success (with troublesome everyday life)
	Strophe 3: Not disclose in job (14 years) – contrast 'work' & SU experiences	*Strophe 8:* Segue – motivated her to enrol for a PhD	*Strophe 11:* Wanted to do 'something on MH' but nothing 'too close to home'	*Strophe 14:* User group research allowed her to use her skills again (though basic)	*Strophe 29:* Manager questioned ability at first but kept her on	*Strophe 38:* 'Up-side to mania' having energy (?to cope with demands)
	Strophe 4: Colleagues 'not supportive' once 'impossible to hide'			*Strophe 15:* Lead to making contact in charity	*Strophe 30:* Example – told 'not allowed' to attend meeting (but did and was fine)	*Strophe 39:* Conclusion – 'that's the narrative'
	Strophe 5: Medically retired; 'on the scrap heap' / out of academia			*Strophe 16:* Contrast resources then vs. now lost funder	*Strophe 31:* Still happens but ignores as can function	
				Strophe 17: Offered research job at charity	*Strophe 32:* Example – 'most recent'; 'special' policy group evenly split prof.s/SUs	
				Strophe 18: DoH getting interested in UI – wanted SU interviewers	*Strophe 33:* Sustained visible injury from side-effects of meds	
				Strophe 19: Turned research into method of peer evaluation	*Strophe 34:* 'Forbidden' from attending 'looking like that' (but did – supportive environment)	
				Strophe 20: Gathered interested SUs and trained them	*Strophe 35:* (Broadens) people 'too over-protective' / 'worried re their reputation'	
				Strophe 21: Recog. need to make research 'relevant to people's experience'		
				Strophe 22: Rolled out nationally / internationally, others doing user-led research		
				Strophe 23: 'Little changes in policy' meant 'disclosing became an asset'		
				Strophe 24: Boss (?) was supportive during ill health		
				Strophe 25: Boss wrote an article about her MH experience		
				Strophe 26: Segue - head-hunted for job at university		

Table 8. Sub-narrative II: 1970s era context

	Parts		
	Part 1: Colleagues' unhelpful stereotypes	***Part 2:*** 'Just didn't' tell in 1970s	***Part 3:*** People's world views – blame the individual
Strophes	*Strophe 1:* Orientation - (R asks for) examples of ‘unsupportive’ / ‘strange’ response	*Strophe 4:* Never told students whilst were students, some told after	*Strophe 7:* Had unhelpful intensive psychoanalysis as others thought she should
	Strophe 2: Colleagues – ‘putting it on’/’get act together’; students – ‘baffled’	*Strophe 5:* ‘Just didn’t’ tell anyone in 1970s	*Strophe 8:* Others wouldn’t believe analyst had stopped it
	Strophe 3: ‘Mental illness means you’re weak’ stereotype, wasn’t helpful	*Strophe 6:* Knew something as saw self-harm marks – ‘was visible’	*Strophe 9:* Validity/truthfulness of her side – analyst confirmed
			Strophe 10: If believe is positive, must be her fault if isn’t, as ‘so in own worldview’

Table 9. Sub-narrative III: Life experiences create identity

	Parts		
	Part 1: Difficulties being ‘out’ / an SU researcher	***Part 2:*** Importance of other experiences	***Part 3:*** Position self as ‘both’, others position as one or other
Strophes	*Strophe 1:* Orientation – being ‘out’ is the point of holding current position	*Strophe 4:* ‘We fail’ people who ‘never move into’ SU researcher role	*Strophe 12:* Orientation – positions self as ‘both’ SU & researcher as ‘SU researcher’
	Strophe 2: Difficult for SU researchers always being identified by others as SU	*Strophe 5:* Do well if already political - raise experience to level of abstraction of ‘social justice’	*Strophe 13:* Example – explaining to journalists it’s ‘multiplicative not additive’
	Strophe 3: Example – colleagues alternating identification / distance to ‘SU’ position	*Strophe 6:* If don’t, not comfortable in (& shouldn’t be in) SU researcher environment	*Strophe 14:* ‘Problem’ – SU identify her as researcher, scientists as SU
		Strophe 7: Only certain life experiences prepares you for ‘survivor researcher’ position	*Strophe 15:* ‘Very different’ problem than in past when ‘not willing’ be positioned having ‘anything to do with MH’
		Strophe 8: Example – ‘trad. mid.-class’ person viewing SU research as ‘ghettoisation’	*Strophe 16:* Example – being positioned as SU (when wanting to use SU-researcher knowledge)
		Strophe 9: Example – hearing someone talk re awful treatment in A&E as human rights abuse	*Strophe 17:* Example – ‘curiosity’ leading to colleague ‘practically giving MMSE’ at a party
		Strophe 10: Exposure to politics/civil rights = primed to see it that way (others would believe A&E view)	*Strophe 18:* Example - seen by some in SU / survivor community as ‘collaborator’
		Strophe 11: Coda - SU experience on own says nothing – what else has gone on leads to how position / identity selves.	*Strophe 19:* Coda – isn’t easy but easier than being ‘community mental patient’

Table 10. Sub-narrative IV: Civil rights & social structures

	Parts		
	Part 1: ‘Discrimination’ vs. ‘civil rights violation’	***Part 2:*** Impact of recession / cuts	***Part 3:*** Have to be able to ‘tough it out’ /(‘up-side’ of bipolar)
Strophes	*Strophe 1:* Orientation - R asks further explain relationship between stigma, identity and sharing	*Strophe 8:* R asks anything else contributes to attitudes/practices changing	*Strophe 13:* (’Up-side of bipolar’) Have to be able to ‘tough it out’
	Strophe 2: Example (context) –prestigious academic press conference re discrimination	*Strophe 9:* (‘Done my bit) Positioning response as ‘from research’	*Strophe 14:* Example – have to manage very heavy workload
	Strophe 3: Contrasting examples given by C (from her research) & manager (from C’s experience)	*Strophe 10:* Anti-stigma campaigns have modest effects, reversed by recession	*Strophe 15:* Has ‘done enough’ but ‘likes developing people’
	Strophe 4: Example manager gave (from ‘c.m.p.’ chapter) – home trashed by a neighbour	*Strophe 11:* Example – competitiveness of academic job market	
	Strophe 5: Would not go to court as being SU made her an ‘non-credible witness’	*Strophe 12:* Impact of government cuts lied about by politicians	
	Strophe 6: Not ‘just discrimination’ but ‘civil rights violation’		
	Strophe 7: (R asks) ‘Worst’ experience at work = teaching colleagues ‘pull yourself together’ reaction		

Table 11. Sub-narrative V: Challenges & advantages to SU researchers

	Parts	
	Part 1: ‘Mixed evidence’ re impact of SU researchers	***Part 2:*** Research power structures limit effect
Strophes	*Strophe 1:* Orientation – (R asks) is ‘mixed evidence’	*Strophe 4:* Has experienced being questioned as SU and participants forgetting was also an SU
	Strophe 2: Quantitative – no difference, qualitative – difference in data gathered & interpretation	*Strophe 5:* Even if do disclose, cannot remove research power structure – are still the researcher-participants
	Strophe 3: ‘Anecdotal feeling’, disclosing changes atmosphere of focus groups	*Strophe 6:* Other factors contribute to power relationship e.g., age

Table 12. Sub-narrative VI: Comparison with other participants

	Parts		
	Part 1: Orientation –other participants	***Part 2:*** Being positioned as a clinician / 'more sympathetic '	***Part 3:*** Professionals dividing 'psychosis' - 'neurosis'
Strophes	*Strophe 1:* Orientation – curious about who else is interviewed	*Strophe 3:* Positioned as a 'clinician' by colleagues struggling (with MH)	*Strophe 11:* OH dr's assumptions – others 'mostly anx. & dep.', 'not like them'
	Strophe 2: Likely to talk about 'recovery' (a 'meaningless buzzword')	*Strophe 4:* Shares her experience with them to try to help them feel better	*Strophe 14:* Assumption only 'common MH problems' if working in research dpt.
		Strophe 5: Tell her as manager, expect 'more sympathetic' as SU	
		Strophe 6: Example – wasn't sympathetic when someone 'so psychotic' they 'caused havoc'	
		Strophe 8: 'Put in the hands' of OH to send off	
		Strophe 9: Wasn't the 'right place' for them – wanted support group	
		Strophe 10: Academic environment – have to perform ('cut-throat')	

Appendix X – Sub-narratives, parts and strophes: Bethany

Table 13. Sub-narrative I: Having to disclose & effects of disclosing

	Parts						
	Part 1: Orientation – not wanting to disclose but having to	***Part 2:*** Background to 'breakdown'	***Part 3:*** Breakdown led to acceptance was ill not neurotic	***Part 4:*** Subsequent situation being taunted by colleagues	***Part 5:*** (Not) being believed – all seen as illness	***Part 6:*** Questioning appropriateness of sharing with clients	***Part 7:*** Not knowing who knows what
Strophes	*Strophe 1:* Clarifying what wanted in interview (example of sharing)	*Strophe 3:* Orientation – background to 'breakdown'	*Strophe 11:* That's when (eventually) managers 'accepted her illness'	*Strophe 16:* Orientation – complication – colleagues now taunting her or illness?	*Strophe 29:* Had a 'fresh start' working different ward after breakdown	*Strophe 44:* Orientation – (R asks about) doesn't talk to clients about it but more understanding where coming from	*Strophe 47:* Orientation – (R asks re why) thinks other colleagues not want to listen
	Strophe 2: 'Having to tell' managers 'springs to mind' (would not have chosen to)	*Strophe 4:* Being diagnosed with adult ADD 'answered q.s'	*Strophe 12:* Even then, took husband (MH prof) explaining ('he they believed')	*Strophe 17:* Thinks is 'genuine' with two colleagues	*Strophe 30:* Was supportive as thought about her needs	*Strophe 45:* Maybe isn't appropriate / what clients want to hear	*Strophe 48:* Regrets having said things – now doesn't but 'it's out there'
		Strophe 5: Put on multiple medications – side-effect being agitated	*Strophe 13:* Took the crisis 'to be believed' – that was the context	*Strophe 18:* Could 'all be illness', 'hard to know'	*Strophe 31:* Can talk to manager when feel 'got at' – responds well '	*Strophe 46:* Contrast self with 'quite open' colleague	*Strophe 49:* 'Lack control' – don't know who knows what (people talk)
		Strophe 6: Was in very stressful work environment (secure ward)	*Strophe 14:* (R asks what shared) Shared diagnosis with managers	*Strophe 19:* Used to be 'everybody', now is specific two people	*Strophe 32:* Being believed is really important – confusion whether manager does		*Strophe 50:* Can't have 'natural relationship' with them due to these thoughts/anger
		Strophe 7 Returned from maternity leave – consultant made it hard to do her job	*Strophe 15 :* Mangers were (?) more sympathetic after (gave time off to recover)	*Strophe 20:* Is 'sure' is 'some reality' but husband thinks it's illness	*Strophe 33:* May be more sensitive/getting unwell but 'definitely' something there		*Strophe 51:* Example – apologised to colleague & had 'emotional outpouring'
		Strophe 8: 'Struggled on' with all these pressures until husband went away (lost support)		*Strophe 21:* Has been 'quite open' re paranoia – now feels colleague 'tests her'	*Strophe 34:* (R raises) clarification what is believed – that she's upset/ill not what's happening (dilemma)		*Strophe 52:* Led to brief change in behaviour (suggested was deliberate)
		Strophe 9: 'Catalyst' for illness was 'medication -induced hypomania' becoming 'full psychosis'		*Strophe 22:* Example – 'intrusive' behaviour daily	*Strophe 35:* ? attempted resolution – maybe wouldn't be inappropriate if wasn't ill		*Strophe 53:* Example – started up again
		Strophe 10: Example – 'total psychotic madness'; paranoid re colleagues		*Strophe 23:* Feels is to 'test her', husband says it's her 'interpretation'	*Strophe 36:* Maybe others would like it		*Strophe 54:* Initially trying to 'smooth over' (after outburst) then annoyed
				Strophe 24: Example – derogatory way spoke about pts. to her	*Strophe 37:* 'Think' to 'must' have known her MH history		*Strophe 55:* Is trying to get her to respond (sometimes succeeds)
				Strophe 25: Feels like 'reference to her' as not how expect to talk	*Strophe 38:* How expect behave (if integrity) vs. how do		*Strophe 56:* Is different to how other colleagues behave
				Strophe 26:	*Strophe 39:*		*Strophe 57:*

Never knows – hard to determine what's reality	Difficulty maintaining boundary - 'knows is real' but others 'attribute all to illness		R summary - not 'choosing' but info comes out and is there
Strophe 27: Feels it is real as is pattern to how they do it	*Strophe 40:* (R clarifying who) everyone speaks to about it / managers		*Strophe 58:* Example – not knowing how much colleagues know
Strophe 28: Coda	*Strophe 41:* Maybe they don't think they're doing it		*Strophe 59:* Apologises to colleagues for alternating 'over-friendly' – 'frosty'
	Strophe 42: Has she been 'formally' discriminated about?		*Strophe 60:* Thinks they monitor how she is
	Strophe 43: 'Hard to say' – managers vs. colleagues		*Strophe 61:* Example context of hormone changes due to health treatment
			Strophe 62: Example – 'natural flirtatious banter' with colleague – others commented
			Strophe 63: 'Sounds ridiculous' / 'like illness' but think was deliberate jibe
			Strophe 64: An example of being talked about – mind gets muddled thinking about it
			Strophe 65: Coda – others doubt her, she is convinced.

Table 14. Sub-narrative II: Benefits & disadvantages of, & contesting, diagnosis

	Parts						
	Part 1: Orientation – help from diagnosis vs. detach from it	***Part 2:*** Colleagues must know something	***Part 3:*** Being open & questioning the diagnosis	***Part 4:*** Fear & aggression – response to ADD diagnosis maybe led to breakdown	***Part 5:*** Discrimination & being believed was 'ill' not 'work-shy'	***Part 6:*** Service-users: knowledge, empathy and revulsion	***Part 7:*** Conclusion / ? solution: forging a new identity
Strophes	*Strophe 1:* R raises 'identity/positioning' – B. distinguish 'in terms of job or illness'	*Strophe 4:* Example –'inappropriate' being on EPR & a prof. – anyone could see	*Strophe 6:* Contrast – 'open' friend; more healthy, respectable, admirable (but she detaches)	*Strophe 11:* R (ref. manager's response) – experiences of being positioned	*Strophe 20:* R q. previous 'not discriminated against' ('probably did in early stages')	*Strophe 28:* Orientation – R asks re possible rlt btw OT identity and SU experiences	*Strophe 39:* Orientation – now trying to 'forge a new identity' / 'era of wellness'
	Strophe 2: R clarifies – interaction, terminology, an SU in services	*Strophe 5:* Living & working in same HA – colleagues must know something	*Strophe 7:* Doesn't because thinks people don't want to hear	*Strophe 12:* Doesn't know as don't know what people know	*Strophe 21:* Related to defending herself during investigation	*Strophe 29:* Maybe gives/enhances empathy	*Strophe 40:* Now thinks meds caused psychosis – if successfully come off may be 'a person without a mental illness'
	Strophe 3: At times want 'help/explanation from diagnosis', at others 'detach self from it'		*Strophe 8:* Struggle with acceptance of / questions illness (not been as unwell as friend)	*Strophe 13:* Example – colleagues being more sympathetic (not know what known)	*Strophe 22:* Response due to lack of clear policies in place for OT work	*Strophe 30:* Example – contrast 'prof' learning vs. from experience	*Strophe 41:* How will she be not in extremely stressful and demanding NHS job
			Strophe 9: Whether was ill before, is now caused by colleagues' beh. (husband not agree)	*Strophe 14:* Generally, managers (who she knows know) are supportive	*Strophe 23:* Became 'quite nasty', maybe explains antagonism	*Strophe 31:* Experience challenged teaching re what helps	*Strophe 42:* Looking forward to not working / taking meds – wonders if will be okay
			Strophe 10 : Is a degree of her that questions the second diagnosis	*Strophe 15:* 'Nightmare' investigation over an error was 'catalyst for whole thing'	*Strophe 24:* Took breakdown to believe was ill / stop seeing as 'difficult' (despite crying daily)	*Strophe 32:* Working on new ward gave some detachment / separation	*Strophe 43:* Coda – being ill and work and so related – interesting see who she is without that
				Strophe 16: Fearful response to ADD diagnosis – was 'scrutinised'	*Strophe 25:* 'Nightmare mix' with hormone treatment and meds (?q. 'ill')	*Strophe 33:* Reasserts R's q	
				Strophe 17: ? more fearful response to ADD diagnosis	*Strophe 26:* Breakdown = catalyst for seeing 'true self' vs. 'work-shy'	*Strophe 34:* R summarises liking separation but influences how work - Experiences make who you are	
				Strophe 18: In retrospect, had been ill/bumbling on for a while	*Strophe 27:* Catalyst due to diagnosis or husband's intervention?	*Strophe 35:* Difficulty – some ways empathic, sometimes (?too similar) 'repulsed	
				Strophe 19: Was context – 'strict' manager affected how her managers dealt with her		*Strophe 36:* Awareness of audience judgement – 'sounds awful'/doesn't affect practice	
				Strophe 20: Feels like 'reference to her' as not how expect to talk		*Strophe 37:* Example – sounds like her (refusing meds) makes her want to stay on them	
				Strophe 21: Led to 'really aggressive' response		*Strophe 38:* Coda – 'definitely true' are 'associations' of not want-	

		ing to be ‘this psychotic person’
	Strophe 22: ‘Unhealthy hierarchies’ cause ‘chaos & misunderstanding’	
	Strophe 23: Coda – hard to get a ‘sensible reaction’ at first, just ‘lots of fear’	

Appendix XI – Sub-narratives, parts and strophes: Ian

Table 15. Sub-narrative I: Is he open, does he want to be?

	Parts					
	Part 1: Having to share, pretending he is open	***Part 2:*** Positions taken / experiences as a student	***Part 3:*** A helpful manager	***Part 4:*** Impact of hearing negative comments re SU	***Part 5:*** Preventing being positioned in ‘mad box’	***Part 6:*** Hatred of services conflicts with working in them
Strophes	*Strophe 1:* ‘Brushed it off’ / didn’t really talk about it (1st job)	*Strophe 7:* Orientation – as a student ‘hadn’t formulated’ how to deal with position	*Strophe 12:* (R asks about) manager in 1st job was exception – ‘really insightful’	*Strophe 16:* Orientation – hear ‘loads of subtle negative things’/terms (?as ‘burnt-out’)	*Strophe 19:* Orientation - R asks re others positioning him	*Strophe 23:* Orientation – never thought re why doesn’t talk about it, used to
	Strophe 2: Contrast – ‘removed from’ own care vs. ‘complicated’ working with them (2nd job)	*Strophe 8:* Example – supporting a client to HVG feeling like ‘had things to say’	*Strophe 13:* Context – had very difficult time with as SU / had rlt. w. prof. involved in his care	*Strophe 17:* Has ‘foot in other side’ – imagines it is him (why he ‘refuses’ to use services)	*Strophe 20:* Example – contrast ‘very open’ colleague talking ‘in the open office’	*Strophe 24:* Maybe ‘huge hatred’ of services (when left) conflicted with working in them
	Strophe 3: Justifying not wanting (felt had to) to share - (‘not guarded’) not defined by MH	*Strophe 9:* After reflection, not ‘really want to share’ but not sure why	*Strophe 14:* Was able to talk about it with manager ‘behind a closed door’	*Strophe 18:* Impacts how he identifies himself (as ‘SU’) / why he works in dementia	*Strophe 21:* His response = annoyance, team’s = ‘protective’	*Strophe 25:* ‘Distinct shift’ in how talked about it at time – ? trying to distance self from services
	Strophe 4: ‘Pretends to be open’ but not say extent of difficulties	*Strophe 10:* Started off ‘being quite open’ as ‘couldn’t avoid it’	*Strophe 15:* Segue - is an effect on how perceive yourself in certain roles		*Strophe 22:* Wants to be defined by what do / not attribute shortcomings to MH	
	Strophe 5: Hard to explain ‘productivity’ of MH – surprised ‘as seem so together’	*Strophe 11:* ‘Common theme’ joking about it / ‘making excuse’ vs. seriousness of it				
	Strophe 6: Difficult in work situation to explain reason for appearance / wishing could ‘be like them’					

Table 16. Sub-narrative II: Uncertainty about discrimination

	Parts	
	Part 1: Relationships maybe create understanding	***Part 2:*** Maybe discriminates against himself
Strophes	*Strophe 1:* Orientation – experiences of stigma/discrimination	*Strophe 4:* Not sure re discrimination – probably discriminates against self but hard to describe
	Strophe 2: Example – ‘definitely quite openly’ in first job (couldn’t work nights), ?implying not pulling his weight / letting colleagues down	*Strophe 5:* Attributes ‘everything’ to MH (when others wouldn’t) – ‘excludes/penalises self’ ‘so can perform at work’ as ‘thinks should’
	Strophe 3: ‘Still there’ but ‘possibly more understanding why’ once rlt built / seen impact of sleep issues (? & not ‘lazy’)	*Strophe 6:* Questioning ‘rightness’ of answer

Table 17. Sub-narrative III: Unsafe to share: Discourses, boundaries & power

	Parts		
	Part 1: Orientation – discourses create barriers / maintain power	***Part 2:*** Safety & professional boundaries	***Part 3:*** Confidence, risk-taking & qualified status
Strophes	*Strophe 1:* Orientation to narrative – what facilitates/prevents sharing (an easy q)	*Strophe 7:* Orientation - (Therefore) why wouldn't (& didn't) he feel comfortable clients?	*Strophe 18:* More confident now / could defend sharing vs. 'vulnerability' as student
	Strophe 2: Orientation to part – prevents = 'all to do with' being told by uni not to ('it's not about you')	*Strophe 8:* Worry was 'overstepping prof. boundary / might not qualify (didn't make it 'about him')	*Strophe 19:* Confidence (in role/abilities/trlts. w. colleagues) increases tolerance to / head-space to deal with 'something negative'
	Strophe 3: 'Strong discourse' (taught is not relevant)	*Strophe 9:* Explaining who / how shared with – made rlt closer (but still not comfortable)	*Strophe 20:* Working in dementia mean not had to think more re how to respond to clients but role-confidence definitely increases 'risk-taking behaviour' ('being honest with clients')
	Strophe 4: 'Holding back' creates barrier / maintains prof (power) vs. 'ill person' positions	*Strophe 10:* Example context – supporting young SU in open, charity-run facility with 'luxury of time' to do 'nice, therapeutic things'	*Strophe 21:* Actually is parallel in dementia and reflects in attitude – is more honest (borne out of own frustrations
	Strophe 5: Sharing could give hope (how else 'convince them' is hope?)	*Strophe 11:* Contrast – 'learned unhelpful communication' vs. 'talking about his life' (info 'not in file')	
	Strophe 6: 'Over-think it' in MH – would be fine to share in physical health	*Strophe 12:* Example – began sharing over 'common ground of medication' – countered disbelief could be nurse & be on meds	
		Strophe 13: Worried would ask details but was 'just a shared experience' that 'changed their rlt.'	
		Strophe 14: Is 'quite proud of that' / was 'quite safe' - other time shared ? not so safe	
		Strophe 15: Contrast context – on a ward, with older SU, 'very medical', short-term approach	
		Strophe 16: ('Just knew' wouldn't use MH services) shared experience using AA / countered myth re AA	
		Strophe 17: Felt unsafe – fear SU would tell others who think 'over-stepped prof. boundaries' / would get 'thrown off course'	

Table 18. Sub-narrative IV: Not just colleagues

	Parts			
	Part 1: Sharing for reassurance (but led to change in how treated)	***Part 2:*** Confirmation colleagues talk about his SU experiences	***Part 3:*** Probably risk-averse response if was more open	***Part 4:*** Partly colleagues, partly people involved in his care
Strophes	*Strophe 1:* *Orientation* – more experiences of sharing (with colleague as student)	*Strophe 5:* 'Massive' example – a blind date being another nurse who knew people involved in care / rlt.	*Strophe 11:* Orientation – (facilitate/prevent sharing) 'logically' can't say too much 'because of prof. regist.'	*Strophe 17:* Manager 'is nice enough' but 'always see partly as someone who'd been involved' in his care
	Strophe 2: Example - seeking 'reassurance' from qualified people (rlt. wouldn't effect work) 'in wrong way' / 'bit of a blurter'	*Strophe 6:* From 'powerful' position stated SUs shouldn't be nurses / colleagues talk about him	*Strophe 12:* If were honest re extent of difficulties, probably get 'risk-averse' response	*Strophe 18:* (R asks) is 'sure' manager sees him in same way
	Strophe 3: Colleague said knew person involved & 'massive change' ('awkward') after	*Strophe 7:* Angry didn't 'defend self more' – was 'so taken aback'	*Strophe 13:* (R asks about) MH is different as sharing 'non-MH' difficulties 'really well received'	*Strophe 19:* Even considered having manager long way away so not involved before
	Strophe 4: Segue – maybe just 'how perceives it' but not really think that	*Strophe 8:* Had 'direct effect' on how worked – 'another person had to blank'	*Strophe 14:* Example – child-care needs 'so easy' to discuss needing (and get) 'leeway'	*Strophe 20:* Example – manager's manager spoke to him re. 'mixed role' – lied about being fine with it
		Strophe 9: 'Rational head' disagrees with her but confirms 'clique of colleagues' do talk about him	*Strophe 15:* Predicts would be more ? controlling / cautious if was for MH needs	*Strophe 21:* Turned out to be 'mildly therapeutic' for both but 'must' see him that way
		Strophe 10: Eventually concluded 'fuck you / don't care' but took time / building up 'own clique' who valued / supported him	*Strophe 16:* Segue – would perceive it as penalising even if well-intentioned – but doesn't know as 'not really honest' with managers	*Strophe 22:* (R asks) is nothing manager has done, maybe is 'omission' (contrast previous manager)
				Strophe 23: Is 'nothing there', just 'stuff in his head' / there being so many 'links'
				Strophe 24: Coda – will he 'ever be able to just be a practitioner'? (is laughing but it's not good)

Table 19. Sub-narrative V: Differences with SUs, colleagues and students

	Parts				
	Part 1: He's different with colleagues & SUs	***Part 2:*** An insight universal to SUs	***Part 3:*** SU experience influences his work with SUs	***Part 4:*** Main issue with colleagues is 'crossed roles'	***Part 5:*** Sharing with students and power
Strophes	*Strophe 1:* R. suggests summary - is difference how SU/prof. identities come together with SUs vs. colleagues	*Strophe 5:* Orientation – an 'insight universal to SUs', e.g. being misunderstood, importance of 'directing the outcome'	*Strophe 11:* Orientation – influence of own involvement in research as SU	*Strophe 17:* (I asks) – space on topic sheet for anything else thinks is important	*Strophe 21:* Orientation – hadn't thought re students – why doesn't he (except 'jokey'/'in passing')?
	Strophe 2: Becomes very 'logical' / 'corporate' with colleagues	*Strophe 6:* Contrasting experiences of practices (feel listened to/not heard) lead to 'directly understand' and changes in practice	*Strophe 12:* Example – experiencing helpful 'therapeutic research' now 'refers loads' to research	*Strophe 18:* (R. suggests) 'crossed-roles' 'absolutely' one for him	*Strophe 22:* Is 'a power thing', 'fear of reprisal' from university if found out
	Strophe 3: 'Adjusts' when leaves office to see SU, then 'thinking about the person'	*Strophe 7:* Awareness of interview – 'jokingly' questioning 'rightness' of answer	*Strophe 13:* Hasn't shared re his involvement when refers (seen MH/dementia separate 'until today')	*Strophe 19:* Hasn't been 'kept separate' as told would, ?couldn't keep separate himself when was 'really confused'	*Strophe 23:* Haven't had student speak to him re their MH
	Strophe 4: In '1:1 situations' with clients is 'completely different' to with colleagues	*Strophe 8:* Thought dementia was separate – actually only' separate as poss.' from profs. involved in his care	*Strophe 14:* Different roles in / 'funny' rlt with older clients – less concern re sharing	*Strophe 20:* Coda – this is 'main thing' influencing 'how speaks with colleagues'	*Strophe 24:* 'Paternal' feeling mean probably wouldn't speak if did come up 'as a topic'
		Strophe 9: Is not only reason works in dementia – also drawn to it	*Strophe 15 :* Power in rlt. / boundaries already shifted ('maternal' / bake cakes) esp. when 'talk re their history'		*Strophe 25:* (R asks for clarification) gets 'self-esteem' from teaching position, maybe would change it
		Strophe 10: Way works with SUs borne of own experience bad/?good parts treatment	*Strophe 16:* Conclusion – 'sharing of disabling experiences of the mind' would be 'quite therapeutic' / make person 'feel useful'		*Strophe 26:* Would 'definitely' / 'happily' share if student 'started dialogue' / shared own experience
					Strophe 26: Awareness of interview/expectations – 'pass yet'
					Strophe 26: End of interview – been interesting, not talked about it much

Appendix XII – Reflexive Research Notes

Designing the study: Where and what is my place as a survivor-professional?

- I spent the first year of training working in a psychosis service and this undoubtedly influenced the research topic I have chosen.
  - Feeling more comfortable with clients, feeling I have more in common with them, feeling safer with them than with colleagues.
  - Service was good in many ways, seemed to appreciate the importance of what's going on in people's lives (their homes and housing, education and work – having a life!). Probably appreciated this more than I realised until this was fed-back in the service evaluation I did with service-users. Also really seem to believe in 'recovery', that people can become 'well' and go on to live full and fulfilling lives.
  - But strange mix of this appreciation and focus, with rigid and dogmatic approach to medication – everyone must take it for 2 years or they will not recover (because they are 'ill').

- Considering I was tapering off medication, this was not an environment in which I felt I could reveal myself with the team.
  - I could with my supervisor and I could and did with possibly all of my clients in some way - very surprised by the number who directly said I could not have experienced 'psychosis' because I was a professional, which was a key reason for then sharing. Less surprised, considering how psychosis is seen, by the number who said they would never finish their education or have any kind of job because they had psychosis – another key time I would share.
  - Quite surprised by how many asked me directly – not for wanting to know (I was always curious about this myself with people who worked with me) but for having the bravery to ask; I rarely did! It felt good to be able to give an honest answer – I hated being brushed off whenever I

  did ask the people who worked with me something about themselves, as if I wasn't really a person, I couldn't know such basic stuff about them that is just natural to want to know.
  - It went ‘well’ every time, led to lots of good conversations, challenging dominant ideas about ‘psychosis’, service-users and professionals, exploring similarities and differences and questioning whether two people can ever have ‘the same’ experience but also whether that matters, leading to further conversations about what is important for someone to help. All said they appreciated it, that it made a difference.
  - My previous work had been in LD, and although I found my experience useful, I never felt this same level of camaraderie, never felt my own experience to be such a tool.

- The difference between this openness and use of my experience with clients and my supervisor versus silence with the team was really difficult – perhaps if I had opened up it would have been different?
  - They often remarked about my ability to work with ‘difficult’ clients, to develop a relationship and the progress my clients made – they put it down to being a ‘psychologist’ but I believe it was this connection and it seemed like a lost opportunity to not tell the team but it also felt very unsafe.
  - So I felt like a fraud and was constantly worried about being found out and, although my supervisor was very supportive, I did worry I would be accused of being ‘unprofessional’ and 'breaking boundaries'.

- I felt very alone during this time. I was open about my experiences at uni but uncertain of what others thought.
  - My fellow trainees were certainly respectful and seemed interested in my experience and knowledge, but no-one else spoke out about having experience ‘mental health’ problems or using services, although I imagine some of them have. They also never raise it with me, so it feels a bit taboo, despite it being fine if I raise it.

  - All just makes me feel different and alone in trying to work out how to be BOTH a psychologist and ‘mad’ – my madness is not and can never be separate to this role for me, and I wouldn’t want it to be. But it is difficult.
  - Also, although I was very much indoctrinated into the ‘service-user’ movement when I started the course – and I knew some of the debates about the validity of diagnosis, and (from my own experience) was angry about professionals not listening to patients, not believing them or taking them seriously, thinking they knew best and forcing treatments, this was the first time (as it seemed to be for many of my fellow trainees) I was hearing about the lack of evidence for the illness model and effectiveness of medication, and it was a shock!
  - I was – I am – angry about this deception. I had always felt my experiences were due to things that happened as a child, but no-one would confirm that they were enough in and of themselves to make me crazy – that my feelings, behaviour and perceptions didn’t have to be completely under my control without having something ‘wrong with my brain’. I believed I had an illness and couldn’t cope without medication, despite it having restricted my experience of emotions and disconnected me from my childhood. I was angry, confused and determined to come off medication, have my childhood experiences validated and reclaim my identity from that of a mentally ill person!
  - And now I am expected to work in services where these same lies are perpetuated. How could I work in that with this new knowledge?
  - I really wish I had a guide in this, someone who had ‘been there’, and some fellow travellers! The rare occasions we have a lecturer who says they’ve been mad, I want to go up to them and say “me too! Can we talk about it? I have so many questions”, but I don't.

- The other key thing during this year was doing the service evaluation. Firstly, I did lots of reading about user involvement for it and all the reasons promoting it seemed completely applicable to professionals who have experienced ‘madness’ / services but any mention of this was almost completely absent, and certainly completely absent from official policies and guidelines. Instead, we learn about ‘boundaries’ and ‘self-disclosure’ and, although I’m not somewhere where it’s seen as a big no-no, the talk around it is so different to UI, so conservative, so tentative and problematic.

  - Why does no-one see the two are similar? Why does ‘the user perspective’ (‘cos there’s only one, obviously!) have to be brought in specifically from someone who can occupy that role? What about all those user voices already in the services? Can’t a professional and mad position be brought together? Isn’t that why I’ve come into this?
  - Secondly, listening to the participants in the focus group, one of the things they emphasised – like I found with my clients – was their need for people “like them”, people who have been through it and have that knowledge and can understand “what it’s like”. If the people we work with are ASKING for this, how can ‘boundaries’ theory claim 'silence' to be ‘for the client’s benefit’?
  - I did a presentation about UI and the conversation that ensued was depressing: SUs would be unreasonable about what they wanted, their illness would make them unreliable and irrational, and anyone who was ‘well enough’ to participate wouldn’t be representative of most service-users. At the same time, UI was positioned as a ‘good thing’ (in theory) and something the service and Trust all included in their ‘mission statement’ and policies etc.
  - There seemed to be such a disconnect between the policy on UI (local and national) and what was actually happening, and this seemed to relate in some way to the disconnect between UI and professionals with S-U experience. I needed to explore this further.

- Reading the literature, particularly the critiques of UI, has given me a language to talk about these things I felt/perceived. It feels clearer what I need/want to ask in my research

  - Reading things from some of the other 'survivor professionals' feels like a revelation (sort of), or like they are creating a legitimate path where I can be both, proudly and openly and keeping faithful to who I am and what I believe.
  - But it's also odd, because there are others who position themselves in this way but take a really different stance. I read one paper from someone who claimed a position of authority from their experience (like I want to) but used it to say that the two most important steps to 'recovery' are accepting you are 'ill' and your experiences are not real, and taking medication. It actually felt like a betrayal. I know it is important to recognise we are all different (and I used to wear my 'I am ill' badge) but it is a painful realisation.

Laura: Recognising and letting go of my search for 'sameness'

- Recruitment has been a nightmare, I did not realise how hard it would be to find people. It seems like I constantly came across people talking about these dual experiences – at conferences, on the internet, in books – now it’s come to finding them they seem to have all disappeared. Like with searching the literature, there is no common term for us.
- Maybe this is good, we haven’t been labelled and categorised, but it also makes me feel we are invisible or silenced, remote from each other.
- From a researcher/student perspective it's also making me feel extremely anxious about getting the number of participants I need and whether I am actually going to complete it on time!

- I’ve completely come off medication now and feel I have rejected the diagnostic label I once embraced. Now I embrace a survivor identity – I have survived my childhood experiences, I have survived my madness and I have survived the trauma of the system.
  - I have been working in a CAMHS service and I felt so at home and

  supported. I could talk about my experiences with the team, using them as a resource to process it and they have used me as a resource too – one of my supervisors said I had changed how they thought about things, which made me feel pretty good.
  - Being off meds and being around children and families struggling, is making me think a lot about my own childhood but being in this position reminds me I am an adult now, I don't feel the same as I did then, although I can remember it and I can use it to empathise with these families.
  - I sometimes share with the families a bit about my family, when it seems like it may help but it hasn’t seemed so necessary or relevant. But I think my experience has helped me to help clients feel understood and cared about – they keep telling me things they haven’t talked about before, and the feedback keeps on being about developing relationships and being non-judgemental.
  - I have been able to be ‘both’ here and felt accepted for this. Furthermore, being both has not meant talking about my experiences exactly, but being able to use them a resource, having other people see them that way (authorise / legitimise it?)

- Meeting Laura, I noticed commonalities between us, especially feeling that being sympathetic to S-U experience stops you 'fully' being a psychologist (or, at least, the kind of psychologist I feel we are taught to be). But (again!), I was surprised at the differences (and surprised by how surprised I was), especially being more comfortable talking with colleagues than clients, her fear that clients will reject her. I haven’t experienced this, it’s always been so positive with clients and my fears are nearly all about colleagues.
  - I feel a bit envious of her ability to state she is a S-U or has been mad and use that, my anger seems to get in the way. I think maybe I was hoping we would be the same, but then how would we learn anything! I think I was expecting to feel more of a sense of solidarity – I do feel it

  and talking with her felt different to talking with anyone else so far but the differences I perceived felt quite threatening, I think.
  - And then I was trying not to let this influence the interview too much, trying to maintain the same level of interest in my response to things she said that I really agreed with and things that differed from my experience. Perhaps I should have owned it more, said something? I don't know.
  - I actually rarely spoke, mostly just 'mm' and the stories seemed to almost pour out. As a pretty novice researcher I'm rather grateful for that, especially when sharing interviewing experiences with other trainees and hearing how 'dry' and stilted some of them were. Perhaps, like me, Laura doesn't get much opportunity to talk about this stuff?

- I found it hard to know how to be a researcher/interviewer; some of things I wanted to say or ask, I didn't because they seemed too much like a 'therapist'. But having spoken to my DOS about this, maybe there is something similar about the two processes and it's okay to? And maybe I'm letting those 'boxes' define too much; they get in the way sometimes of just two people talking together and trying to make sense of something, when you start questioning, 'but is that being a therapist?', 'is that appropriate to this situation?' I believe in trusting my instinct and feeling our way together, I need to stop letting the professionalisation of human contact get in the way of it!
  - Transcribing the interview, I can really see how clumsily I did ask questions, making a complete mess of it as I try too hard to be a researcher not a therapist, to position what I'm saying in terms of what Laura said, and to 'own' everything that is my own words, any word or idea that I'm introducing. It makes my questions so incoherent, I am amazed Laura understood me, and yet she seemed to.
  - I also realise just how much I didn't follow up on, things she said that now I want to ask more about it. I guess there is so much being said that I can only remember and focus on certain bits, but it is certainly

frustrating that I haven't asked her to clarify or go into more detail on certain things. Meaning seems so obvious at the time but going back over it now a lot of it seems quite ambiguous. Something to remember for next time – uninterrupted stories are good, but don't take so much for granted!

Christine: Reflecting on history and context

- The interview with Christine felt very different to the one with Laura, less intimate, more business-like. In a way I felt more like a researcher than with Laura, perhaps beginning to get into the role and building confidence having done an interview before. However, interviewing a professional researcher definitely made me feel like a bit of a novice, or 'part-time' researcher!
  - The location also made a difference; an office is less intimate than someone's home and it feels more like work when it's during office hours rather than in the evening. Maybe also there's a different feeling interviewing another psychologist. Made me realise just how in-group/out-group I have become about different disciplines, even though this kind of attitude has really annoyed me in the services I've been in.
  - Whether it was this, or experience, I wasn't surprised by differences in our perspectives and experiences. I think I'm beginning to appreciate the subtle nuances of the positions we take and noticing the (naïve and incorrect) assumptions I've made about if you believe x then you believe y. For example, Christine talked about 'having' the illness but was also part of the survivor movement and put everything in a human rights framework. I had definitely made assumptions about the survivor movement rejecting the medical model, which is daft because I also used to hold to the medical model, whilst seeing the way we are treated (by society and services) as a human rights issues. And some of the worst treatment I received was under a 'psychological' model! I

  think I keep losing sight of what I used to believe before the course, my ideas have been so altered by it and this exposure to different frameworks.
  - I think it also makes a difference being on a new placement, being at the beginning of it so I'm less connected to a team and to my clinical role, allowing me to focus on being a researcher more. Then again, maybe it is a desire to *not* think about it, wanting to forget about the clinical stuff!

- This all seemed to help me be more present in the interview, I think, to sit and take in what was being said without connecting to it in a very personal way, without thinking how it fits or differs with my views or experiences, which felt like quite a different position to be in. Perhaps this was also influenced by what Christine was talking about, both in terms of talking about changes over time, from the 60s and 70s (when I wasn't born), and the world of academia and research and the third sector, which I have such limited experience of.
  - I found this historical perspective really fascinating and the idea of progress (even if limited) Christine put forward was quite appealing, even if at odds with some of the messages during training. It made me think about the background reading I did (seems so long ago now) about the survivor movement and the different views there regarding whether progress has been made or not. Certainly there are differences between now and the days of the institutions, between pre-survivor movement and UI and post, but do these warrant being called progress?
  - It's hard because I can only go by what other people say, I was not around in those days to experience it for myself. The differences I've noticed in the decade or so between being in hospital and working in one do not suggest progress – the open wards are now locked, the kitchens and gardens are locked, whereas ours were open and accessible at all times. It seems so much more restrictive, all in the

  name of safety, or health and safety, yet this lack of basic freedom seems so unnecessary and unhelpful. Patients seem to have fewer rights/freedoms, not more.
  - But then, I guess these are not the changes she was talking about, Christine was talking about employment and about the legitimacy of a service-user voice/perspective, the value of disclosure, and also in the realm of research, not services. Perhaps there are important differences between these. It also makes me think, if there is more value to a user perspective now (due to the survivor movement and then UI) then why, in what ways and with what impact, and what are the limitations of it?

- I've particularly noticed, when transcribing this interview, a difference between Laura and Christine in terms of their focus on context. Christine consistently places everything in context, attributes her actions, etc., to what the context makes possible. Whereas Laura frequently said things were 'her issues' but then described situations or discourses which would suggest otherwise, which make things possible or not.
  - I was particularly struck by what Christine said about her exposure to the civil rights movement 'priming' her to accept a human rights framework and get involved with the survivor movement. Do we still have a survivor movement in the same way as when there were so many 'Leftist' social movements? Has consumerism and UI taken over? Laura spoke more in terms of UI that the survivor movement and that had been what she had been involved in, and comparing their narratives, it does seem to lead to quite different ways of talking about things.
  - I think my exposure has been more to a UI discourse than a survivor movement one, or rather, to a service-user movement rather than a survivor movement, and having lost some of its edge because of this change, even though, through my upbringing, I've also been primed to see things in a human rights way, being brought up by someone who

lived through the civil rights movement and was shaped by these ideas and also Quaker ideology.

Bethany: Breakdown and work

- Everything is clouded by the placement I'm on at the moment and what it brings up for me. I'm desperately not wanting to be part of it but also not wanting to leave the patients, I feel like every way I turn there are only bad choices available to me.

– This is not a reminder or connection with the past, this is like reliving the worst times of my life.

- Interviewing Bethany, it was actually a good day. It was a relief to be going back to the research after this period where I haven't been able to do anything regarding the research. So getting back to it was really good, a chance to be a different person for a bit and focus on someone else's story instead of my own.
  - It wasn't that much of an escape, though, for it very much coloured what I connected to, especially the repeated focus on what is going on for her and the importance (but absolute difficulty) of being believed. Also the lack of good options she described, where every path available leads to an unsatisfactory position, where the actual problem is not addressed and changed – the only solution is to get out!

- To be ill or not to be ill, that seems to be the question! Each brings its own 'rewards' and problems. Although I reject an 'ill' identity now, I haven't always, and I can certainly understand why someone would embrace it.

– My first contact was with people who said I was ill and were really nice and sympathetic – I wasn't to blame for feelings/behaviour that felt so out of control. I felt the diagnosis gave me entitlement to my feelings and behaviour, I was ill not a bad person.

- Then, the next people I met, told me I wasn't ill, told me I made people treat me badly because of my personality, that I was responsible for it. I couldn't do anything right, and their solution was to ignore me unless I acknowledged what a horrible person I was, that I was completely in control and at fault. People they saw as 'ill' got sympathy, got help to learn to control themselves and the emotions which felt so overwhelming. Being labelled as ill felt like some kind of reward, a judgement that you were worthy of kindness and entitled to support and to struggle to control yourself (emotions, behaviour) on your own.
- Being treated this way made me fall apart more but I think I also then embraced an 'ill' identity, so desperate was I to not be seen as a bad person, for someone to help me. And I almost lost myself in this because, over time, everything became seen as illness (I could not have nodded more emphatically when Bethany said this!) and I lost the connection between what I was experiencing and my past.
- So, although I always embraced a philosophy that users should not be controlled, that we know our own minds and should be believed and our lived experience valued, this was, for safety, within a biological illness model. And I drugged away my feelings, and I didn't deal with what had happened until I felt more lost and numb inside. And then I pounced on the knowledge that the illness model is poorly evidenced, that there is no efficacy for medication long-term, and, most importantly, the permission to see my experiences as *causing* the madness. Then I embraced a critical, survivor discourse and identity.

- Where I've been working, the same thing seems to be happening, dividing people into those who are 'really ill' (and deserve sympathy) and those whose distress is 'behavioural' and aren't believed or helped.
- This ill/not ill dichotomy is awful. If there was some objective test that could be done, fine – you have cancer, you do not, you each need different treatment. Fine. This is not like that, it's just down to what the professionals think, how much they like a person, how much 'space' they

have left for sympathy, patience and kindness, etc..

- This makes it impossible to do your job, if you feel your job is to help, to work with and to understand people, not treat illnesses. I am connecting with what Bethany said about NHS jobs making you mad!
– But it is so difficult to be confident in saying “this service is the problem, this is why I'm feeling so bad”. Is this just others doubting our perspective and then this makes us doubt ourselves? Is there some other reason that makes us internalise it, or do we never internalise it, only the doubting and use of 'illness' discourse mean we have to show we have considered it might be 'our problem'?
– Bethany seemed to be doubting herself, but when I said this she was very firm in saying it is others who doubt her and she is convinced (about the situation with colleagues happening) and, in terms of the job being the problem, she pretty much started with this and ended with it to. This surely supports the latter conclusion?
– And what about me? I've been flitting between saying it's me, that I'm having problems and my own experiences are colouring my perceptions and emotions, and saying it's definitely the service, this service is having problems and that's why I am. Maybe it's more distressing because I know what it feels like to be these patients, I can identify on such a close level, but it's still the problems with the service, the way patients are being treated because of it, that it causing me this distress. It's definitely the latter I feel convinced of currently, but maybe that's because there are others in the service saying it's in serious trouble?
– So is this doubting – Bethany's and mine – real? Or maybe this is what is meant by reality being socially constructed in the interactions between people, why it is nonsense to talk of the 'true' reality of a situation.

- In transcribing Bethany's interview there is an interesting process of the transformation of confusion into clarity. I felt confused during the interview, confused about what the answers were to the research questions, as it seemed our conversation didn't really focus on them, it kept coming back to the 'situation' with colleagues and how to understand that. But there is a clarity, a coherence, and it speaks of the importance/centrality of this situation and the dilemmas surrounding an ill/not ill dichotomy and how to be believed and achieve desired outcomes within it.

– I think this is another lesson to take forward –to recognise the assumptions I've made about how the questions will be constructed and answered and 'open my mind' to notice and engage with alternative ways

Ian: Conflict and anger

- Ian has been the person that I identified with the most, even though I had stopped searching for this. I haven't had the same experience of working with people who had been involved in my 'care' but I felt a camaraderie with him, nonetheless, particularly the anger with services he described and ensuing conflict with then working in them.

- I particularly connected with the fear of being a S-U again, of being made to access services and so keeping problems to yourself (but then not being able to get the help you need, although, whether it would be available anyway, is questionable). Now my placement has ended, I need time to 'heal' and I need someone to talk to about what has happened and is happening.

– So I've been toying with the idea of accessing services again. But the fear of being controlled! Actually, no, of someone else defining who I am, the meaning of my experiences, that is what scares me most.

- Ian's anger at how he had been/was being treated was so palpable during the interview but each time he showed it he laughed after, as if embarrassed.

– I really wanted to let him know I thought his anger was reasonable, that I understood and shared it – particularly when telling the story about the date. But it didn't quite feel appropriate to my researcher role – not 'objective' enough (despite my rejection of this possibility!)

- I wish I had now. Maybe then he wouldn't have had to hold back, describing her as “...not a nice person”. I feel he deserved better. We all do.
- I think we should be angry at how we are treated, at the boxes people put us in, at the outright rudeness and dismissal, at being treated like second-class citizens.

- I realised, when transcribing the interview that I didn't pursue what the conflict of working in services when you hate them meant. It just seemed so obvious at the time, that the dissonance between the two is fundamental. I assumed we shared an understanding of this – just shows how you can still make assumptions, especially when you are feeling like you identify with a person so much, and despite having been determined, three interviews ago, not to make this mistake again!

- To me, the conflict is because you are choosing to be part of something damaging (how I felt on my placement) and then it is like you approve of it, or, as Laura put it, that working in the system is some kind of endorsement of it.
- Funny, because my whole aim of getting into it – my starting point of this research, really – was becoming a professional, because of my experiences in the system, in order to change it, as commonly stated throughout the literature and in each of these interviews (apart form Bethany's).
- So is that a conflict? Perhaps it is if you don't feel you can change it, or that you're not working to change it. Maybe it relates to this idea that keeps coming up that, as a professional, you are supposed to 'side with' your colleagues as if staff and SUs are against each other.

- This was another reason I felt so close to Ian, the apparent ease with clients and conflict with colleagues. This was what I had originally expected (making assumptions based on my own experience) but had seen different positions in the background literature and the previous interviews.

- It was kind of a surprise, having accepted these differences (and now expecting them), to then hear someone describing how I feel. Of course, there are still differences, the 'crossed-roles' are clearly central to Ian's story, and the ease I feel with clients has led me to share my experiences with them more than Ian seems to have.
- I've felt that riskiness he spoke of about sharing but not to the same extent, I don't think. I wonder if that's a difference between our professions, or the ethos of our training courses – I haven't been explicitly told not to share with clients (on training, anyway).
- But then, there did seem to be something important about that explicitness in how he was then able to contest it, to turn it on its head.

- Transcribing the interview has really highlighted a process of developing answers to the research questions over time, how they all fed into each other, switching between questions from the topic sheet, which was pretty much completely led by Ian.

- It's interesting to notice the difference between participants in this. Laura went through each question in order, with little input from me. Christine told a long, chronological story, and then I asked questions clarifying and expanding on bits from it. With Bethany, I asked most of the main questions on the topic list, and she brought it back to this situation with her colleagues, and with Ian he goes back and forth between questions, not following the order but saying he's finding one he knows the answer to, then comes back to them and my questions are to clarify things he's said within them or summarising what I think I've heard.
- I'm really glad I made the decision to use this topic list, both having a copy. I think it has enabled the interviews, questions, answers, etc. to be constructed in different ways, to capture those differences.

Analysis: Puzzling my way through the 'jigsaw'

- In transcribing and re-transcribing during this process, I've really needed to listen again and again to the recording to work out pitch glide. Each person has a remarkably different pattern of speech. I've listened so many times I can hear them when they're not playing!

- I'm really quite enjoying this process of analysis, there are so many different layers to it, especially as I keep coming back to them as other levels shed more light on them, or a different light on them.

– So it's complex but it seems to make sense, all these different aspects coming together. It's interesting how it starts to come together as I get further through the analysis, an overall narrative does 'emerge' and patterns begin to recur.

- Sometimes it's hard to think what I'm putting into it, although I guess that's the point, you cannot know what's you and what's them, the two interact and create something together. I can definitely see how I introduce ideas into the conversation, how I shape what is then said.

– I do this much more in the last two interviews, I'm not sure why. Perhaps it's from 'the lessons' to make sure I question and clarify what is being said, not make so many assumptions about meaning.

– It might also be to do with the interview dynamic; there are far more long pauses in the last two interviews and more uncertainty, in a way. Laura and Christine seem to tell their stories quite clearly and without much prompting, but perhaps with Bethany and Ian the pauses give me a permission to 'come in' to the interview more?

- Sometimes (a lot of the time!) I feel like I'm getting lost in this analysis. It connects with my experiences but it is not so personal, definitely less personal than when I started, somehow. I feel more like a 'researcher' – not detached and objective, but interested in what is coming from it for its own sake, for what it can teach us and what can be used in the field, rather than for something for me. I'm not searching for my own place as a survivor worker through it.

- Perhaps because it is so real now, because there are stories that have been told that have so many similarities and differences with my own and with each other that my story is just one story 'out there' amongst many?

Hopelessness and powerlessness

- Trying to do the write-up, and I've got some way with it but I'm connecting too much to powerlessness to change things in the narratives (and for myself). This is making it pretty hard to write-up; something useful is supposed to come from this, ideas and recommendations.

- This 'mental illness' discourse is like a little fail-safe that is employed to prevent anyone ever being able to change things. There is no power for us 'mad' people in this system, we can just be discredited or silenced. The systems around us ensure no-one can act from alternative beliefs and perspectives.

- I know this is at least in part due to having contact with MH services as 'user' again. It's been a mixed experience but ultimately reinforced my anger.

- My perspective had more credibility than when I was last in it and this was definitely due to being a professional. It was written in reports as a reason why I had a good understanding of what was going on. One doctor said he could be honest with me about the lack of validity of diagnosis and the medical model because I was a psychologist! Does that mean he would lie to service-users who aren't?
- Another encounter really validated and reinforced my fears, took my description of specific things I was struggling with at this particular time in this unique context, and turned it into something internal and permanent

about me.

- Even the ones who accepted my explanation for what was happening, said I wouldn't fit into any of their services, they couldn't offer me someone to talk to about my experiences. The only options were medication or a specific model of 'therapy' I knew didn't fit what I needed.

- I started this research wondering how survivor professionals negotiate their position in a system with such contradictory messages and how change can be effected. I though it was important that professionals were able to share their 'mental heath' experiences in their work to help bring about this change. But now change seems impossible and sharing seems unimportant, an impotent tool.

Reclaiming purpose: Resistance and hope

- A number of things have helped shift my perspective. I found a way to act on my concerns about services in difficulty, I got away from everything, spent time with loved ones, and re-found my peace, strength and determination. I've been re-reading Foucault, about power, resistance and subjectivity, and I've been re-reading all the transcripts.
- This has all given me a more hopeful perspective, made me see the point of fighting and the power there is, there always is, to resist – resistance is not futile!

- I realise was looking too much at contesting discourse by sharing S-U experiences/position, contesting the reality of these with the reality their/our duality represents. This isn't where the resistance is in the narratives, as there are strategies to counter this and maintain the status quo.
- Resistance in is the ways they talk in the interviews, in the way a difference is presented between how they construct things and how others

do. They don't accept a damaging subjectivity as true, they resist it.

- Laura says these are problems anyone might experience and questions the rightfulness of her supervisor checking up on her, she doesn't accept this is 'illness' and such monitoring is valid. Christine ignores her co-director when told not to do things and says in the interview even when ill, people can still work, can still make their own decisions. Bethany refutes my conclusion people make her doubt herself and says others doubt her and attribute everything as illness – she presents her view as real. And Ian claims the right to make his own decisions, to keep control and presents the response of others as putting people in mad boxes.
- None of this is accepting subjugation. And they all contest the arguments against self-disclosure, whether they feel able to share or not. There is so much resistance! They seem to appreciate what it has taken me this long to realise, which is that there are more subtle, subversive ways to affect change. And it starts with constructing ourselves from a different discourse, claiming a different, more empowering subjectivity. I'm surprised I didn't see this sooner, it's what I've done!

- It's interesting to see how much the order of the interviews seem to mirror my journey through placements, although this might just be what I've connected with, the placements making salient particular things in the narratives and probably overlooking other things.
- But then, there must have been an effect of the interviews, of hearing their stories, that then influenced how I was understanding my work and what I was connecting with there.
- Interactive feedback loops between a number of different aspects, all coming together to form the context within which this research (and my life over the last 4 years) has been conducted, and which must be considered when judging the coherency of what has been produced.

- In a way, I feel like I've come full-circle (although, to end up at a different place, so maybe it's a circle in a spiral!)

- I started at the point of how to be a survivor worker, how to use experiences to change the system and, through a journey back to the beginning of the experiences that drove me mad, being a service-user, feeling broken and despairing, then wanting to use this to make a difference by becoming a professional.
- It's been a crazy journey but along the way I have picked up many other stories that have given new ways to think about things, new strategies, new hope. And I feel ready and eager to take this forward!