

‘GETTING BETTER – IN THEORY’
CREATING, THEN USING, A FOUCAULDIAN MENTAL
HEALTH SERVICE USER/SURVIVOR THEORETICAL
STANDPOINT IN MY OWN JOURNEY OF ‘RECOVERY’

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In late 1998, I saw an advert in the Guardian for a doctoral studentship, at what is now the University of Bedfordshire, to research the effect of community care policy on one of the disabled people’s social movements. My application was successful. This is my story of doing a doctorate and the effect it has had on my mental health.

After I started in 1999, and following discussion with my initial doctoral supervisors Kathryn Ellis and Hartley Dean, I decided that one of the aims of my thesis would be to indicate how a theoretical ‘service user/survivor standpoint’ could be achieved. This would be a synthesis of existing social theory, which could offer new insights into the views and experiences of mental health service user/survivors.

PART 1: MY THEORETICAL JOURNEY

Q: WHAT IS A THEORETICAL APPROACH?

A: Before beginning to look at the theoretical standpoint I produced, I will just say what I think a theoretical approach to research is, since many people are put off by the complexity associated with the word ‘theory’. Well, for me, all it means is one person’s, or group of people’s, ways of understanding aspects of human experience. Looked at like that, is using a theoretical approach any different from going to your grandmother/father for a different, hopefully more experienced and wiser point of view? The fact that you probably know the advice of your parents, or grandparents, before you even ask, is the same as reading enough about the thought of Max Weber or Pierre Bourdieu to be able to say how trying to think like them will give you the best answer or solution to a problem. University lecturers and supervisors can therefore act like respected friends whom you can approach to ask who would be a good person to give advice about a problem (i.e. which social theorist/philosopher will help you understand and explain the academic question you are writing about). It turned out that I was extremely fortunate with my doctoral

supervisors. In particular, my primary supervisor Kathryn Ellis is knowledgeable and concerned about the plight of all people with disabilities.

HOW I CAME TO DEVELOP A SERVICE USER/SURVIVOR THEORETICAL STANDPOINT

Q: WHICH THEORIES SHOULD I SYNTHESISE?

A: Theoretically speaking, I did not know very much, was in awe of 'theoretical greats', and thus relied heavily on whatever advice I could get (which I think was very good). I was not able to defend an interest in Giddens' theory of structuration (Giddens, 1984), but I guess most apprentices for any skilled employment will feel this way at the start, since the best usually want to learn everything they can from the master craftswomen.

I therefore explored Foucault's works, such as *Madness and Civilisation* (1989/1961) because it directly addressed mental health; I later discovered that Foucault had experienced severe mental health problems himself (Horrocks & Jevtic, 1999: 14), as had many other theorists. Furthermore, because I valued my own experiences of mental distress and mental health services for their potential to provide insights that other students might not have, the idea of creating a specific service user/survivor standpoint, to help me focus on the most important aspects of our shared experiences, seemed logical when it was suggested by Hartley Dean in 2000. This would entail taking what Foucault had written, adding a feminist standpoint perspective, and then seeing if the two could be joined together without contradiction (theoretical synthesis) for service users/survivors to make use of.

There were a number of feminist standpoint theorists to choose from. For instance, Hilary Rose's (1983) theoretical concerns are within the sociology of knowledge discipline; Nancy Hartsock's (1983) and Alison M Jaggar's (1983) theoretical discipline is political philosophy; whilst Sandra Harding's (1986, 1991, 2004a/1993) discipline is the philosophy of natural sciences (see Harding, 2004b: 12). I eventually chose to use the work of Sandra Harding. Diana Rose gave me the idea for a Harding/Foucault synthesis when she provided a brief summary of Harding's work in a couple of pages she wrote concerning her own ideas about the user/survivor standpoint presented at the Survivor Researcher Network (SRN) in 2001 (Rose, 2001). I decided Harding warranted further reading. Harding's refusal to theorise about women's experiences as if there were 'one true story' (1986: 194) convinced me that a synthesis with Foucauldian discourse theory was possible. I will now briefly outline the theoretical service user/survivor standpoint that determined the way I analysed interviews with service users/survivors in my doctoral thesis.

Q: WHAT IS A THEORETICAL ‘STANDPOINT’?

A: Feminist researchers have developed ‘feminist standpoint’ theory as a way of telling better stories about women’s lives than the stories told about women’s lives by male researchers (Ramazanoglu & Holland, 2002: 63). Put in a mental health context, the idea that service user/survivor researchers can use their experience to explain better the experiences of other service users/survivors has a ring of commonsense about it. So far, so good.

Q: CAN A THEORETICAL STANDPOINT ALWAYS SPEAK FOR ALL SERVICE USERS/SURVIVORS?

A: The main problem is that a service user/survivor who says that he or she can tell a better story about the experiences of other service users/survivors implies that service users/survivors can speak with one voice, when this is patently not the case on many issues. For instance, service users/survivors are individuals with highly diverse psychological issues and needs. Furthermore, service users/survivors have different genders, ethnicities, sexualities, social classes, religions, and physical and mental impairments. This clearly means that a researcher cannot talk about the service user/survivor population as being the same, or even similar, in many respects.

Q: CAN A THEORETICAL STANDPOINT EVER SPEAK FOR ALL SERVICE USERS/SURVIVORS?

A: Harding acknowledges this, in relation to her own work on women’s perspectives, by stating there is no ‘we’ of feminism, and therefore feminists should give up the search for a single theory that can tell the only truth (1986: 244) about the gendered nature of social relations. From my perspective, I would also say that there is no ‘we’ of the service user/survivor population; that is, except that we have all experienced mental distress and *dominant mental health discourses*. However, when I say that ‘we have all experienced dominant mental health discourses’, it is also necessary to take a form of discourse theory on board in order to make sense of that statement. The discourse theory used in my thesis was ‘Foucauldian’.

Q: WHAT IS FOUCAULDIAN DISCOURSE THEORY?

A: If you accept Foucauldian discourse theory, then you agree that there is no single explanation of social relations within the world. Therefore, according to this discourse theory, traditional Marxists are wrong to claim that all history is the history of class struggle, and that all social relations can be explained by that struggle. Foucauldian discourse theorists/analysts would also disagree that Buddhism, capitalism, Christianity, Islam, Judaism, liberal democracy, patriarchy, or socialism can be used as a lens through which the truth about social relations can be explained in every situation. By giving up on the possibility of talking about theories that are

true for all people, Foucauldian discourse theorists/analysts can be described as *relativist*. This is because they do not believe that one set of claims about the truth is necessarily any more an expression of the truth than another (e.g. socialism versus capitalism).

Foucauldian discourse theorists/analysts also believe that anything that can be expressed by talking, pictures and/or writing is expressed through *discourses*. A discourse is simply all the possible ways in which statements on a particular issue can be framed/grouped in a set, which in itself decides what the rules are for a statement to be given legitimacy (i.e. allowed to be heard) on the particular issue. This might mean a member of the public may be drawing on the themes with which they are familiar from the popular mental health discourse, supported by strong elements of the mass media, when they converse with you. For instance, these themes may concern danger, homicide, irrationality, nuisance, drain on welfare, incapacity benefit rates, the nature of evil, and malingering. If you think about these themes every time you think about mental health problems, then you could be said to be drawing on *dominant mental health discourses*. (Of course, a service user/survivor may find this both tiring and offensive, in a similar way to how a person from a black and ethnic minority group might feel about the way certain crimes are often associated with particular ethnic groups and not the individuals who perpetrate them.)

If you accept the existence of discourses, it usually means that you accept that all knowledge is relative, because it is framed in a language and imagery that does not correctly describe reality. In relation to mental health, for example, the discourse allows people to make assumptions, ask questions, and draw conclusions informed by the dominant themes that they associate with conversations about mental health.

Q: DO YOU AGREE WITH RELATIVISTS THAT THERE IS NO SUCH THING AS TRUTH, OR RIGHT AND WRONG?

A: See the conclusions.

THE IMPORTANCE OF POWER

Q: SO, HOW DO FOUCAULDIAN RELATIVISTS DECIDE WHOSE STATEMENTS TO SUPPORT?

A: Foucault thought that power and making claims about the 'truth' always go together (Smart, 1985: 80). Therefore, psychiatry is powerful because it controls the way most of the knowledge about mental health is created, which in turn is used to create and maintain *dominant discourses about mental health*. These define

service users/survivors negatively (and thus reduce our life opportunities) in the following either/or dichotomies: you are either, rational or irrational, sane or insane, normal or abnormal, healthy or sick, self-controlled or dangerous, predictable or unpredictable, go-getting or work-shy, independent or dependent, and perhaps even good or bad. Subscribing to these either/or notions and going with the majority is one easy way of deciding whose statements to support, since challenging them is sometimes difficult, particularly when the media usually bring up discussion about them in the aftermath of a heinous crime.

There is hope however. Foucault also argued that power does not exist in isolation – there is always resistance (1990/1976: 95–6). Therefore, service user/survivor researchers who highlight strategies such as complementary therapies, spirituality, exercise, art, and education, which other service users/survivors use to live with their conditions (see Lindow, 1994; Faulkner & Layzell, 2000; Gilbert & Nicholls, 2003), are resisting the power of traditional psychiatry. That is, traditional psychiatry that would primarily judge the value of an activity according to whether there is any symptom reduction, rather than whether a service user/survivor subjectively believes the activity is improving their quality of life. Moreover, the research conducted by service user/survivor researchers can be said to be better knowledge than the research of professionals. This is not because it is unbiased: quite the opposite, because it is bringing to centre stage arguably the most important perspective – that of service users/survivors. An example of service users/survivors claiming production of better knowledge is that service user/survivor interviewers have recently found that other service users/survivors will speak in a different way to them, from how they would speak to non-service users/survivors, about their experiences of ECT (see Rose, Fleischmann & Wykes, 2004).

Q: DO SERVICE USER/SURVIVOR RESEARCHERS ALWAYS PRODUCE BETTER KNOWLEDGE THAN NON-SERVICE USER/SURVIVOR RESEARCHERS ABOUT EVERY QUESTION?

A: If you want to know about the general effects of a new medication on particular symptoms, maybe using data from standardised postal questionnaires, you might reasonably go to a medical statistician who need not necessarily be a service user/survivor. Frequently it is statistical research, however, that has the aura of infallibility, and that provides the knowledge that is used to support the *dominant discourses about mental health*, which limit the opportunities, respect, and expectations that we experience. It is therefore very important to remember the two things I stated earlier that are the central focus within the boundaries of a theoretical service user/survivor standpoint:

- i) All service users/survivors have experienced *severe forms of mental distress*
- ii) All service users/survivors are forced to experience their real lives in relation to the ways they are portrayed by *dominant mental health discourses*.

Q: WHAT GOOD CAN THIS SERVICE USER/SURVIVOR THEORETICAL STANDPOINT DO IN THE REAL WORLD?

A: Foucault's discourse theory allows us to identify, and draw a boundary around, the particular discourses that shape all our lives; a Foucauldian service user/survivor standpoint can then be applied to understand, challenge and hopefully change those discourses (and our lives).

Q: WHICH OPPRESSIVE DISCOURSES CAN THIS USER/SURVIVOR STANDPOINT CHALLENGE?

A: The power of a challenge to dominant mental health discourses, however, would be greatly enhanced if service user/survivor theoretical standpoints were used to challenge a particular mental health discourse that influences many others. Foucault (1989/1961: 64) states that when Western peoples began to create the asylum system during the Enlightenment in the eighteenth century, they stopped living 'cheek by jowl' with 'mad' people. Enlightenment ideas began a process where the value attached to the mental capacity to 'reason' rose far above any other mental capacities, with 'madwo/men' becoming the embodiment of 'reason's' polar opposite – 'unreason'. What is more, Foucault identifies within the Enlightenment the view of the uttering of 'unreason' as 'nothing', or meaningless (1989/1961: 116), because there is no 'reason' within it. A Foucauldian might argue that this is the underlying and fundamental discursive justification for negatively discriminatory behaviour and the use of oppressive discourse which can be described as 'mentalism'.

Q: HOW CAN SERVICE USERS/SURVIVORS RECLAIM OUR CAPACITY TO REASON?

A: The above means that one of the first tasks of a service user/survivor standpoint must be to challenge the 'reason/unreason' dichotomy. Starting from a service user/survivor perspective, it could be argued that service users/survivors can reclaim the term 'reason' in a number of ways, if all that it means is that 'conclusions are drawn from premises' (Oxford University Press, 1990: 999), and 'rationality' refers to beliefs that are 'coherent, not contradictory, and compatible with experience' (Abercrombie, Hill & Turner, 1994: 346). Service users/survivors are well acquainted with the reason of depression, paranoia, obsession, and even psychosis. Certainly, anyone who is suicidally depressed will be familiar with the chain of reason that leads to the loss of all hope. Perhaps it is the use of reason in depression that makes cognitive behavioural therapy (CBT) effective (see Layard, 2006: 1030). What is more, experiencing 'the oneness of the universe' whilst psychotic may lead to the

wholly reasonable lifetime view that there is a spiritual power at work in the universe. Not only that, there is now evidence that people with a schizophrenia diagnosis may be better at theoretical reasoning than other ‘healthy’ people in some circumstances (Owen, Cutting & David, 2007).

Employing a service user/survivor standpoint can help to redefine the term ‘madness’. One of my thesis respondents implied that ‘losing control’ and ‘madness’ are the same thing. Using this logic, the following cannot necessarily be described as ‘madness’: depression, anxiety, obsession, paranoia or voice-hearing interpreted in different ways such as telepathy, the supernatural, and/or as the psychological expression of the ‘internalised generalised other’ within the mind which is thought to be affected by societal norms, rules and values (Kirby, 2007). Indeed, this means that people who lose control (‘a moment of madness’), who have never used specialist mental health services, can be equated with people who experience an episode of psychosis – and don’t most people think they could lose control under some circumstances?

Q: DO ‘NORMAL’ PEOPLE THINK ABOUT MENTAL HEALTH PROBLEMS USING ONLY DOMINANT DISCOURSES?

A: I would say that it does not assist service users/survivors in overcoming whatever problems they have if they attempt to make real the oppressive dominant discourses in their own minds by assuming that they will be met with negative reactions by everyone they meet, and thus become isolated. Indeed, my experience is that many professionals, and people in the wider community, are willing to make their own decisions about the people they meet. They may believe that examples of courage, altruism, honesty, integrity, and prior knowledge, as well as, for some people, facial expression, tone of voice, steady eye-contact, and confidence are better evidence about an individual’s character than the dominant ‘psycho-killer’ discourses reported in the media. (Incidentally, Walsh, Buchanan, and Fahy (2002) note that annually only 0.03 per cent of people with a schizophrenia diagnosis are convicted of a violent crime.) A service user/survivor standpoint therefore has to say something about how to ascertain objective reality, as well as discursive ‘reality’, if it is to be of any serious use to other service users/survivors.

The concluding part of this paper covers how my theoretical journey and service user/survivor standpoint ideas have helped me to cope with my own mental health problems and carry on.

**PART TWO: RECENT LIFE EXPERIENCES AND A MORE
'SENSIBLE' APPROACH TO SCIENCE**

Q: WHAT HAPPENED DURING AND AFTER MY MOST RECENT BREAKDOWN?

A: The crisis team that visited me, following a psychotic episode in 2007, was adamant that they wanted me to say what I honestly thought to be true, and through this process I was able to see that many of my thoughts were based on what might have been, rather than real reality. The process was hard, and when they left I felt that I had nothing to lose by just being myself. My reason told me that if I allowed my mental life to be based on assumptions, faulty mental models, second-hand knowledge, media reports, and even individual, peer-reviewed scientific journal articles, then I would again be doomed. My only solution would be to find a way of getting nearer to the real truth and speaking it.

Q: WHAT DO I STILL BELIEVE IS VALID IN THE SERVICE USER/SURVIVOR STANDPOINT I HAVE WORKED ON?

A: I still think that the only things that unite all service users/survivors are experiences of severe mental distress, and experiences of the power of dominant mental health discourses on our real lives. I also still think that Foucault was right to challenge the pre-eminent status of the capacity to reason in modern science. Therefore, I still think relativist Foucauldian theory has something valuable to add to the search for truth. The problem was that it was always obvious to me that there are such things as true and false, and moral right and wrong. Therefore the relativism weaved tightly within Foucauldian thinking makes me think this philosophical tradition is severely compromised.

Q: OK, HOW DO I KNOW HOW TO GET AT THE REAL OBJECTIVE TRUTH?

A: I looked back on what I had written about the need for user/survivor knowledge, about, say, spirituality or reason in depression to be treated as just as worthy of attention as the symptoms which interest professionals. This informed my view that the only way to judge between true and false is through the subjective use of all of our senses – physical (touch, taste, sight, hearing, and smell) and instinctual, intuitive, or other emotional and/or spiritual senses (in this respect I contend I am a more 'sensible' scientist than those who say they rely on reason alone). Service users/survivors have reported using all of these in their strategies for living and coping with severe mental distress (see Lindow, 1994; Faulkner & Layzell, 2000; Gilbert & Nicholls, 2003). Moreover, just as we require holistic support (mind, body, and spirit) – something some professionals also acknowledge (see Richards, 2002: 165–78) – I thought a service user/survivor standpoint should stand by any researchers who might want to pursue what could be described as 'holistic science'.

Without a commitment to communicate subjective truth and holistic scientific methodologies, I believe it is less likely that anything objectively true, or truer than existing understanding, will be achieved.

Q: HOW HAS THIS JOURNEY HELPED ME?

A: Number one, it has given me my self-confidence back. This has happened through getting used to mental exercises in subjective truth-telling throughout years of study. Then, through the realisation that I had the courage and the right to speak my mind on anything, although sometimes I have found it may be better to let other people, who have more experience on a given subject, make their points before I make mine – that is, if I still have something constructive to say.

Secondly, I managed to understand my OCD-like (Obsessive Compulsive Disorder) symptoms by listening to my thoughts and emotions, and realising that I was trapped like a Pavlovian dog into set responses to particular situations (which might be similar to thinking discursively). This was because I was not challenging my own mind to approach each situation differently with potentially all, not just some, of my knowledge and experience available for the task. I did not think I could think differently, and I thought my thoughts were ‘who I was’ (my identity), when in actual fact I found that all I had to do was ask myself whether my thoughts were telling the truth about me to me. I concluded that it is much better to choose an identity, if one is needed, based on what I aim to be, since the human being is always a ‘work in progress’. After that, I began to trust my own judgement/memory in small ways, like not checking whether I had locked the door three times before leaving the house. The OCD began to go away.

Thirdly, instead of seeing the ‘inner voice/thoughts’ (which emerged at the same time as the OCD was retreating) as oppressive, I saw them variously as divine messages, inner thoughts of conscience, and/or telepathic communications, which required interpretation. When I realised that I was in a kind of mental boot camp, where my own mind was demanding that I give respect to myself and others in my daily life, I began to treat the inner voice as an idiosyncratic helper with a strange sense of humour, and mental pain the result of not getting things right.

Fourthly, small altruistic gifts and voluntary work, without any expectation of return, were a self-esteem key to recognising that I have as much right to live and prosper as anyone else. Being prepared to stand up for the perspectives of other service users/survivors through my research also made me realise that I have the courage to live my own life, too.

Q: WHAT BENEFITS CAN DOMINANT MENTAL HEALTH DISCOURSES POSSIBLY OFFER OUR SOCIETY?

A: My view is that elements of the mass media stigmatise mental health problems

in order to frighten the majority of people to give up ‘wild life’ and ‘grow up’ at the earliest opportunity. The chaos and misery of many mental health service users’ lives are thus used as a ‘morality play’ example of what will probably happen if you do not want adult responsibilities such as career (#1), partnership (#2), and/or parenthood (equal #2). Gordon Brown frequently appeals to ‘hard-working families’: they are very much included in our society. Not included are those with ‘mild’ mental health problems who are ‘work shy’, whilst those with ‘severe’ mental health problems are, to my mind, the scapegoats for some people’s feelings of selfishness, aggression, and weakness. Think about it: when do politicians ever appeal to ‘hard-working families with mental health problems and/or alcohol abuse problems’ (i.e. families as they are)?

Becoming a ‘mentally healthy’, responsible, democratic, hard-working, tolerant and relationship-orientated adult is not easy – even if you want it and/or think it is a better way to live. But is there any other way of being mentally healthy in UK society? That is undoubtedly a task for service user/survivor researchers. Personally, I want to be part of society (since I do not want to live on a desert island). In that sense, I acknowledge that almost all people are socialist with a small ‘s’. This, moreover, makes me better able to appreciate and respect the self-reliant rites of passage ingrained in our culture, in which we are told we are free to explore and make our own minds up about the way we want to live when young, but are expected to make rational choices (in a UK context) during that exploration and come to adulthood eventually. That said, I am still critical, and refuse to become totally conservative with a small ‘c’ just for the sake of appearances: to me, that would be mentally unhealthy as well. In any case, my awareness that I can realistically imagine taking on the basic responsibilities expected of adults (forming loving relationships [usually ending in a partnership], and providing a living for a partner and any dependents), means that I have no choice but personally to challenge the small ‘c’ conservative discourses around mental health.

Q: MY ADVICE FOR LIVING WITH LESS MENTAL STRESS?

A: The short existentialist answer is to accept that stress cannot be avoided, and so I began with small steps to help me cope, and then kept on going forward. I have no choice, because I have faith that all lives are worth living.

I think the main thing is just taking the trouble to be interested in other people, and be especially interested in what I myself want out of life. Part of this understanding is the recognition that there is an order in which all responsibilities need to be attended to; there is a relationship between responsibilities, in so far as the primary responsibility is to make sure that you are yourself alive, healthy, and aware of your own independent contribution to your own life and those of others.

In this last respect, I also agree that giving support, and nurturing relationships of care with others, is a basic human need (see Sevenhuijsen, 2000). Many religions believe that the expressed word is holy and should be honest: I know that speaking and writing my subjective truth is absolutely essential for my own mental health. When I realised that, I finally experienced the wonder of making informed and responsible decisions.

In terms of strengthening my mind to cope with the stresses and responsibilities of life, I have found out for myself that nutritious food, giving up all non-medical drugs, regular exercise, a social life, a spiritual life, consistent study and enquiry, an appreciation of nature and art, and a willingness to take risks to build and maintain all kinds of relationships have helped build up the capacities and strength of my mind.

I have only refused to take medication for two periods of three days in the last fifteen years. I do not believe that my psychiatric team is persecuting me (my experience of achieving a doctorate makes me believe that the good characters of doctors are tested), although I do believe they aim to help me fit in with UK society as it is (to think you can live outside society is, in my opinion, deluded). This has sometimes made me feel that my psychiatric team have tried to make me into a different person – that has been scary – but if being a different person means being more aware of the people around me and my effect on them then I am happy with that. (In actual fact what has happened is that I have built on the strengths of my existing character and found that I also have access to hidden strengths which I never thought I had – like the courage to write this chapter). I know that, whatever I choose to do or be in the future, I have no need to fear myself, because I am able to make an honest assessment of myself, and I don't personally accept the 'mad/bad' label. In this respect, I had to learn to be assertive with the frightened people who cannot/do not want to see beyond the label and associated dominant discourses.

The last thing I have to say is that all of the advice for living with stress I have just mentioned has come to me partly as a result of my studies and the realisation that, for me, and perhaps you, it is essential to be able to express and test my own sensual experience. Moreover, sensual data, which may appear and sometimes are delusional, had to be either verified or eliminated via discussion with close family and friends, or professionals (who have all been generally great). This has been difficult for all concerned, but necessary – firstly, because none of us exists in isolation; and, secondly, because if areas of social and sensual experience cannot be discussed, then assumptions rule, which cannot be good for anyone's mental health. Certainly, if I cannot trust my own senses and do not feel able to discuss sensual data, then my sanity is clearly lost. I have found the only way to begin to get it back is to reclaim my right to talk about my own perceptions. My theoretical journey in higher education has helped me do this and, in doing so, has, helped

me understand the others in my life too. As well, the others in my life have all eventually understood that, from their own experiences of life and achieving adulthood, I really did have to work my own sanity out for myself, and with their support, and like them, will continue to do so every day.

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