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Listening for what is not being said:

Using discourse analytic approaches in mental health research

Julianna Challenor, Eugenie Georgaca, Rebecca Aloneftis, Helena Curran & Nobuhle Dlodlo

Introduction

In this chapter we argue that a discursive approach to research in mental health and mental distress is important for understanding not only what is being talked about and how, but also what is not spoken of, or not-said. We are interested in the ways that discourse analytic approaches can illuminate which particular ways of knowing and speaking are left-out or omitted, and once identified, investigating how this happens. And finally, this method of research can suggest in whose interest it might be that certain discourses or discursive repertoires are not heard, in other words why it happens, and the effects of this absence for the individuals concerned.

Discourse analysis is a qualitative method that asks how a particular psychological or social construct comes to be through being spoken of, written about and enacted, in everyday interactions as well as in policy and institutional practices. Moreover, it examines the function of invoking and utilising particular discourses in terms of normalising types of experience and legitimising forms of knowledge and practice. It also investigates the effects this has for particular individuals and groups, whose experiences and practices are defined by these discourses. We would argue that the same interrogation can be made of what is *not* spoken of, thought, written about or enacted. Discourse analysis is suited to identify the gaps in discourse, that which is not addressed and talked about. Furthermore, it can be used to

interrogate how something is left out of discourse, what processes are implicated, what function this omission serves and whose interests are being served by it. In other words, we contend that discourse analysis can be used to examine not only *what* is not said but, perhaps most importantly, *why* certain things are not said, and what function is served by the absence of alternative ways of speaking, thinking and doing. This effectively amounts to an investigation of the workings of power in defining reality and subjectivity. Highlighting the role of power opens up, in turn, possibilities for resistance, in terms of enabling more varied and empowering ways of defining experience and constructing subjectivities. In this chapter we will illustrate what can be produced in taking this perspective, using three examples of research studies that use a range of discourse analytic methods to demonstrate how the not-said can be accounted for.

Accounting for the not-said

In arguing for this dual focus on both what is and what is not said, a question arises about the status of the not-said. Is the not-said to be considered to be 'outside' discourse or perhaps pre-discursive? The status of the not-said is intimately linked to the ways we theorise the relationship between experience, meaning-making and discourse. Willig (this volume) argues that there are two poles in the theorisation of this relationship. On the one hand, there are approaches which view experience as primary, as having an embodied affective basis that pre-exists discourse. From this perspective, discourse may shape experience through determining how certain experiences can be talked about and understood, through covering up and constraining, or reversely foregrounding and amplifying, aspects of lived experience, but does not determine a phenomenon as it is experienced in its primary affective aspects.

An example of this might be an embodied experience, such as giving birth, or the emotional experience of psychological distress. This argument proposes that there are aspects of embodied and affective experience or material realities that cannot or ought not to be reduced to discourse. Critical realism has been offered as one way to give an account of an individual's experience while remaining within a constructionist framework. From this perspective, distress and other subjective experiences are conceptualised both as product of discourse and a pre-condition of existence. Critical realism attempts to account for the ways in which we are both constituted by discourse and simultaneously exist partly outside it. Drawing on Bhaskar's (1989, 2014) work, Sims-Schouten, Riley and Willig (2007) describe critical realism's concept of "a relationship between deep material and social structures that are not object-like and concrete and that are, therefore, not directly accessible to the researcher. They can only be known through the phenomena that they generate, that is to say, their presence can only be deduced from the processes and experiences which they have made possible" (p. 105). Sims-Schouten and Riley (2018) have developed a method called Critical Realist Discourse Analysis (CRDA) with the aim of examining how individuals understand and experience their own mental health problems, founded in this view of a "…stratified model of reality" (p. 2). In theorizing this approach Sims-Schouten and Riley also draw on Wetherell's (2013) proposal for a discursive focus on affect.

From this perspective, that which is not talked about may point to some aspect of embodied experience which is difficult to speak of, perhaps because of the nature of the experience or because of the limits of language. The not-said may be related to experiences that are beyond discourse and in this sense point to the pre-discursive or extra-discursive, that which lies outside discourse. In some cases, this can be seen to indicate experiences that are so primary they are inaccessible to discourse. In these cases the not-said can border on the

unsayable, pointing to experiences that by their nature cannot enter discourse. What is left unaddressed in talk may represent experiences that, for various reasons, have not been put into words.

The other pole, according to Willig (this volume), is occupied by a more traditional social constructionist perspective that sees discourse as primary and as constituting all experience. In this conceptualisation, there is no pre-discursive or extra-discursive experience; experience itself is produced by the action of discourses, which necessarily entail subject positions and thus constitute subjectivities. More generally, from a social constructionist perspective, material processes and structures, be it bodily, social or institutional, are always already inextricably interwoven with systems of meaning, knowledge and practice. From this perspective, that which is not talked about does not refer to some pre-discursive experience which has not been, or even cannot be, put into words, but to something that has been silenced and excluded in and by discourse. In other words, the not-said is that which is not-permitted, and in this sense it represents subjugated meanings and knowledges that are actively excluded from entering discourse and therefore shaping experience. From this perspective, then, what is left unaddressed in talk may indicate aspects of experience that, for various reasons, are not allowed to be put into words, and thus to become part of individuals' experience.

Subjugated forms of knowledge are linked to the operation of power in relationships between individuals, between individuals and organisations, as well as between organisations. This approach is founded on Foucault's (1982) claim that discourse constitutes experience, or what can be talked about, thought, felt and done. Through the constraining effects of discourse, power is enacted. When no discourses are available to talk about an experience, this experience cannot be had and therefore remains un-addressed. In the field of mental

health, social constructionist approaches have argued that mental distress is to a large extent due to the operation of dominant discourses, mainly deriving from the biomedical model, which conceptualises distress as an illness, an effect of bodily dysfunction, and in this way precludes other, potentially more meaningful and empowering understandings of distress that individuals can draw upon to make sense of and manage their experiences (see for eg. Cromby & Harper, 2009). Taking this stance further, postmodern, systemic, narrative and other social constructionist inspired therapy approaches have argued that the direction of therapy is towards deconstructing the dominance of the biomedical discourse and facilitating the development and utilisation by the therapy clients of other discourses that can render distressing experiences meaningful and manageable (Smoliak & Strong, 2018).

Regardless of whether they posit the existence of pre- or extra-discursive experience, both theoretical perspectives on the relation between experience and discourse view discourse as crucial in shaping experience. According to both, experiences that are considered to be psychological are filtered through a discursive lens in order to have meaning. Even if an experience exists on some level that is pre-discursive, the *forms* that the experience can take are discursively constructed. In mental distress, a raw sense of suffering is channelled and takes different forms through socially available systems of meaning. Discourse transforms a raw embodied state into a fully experienced phenomenon, and with this transformation power can be exercised to actively shape human experience through the dominant discourses available. Foucault's (1980) concept of power/knowledge underpins this account of subjectivity. An individual's account of themselves, their 'truth', is historically constituted, and accordingly constituted through power relations. From this perspective, discourse is a system for representing knowledge at particular historical, social and cultural points. Accordingly, identifying where and how individuals are subjected to power in the form of

knowledge and the way they respond to it is central to discourse analytic methods. The process becomes one of uncovering how through discourses individuals can be positioned by language and knowledge regimes in ways that shape, constrain, and in some cases, exclude something central to the individual's subjective experience that, if acknowledged, would present opportunities for resistance.

We contend that attending to what is not said, what is left unspoken, is important in this attempt to highlight the effects of power and the way in which the mental health of individuals is constructed, as it points to aspects of experience that cannot be talked about, made sense of and ultimately fully experienced. The not-said refers directly to the constraining operation of power, to the aspects of meaning making and experience that are inaccessible to speaking beings and unavailable to them to use in order to understand and manage their experiences. In this sense, attending to the gaps in talk, identifying what is not addressed, can be argued to be a more direct route into discursively investigating the operation of power than analysing the discursive constitution of subjectivity through dominant discourses. We certainly want to suggest that identifying what is not talked about and interrogating its functions and effects is a valuable part of discursive analysis, especially for those adopting more critical approaches that seek to address issues of power and resistance.

In what follows, we provide three examples of such discursive work, discuss the ways in which in each case the exploration of the not-said enhances our understanding of power, and in this way showcase the usefulness of this approach. Each study uses different versions of discourse analysis, and in doing so illustrates the flexibility of the method. The versions are Foucauldian discourse analysis (Willig, 2013), critical discursive analysis (Edley, 2001; Wetherell, 1998) and Machin and Van Leeuwen's (2016) approach to analysing different

modes of discourse, in this case, images on social media. A university ethics committee approved all of the studies.

In the first, which examines the discourse of professionals, we will show how what is left out of the construction of clients serves the interests of creating a legitimate professional identity, and in the course of doing so closes down, or neglects, important discourses and subject positions that clients can draw on. In the other two studies, with voice hearers and women after giving birth, we examine the effects of dominant discourses on experience. In these, what is not said reflects aspects of experience that are excluded by dominant discourses of voice hearing and giving birth respectively.

Study one: Silencing aspects of experience in the service of constructing professional identity

In keeping with a focus on action orientation and context, an important part of analysing that which is not-said is examining its function. A first step is interrogating who articulates the text and in what interactional, institutional and socio-cultural context it is produced. An example of this is research by Dlodlo (2018). She interviewed five leaders of British social enterprises who were participating in programmes designed to enhance employability of clients at risk of social exclusion. A semi-structured interview schedule focused on how they constructed employability for their clients, who were unemployed individuals belonging to various vulnerable social groups. Of the five participants that took part in the study, four were white men, and one was a white female. Their unemployed clients had experienced issues with mental health, or had physical and learning disabilities. One organisation worked with young homeless people. All but one had direct links with

governmental organisations such as the Job Centre and IAPT (an NHS mental health provider; Improving Access to Psychological Therapies). The participants' organisations worked with clients on employment-related tasks such as Curriculum Vitae (CV) writing, interview preparation, coaching, job searches and placements.

Analytic procedure

The transcripts of five interviews were analysed using Foucauldian Discourse Analysis. Willig's (2015) 6-step method was used, as it permits an exploration of what is considered pertinent to understanding the issues that are key to a Foucauldian approach to discourse analysis.. Willig (2015) offers a detailed description of what each of the 6 steps asks of the data, and a simplified description is presented here to reflect the questions asked at each stage of analysis:

1. Discursive constructions*: Identifying the different ways the discursive object of employability is constructed using language, including references to its determinants and effects.*
2. Discourses: *What are the wider discourses within which the various discursive constructions of employability can be situated*?
3. Action Orientation: *When is the discourse being used and to what purpose? What function is being fulfilled, or what may be gained through constructing the employability in a particular way?*
4. Subject positioning: *What rights and duties are ascribed to different subjects through the use of the discourse? Taking up a subject position within discourse offers a position from which to speak and act, and positioning others in discourse has implications for what these others are expected to do and say. Positioning also determines whether and how subjects can exercise power in relationships with each other.*

5. Practice: *What can be said and done from those positions? How do the discursive constructions allow or disallow opportunities to act and make particular practices possible?*
6. Subjectivity: *What can be thought, felt and experienced from the subject positions that have been identified in the earlier stage? This final stage of the analysis can only make tentative claims.*

Results

We will describe the discourses with which participants construct employability for their clients, and consider what is left out of these constructions, together with the implications.

Neoliberalism as a meta-discourse

A neo-liberal discourse was identified as the dominant framework for constructing employability. Neo-liberalism interacted with all the other discourses and was considered to be a meta-discourse or a larger discursive framework, within which the participants' use of various discourses could be contextualised. Within this larger discursive framework of neo-liberalism, discourses were divided into two categories. The first constructed employability as an internal state attributable to the aspirational neoliberal citizen. According to these constructions, intrinsic employability can be optimised within particular contexts. However, the barriers faced by clients challenged assumptions of the "citizen", or employable individual, and the participants' talk illustrated some resistance to these assumptions.

Yet, even as these assumptions were resisted, neo-liberalism remained relevant as a meta-discourse. It informed participants' use of the second discursive category, of

paternalism, which was a way for them to resist some punitive aspects of neo-liberal citizenship discourses. Neo-liberal paternalistic discourses offered participants a way to accommodate their clients' vulnerabilities, whereas neoliberal discourses of citizenship failed to do so.

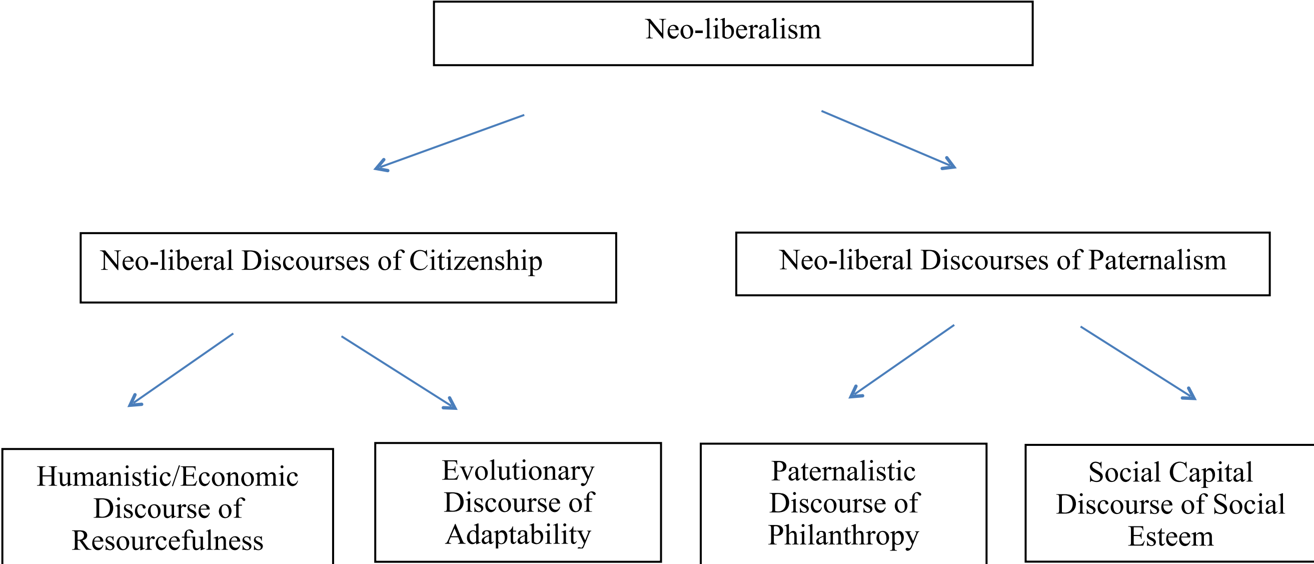

Figure 1. Relationships between discourses

Neoliberal discourses of citizenship

Kock and Villadsen (2015) argue that citizenship is both a discourse and a mechanism by which discourse is enacted and in this study it interacted with all the discourses presented in the first category to shore up certain assumptions of the employable individual. According to Woolford and Nelund (2013), the neo-liberal citizen is active, and typically that is taken to mean employed. They are able to manage risks as an actuarial subject and are capable of self-management and privatized responsibility. Importantly, given the client group that the participants support, neo-liberal citizens are not reliant on government or social services for survival but are instead autonomous, self-reliant and empowered. Finally, the neo-liberal

citizen is entrepreneurial in their ability to maximise personal interests (Woolford & Nelund, 2013). Participants constructed fostering these capacities as their main objective, suggesting that the main requirement for the employable individual is to be able to draw out some internalised sense of their own abilities. Participants talk about their role as helping clients to position themselves within society among other self-esteeming citizens, which will lead to the actualisation of the clients' own employability.

> *I wrote an article for the History of Employability professionals last year that really said you can only really do one thing with an unemployed person, increase their levels of self-efficacy around job searching and the job they want to do. Because if you don't address self-efficacy, you are forever pushing a person up a hill and the moment you let go, they are gonna roll back down again. (Christopher)*

Humanistic/economic discourse of resourcefulness

Within this discourse of neo-liberal citizenship, employability is also constructed to include an individual's intrinsic capacity to be economically productive, and this is combined with an assumption that growth is ultimately fulfilling for the individual. The discourse of self-actualisation comes from humanistic theory in psychology, and claims that all human beings possess an innate drive towards growth. Constructions of employability here suggest an innate propensity in individuals towards employment. Any challenges that emerge around an individual's capacity to work are constructed as functions of inefficient, ill-suited, non-optimising working environments or barriers that can be overcome. Overcoming these challenges is described as a function of economically rational perspective taking.

> *All the evidence shows that clearly people are better off whilst at work than being out of work and that the majority of barriers to support people to go back to work can be overcome. (Adrian)*

> *Many times, they will consider something an obstacle, "I'm just a victim, a passive victim to it." When actually, when we talk to them about it, we can get them to see that it's actually a barrier and if we do something about it, we can get rid of it forever. (Christopher)*

Here is an assumption that the employable individual or citizen is able to optimise their humanistic and economic 'resourcefulness' to eliminate employment barriers altogether. However, the socio-political factors, which exist outside of the individual, are not acknowledged as potentially complicating employment outcomes. Actual employment outcomes are of limited interest when the individual's employability is emphasised in this way.

Evolutionary discourse of adaptability

The discourse of 'adaptability' implies that a challenging environment can be valuable, because it stimulates an individual's ability to adapt their employability and to develop, in the form of gaining employment and career progression.

> *First and foremost, we look at the circumstantial side and say "Let's see if we can help this person have a lifestyle that is compatible with work". […] This is my 20th year of being in the employment sector. I fell into the sector through having a nervous breakdown. Saw a psychiatrist for some months and ended up staring at the walls 20 hours a day at home. Started claiming employment benefits… (Christopher)*

Participants position statutory settings like mental health hospitals and Job Centres as insufficiently stimulating or even stifling. Adaptability, and therefore employability, is constructed to facilitate economically rational choices about what one feels and does in a given environment. This use of language suggests that adaptability involves the 'rational' management of emotions according to the demands of the environment.

So what our guys do is a lot of work on challenging attitudes and behaviours, modelling the attitudes and behaviours [...]. To be able to switch an attitude on in an appropriate environment and go back to normal self when out of that environment… that's really vital for me […] being able to help choose the attitude they show in a work environment. (Christopher)

Neo-liberal discourses of paternalism

The neo-liberal meta-discourse permitted participants to uphold the expectations of neo-liberal citizenship, while using neo-liberal paternalistic discourses to accommodate their clients' dependence. Kettl (2006) demonstrates the ways in which neo-liberal paternalism is enacted through social entrepreneurs, such as the participants of this research study. The aim of neo-liberal paternalism, as Suvarierol (2015) writes, is to create citizen-workers through civic integration via mechanisms insistent upon the internalisation of moral codes that favour one's participation as an employed, active agent in a redefined community.

A paternalistic discourse of philanthropy

This is arguably one of the seminal discourses available to social enterprises positioned as responding to social problems. Dean (2007) states, "…the essential nature of philanthropy is paternalism" (p4). Within this discourse, the philanthropist is a judge, mediator and pastoral carer for the poor. They take on responsibility for the poor individual's morality, in the service of larger societal goals of ensuring the individual's capacity for self-policing.

Often it takes me to be in a meeting with him and either talk for him or say "Look, he's not an angry guy. He gets really worked up, he is in a really difficult financial situation and he's fallen into a bit of bad luck et cetera". But if I wasn't there for that…dunno…he would probably get arrested, barred from places or whatever it

might be, but no one knows why he is like that. I know why he is like that and there are reasons why he is like that. But no one else has that relationship, so they just see him as an angry guy. (James)

Morality is key within this discourse, and participants take up a position of the moral, uniquely perceptive philanthropist. Without this benevolent oversight, their clients are positioned as unable to manage expected behaviour independently. The client's moral and social dependence is maintained by their persistent employment needs, which in this use of language is suggestive of moral needs. This permits a measure of social control for those who are yet to internalise the desired moral codes.

Social capital discourse of social esteem

Finally, employability is constructed as a product of socialisation to the surrounding society, and to people. The client is encouraged to generate social capital by engaging in multiple, esteeming, socialising relationships. However, the paternalistic relationship that the client shares with the participant remains the most important. In it the client is intimately positioned to be seen and to see the world specifically through the provider's eyes. This is argued to be vital to triggering that initial generation of social capital.

Offering things like doing the football and doing other sports and the trapeze and the drama is a way of engaging with them and not actually putting employment straight away to them but actually about saying "Listen, try it and see how you feel", get that relationship going. So it's about starting to build a relationship so that eventually they feel better about themselves and feel that they can actually take on people…and take on…because it's quite a very…it's a very hard journey for anyone who's not worked for a number of years to suddenly feel like they can get a job again. (Richard)

The participants contrasted their socially-esteeming, paternalistic relationship with the distant, though similarly paternalistic, relationships they understand other ‘blinded’ expert professionals to share with the clients. They construct institutional practices, such as Psychiatry or Job Centres, as pathologising, isolating and censuring the individual, thus limiting their potential social capital. The ‘expert’s’ insulated subjectivity does not allow them to demonstrate the degrees of engagement and encouragement that facilitate ‘social esteem’ or favourable socialisation. The expert does not build social capital. They cannot accommodate the informality, and therefore freedom, that neo-liberalism espouses.

> *There is, there is documented evidence that the average level of expectations of clinical workers, uh, not all, obviously, you can't generalize, but the more severe and enduring, um, diagnoses, category of illnesses, that they work with, typically the lower expectations are in terms of work and recovery…Why would a psychiatrist, who only ever sees people on a ward, have any idea of what they are capable of achieving at work…Whereas to have people who see it from the other side and are conscious of the work side of managing mental health, as opposed to the clinical and the, um, incarceration, and the in-patient aspect of it. (Adrian)*

Discussion

Drawing upon neoliberal discourses, study participants constructed employability for their clients via the culturally dominant image of the ‘homo economicus’, excluding any psychological and mental health concerns that the clients might have. They constructed the process of helping their clients through notions of disadvantage or deficit rather than vulnerability or distress. In the broader sociocultural imaginary employability is treated as an individual characteristic, and unemployment is linked to individual psychological

vulnerabilities. This view is reinforced by the appointment of counsellors in UK government Job Centres. The question of why these study participants systematically exclude psychological, emotional and mental health issues from their depiction of employability therefore becomes particularly pertinent.

From a discursive perspective we would focus on the function that this omission has for participants and their clients, and we would start by examining who articulated this discourse and what subject position they construct for themselves. If we take into account that the research participants are social entrepreneurs, leaders of social enterprises, it is no surprise that they foreground a neoliberal ideal of people as individual entrepreneurs seeking self-improvement through calculated actions, and portray the obstacles to employability in terms of social disadvantage that hinders the process of self-improvement and socioeconomic ascent. In this way the study participants construct their clients as in need of enhancing their entrepreneurial skills and thus legitimise their own professional identity. It may be hypothesised that if the research participants were employment *counsellors*, they would foreground psychological and mental health discourses and instead silence entrepreneurial and socioeconomic aspects, when discussing the employability of their clients.

Most discourse analytic research of mental health professional perspectives has focused on the discursive strategies through which professionals account for their practices of assessment, diagnosis and treatment. These studies have shown that, when professionals are called upon to account for their practice in a research study, they actively develop strategies of legitimation of their actions, through evoking expertise and mobilising dominant discourses in order to pathologise their clients and naturalise their actions (Stevens & Harper, 2007; Liebert & Gavey, 2009). In other words, mental health professionals actively construct their identity through legitimising their knowledges and practices (Georgaca, 2013).

Systematically silencing understandings of their clients that do not fit in with their professional role seems to be one more of the strategies that professionals have at their disposal. We would argue, in conclusion, that when studying professional discourse, investigating what is left out can shed light on the construction and legitimation of professional identities. Excluding aspects of client experience and identity, apart from shaping professional identities, has repercussions for clients. We will address this more directly below.

Study two: Dominant discourses and the construction of a mentally disordered identity

While discourse analytic studies examining the talk of mental health professionals tend to focus on the discursive strategies of accounting for professional practices and legitimising a professional identity, studies examining client perspectives tend to investigate the discursive resources that clients draw upon to understand their distress and the effects of these discourses on their experience and identity (Georgaca, 2014). In this second example, Aloneftis (2017) examined the ways in which individuals who hear voices make sense of the voice hearing experience and the effects of this experience on their identity. The eight participants were all members of the UK Hearing Voices Network (HVN), an organisation that takes a pluralistic approach to understanding the phenomenon of voice-hearing. Seven females and one male, aged between 19 and 20 years, and who identified as voice-hearers were interviewed.

The study illustrates how individuals who hear voices get caught up in a dilemma in which they must denounce or disavow important aspects of their experience in order to claim a socially acceptable and valued identity. The subjective experience of distress is explicitly

linked here with identity constructions and power relationships in every day and institutional settings.

Analytic procedure

The discursive approach in this study operates on the assumption that language has a performative function. It is where identity work occurs and due to this an analysis of discourse is a useful method for investigating identity construction (Benwell & Stokoe, 2006). Moreover, adopting a discursive perspective enables researchers to critically examine the power implications of particular identity constructions and the ways in which these are reinforced by institutions and practices (Parker, 2002).

This study draws upon Davies and Harré's (1990) theory of positioning, which is helpful for the examination of the active role the individual plays in choosing between the discourses available to them. Positioning theory was used in the analysis to identify how participants positioned themselves within available discourses of voice hearing and with what consequence for identity construction. However, this is a cyclical process, because discourses have an impact on individuals and practices, and conversely the way that participants position themselves serves to reinforce or undermine discourses (Sims-Schouten, Wiley & Willig, 2007). Critical discursive psychology is therefore both agentic and deterministic (Burr, 2015). Despite individuals being determined by discourse, they are also considered to be creative actors in the way they deploy language and construct accounts to accomplish a purpose (Edley, 2001). It is in this positioning within available discourses that identity work occurs (Davies & Harré, 1990).

The study sought to address the following research questions: How do people who hear voices talk about their experiences? What resources in the social domain do they draw upon

to negotiate this identity? What are the consequences for the way in which this identity is negotiated? The critical discursive method used here entails a dual analytic focus, combining conversation analysis and post-structuralism (Billig et al., 1988; Edley, 2001; Wetherell, 1998). A micro level analysis of the action orientation of participants' talk looked at what participants tried to accomplish in interaction. This stage of the analysis examined the discursive strategies that participants utilised, the rhetorical devices they drew upon to support their discursive strategies, the interpretative repertoires (common ways of talking about things formed by shared social consensus) employed, the ideological dilemmas (deliberations, contradictions and inconsistencies in talk) posed and the subject positions (how participants positioned themselves in discourse) used to do identity work.

The macro level of analysis looked at the wider discourses that participants drew upon to construct the experience of hearing voices, attempting to locate the discursive constructions without losing the action orientation of talk. This level of analysis seeks to address power implications and address questions such as: What possibilities of action do the identified discourses enable? Whose interests are being served by the prevailing definitions of voice hearing? What is the relationship between discourse and practice? And how are these discourses and practices maintained, resisted or transformed? (Willig, 2013).

Results

Participants used two types of interpretative repertoires to construct the experience of hearing voices. Each of them was pursued through different discursive strategies.

Voice hearing constructed as a difficult and distressing experience

Voice hearing constructed as a normal, ordinary experience

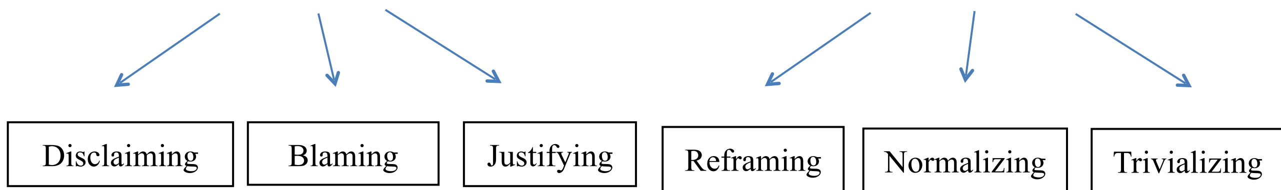

Figure 2. Interpretative repertoires and discursive strategies of voice hearers

Of interest is the polarity of these constructions, which was observed both between interviews and within the same interview. We take these polarities to reflect the dilemmatic nature of talk, illustrating that what participants are trying to accomplish with their talk is dependent on both the immediate interactional and the broader sociocultural context. In this study it was useful to explore the differential identity constructions found in the material through the concept of negative and positive identity construction (Bucholtz, 2009), as well as by examining the orientation of identity construction in relation to the in-group or the out-group (Wetherell & Edley, 2009). Negative identity practices are employed where individuals want to distance themselves from a rejected identity and emphasize identity as an intergroup phenomenon, whereas positive identity practices actively construct a chosen socially valued identity and thus emphasize the intragroup aspects of social identity (Bucholtz, 2009).

By drawing on the interpretative repertoire of voice hearing as a difficult and distressing experience, participants created a division between themselves and non-voice hearing populations through maximising difference in terms of their distressing experience. The construction of voice hearing as a distressing experience exemplifies negative identity practices, because participants seek to define what voice hearers *are not* by rejecting pathological notions of voice hearing and distancing themselves from negative constructions in the social domain. This repertoire is associated with discourses of pathology and is why,

when using it, participants oriented towards avoiding being positioned by others as 'mental patients' within biomedical discourses of psychopathology.

With the second repertoire of voice hearing as a 'normal' experience, participants used rhetorical devices to normalise the experience of hearing voices and in doing so attempted to achieve a greater level of proximity with the rest of the population. With this interpretative repertoire, participants minimised difference by constructing their experience as ordinary. This was an example of positive identity construction, whereby participants attempted to disclaim any relation to the dominant discourses of pathology that might be ascribed to them through building up their credentials as 'normal' people.

Voice hearing constructed as a difficult and distressing experience

Disclaiming

Participants adopted this strategy to disclaim pathological constructions of voice hearing in the social domain, when they perceived their identity to be under threat, for example when voice hearing was associated with pathological labels and notions of dangerousness. In this strategy, participants overtly rejected pathologizing assumptions linked to voice hearing. Thus, through minimising the pathological associations to voice hearing, they tried to recover a valued identity as voice hearers.

> *The three areas that they look upon is, one is just general prejudice, you're mad, you're crazy, you're bad. The other area is basically in some respects it's your fault that you've suffered it and the other respect is in some warped sense, you must be weak in some respect or suffered a breakdown. And that's absolute rubbish on all three fronts. (Jack)*

Through using a three-part list ("*you're mad, you're crazy, you're bad*") and extreme case formulation ("*absolute rubbish*"), Jack initially articulates and then strongly rejects the negative, pathologizing attributions that he sees as socially ascribed to voice hearers.

Blaming

This strategy apportions blame to others – the media, institutions, health professionals, pharmaceutical companies – for negative constructions of voice hearing in the social domain. This is not simply an attempt to reject pathological notions of voice hearing, as with the previous strategy. This strategy goes further in seeking responsibility for these presumably unfounded negative attributions. Apart from implicitly reinforcing the claim to the falsity of these attributions, this strategy serves to construct voice hearers as honourable moral agents, who are wronged by the misguided representations of others. Here, participants construct their identity in relation to what they are not and in direct comparison to others, who are positioned as not understanding and not knowing.

> *Society in general and the media. I think the media more than anything. The media, maybe psychiatry a little, drug companies. I usually blame drug companies for most things. But actually more than psychiatry or the pharmaceutical industry is the media, and you know it's the media for so many things, but it is, you know, this kind of need to print shocking scary things because that's what people want to read. And then print them in a really ill-informed way and report them in an ill-informed way, like every time something awful happens, there's like a query about whether the person who did it had mental health problems. (Neve)*
>
> *I don't think they would have people cycling in and out of hospital if they would stop putting this as a "Oh it's a pathology", "oh you're nuts" that kind of thing. Ah, "I*

really must keep you away from society, because you're a bit of an embarrassment". (Zoe)

Neve uses repetition ("*you know*"), generalisation ("*every time something awful happens*") and extreme case formulation ("*shocking scary things*", "*really ill-informed*") to maximise the impact of her claims that, more than "*psychiatry*", "*the pharmaceutical industry*" and "*society in general*", "*the media*" is responsible for the disastrous circulation of negative stereotypes regarding individuals in mental distress. Zoe voices in direct speech the exaggerated and misguided claims that people in general ("*they*") make when talking to people with mental health difficulties.

Justifying

Participants also repeatedly justify the mental state and actions of themselves or others, when confronted with pathological constructions of voice hearing. In this way they distance themselves from negative constructions of voice hearing though explaining how they have come about and why they do not conform to available constructions.

> *My brother said "Yea well everything you say when you're unwell is all gobbledygook". And that really, really hurt. Because it was like, you know, "I'm maybe unbalanced and not, and confused and not remember things, but it's still, I'm still me?" And to scrub out everything I'm about when I was showing those symptoms is very hurtful. (Angie)*

> *I have been abusive myself and people have kept out of the way from me. But the thing is I'm more frightened of them, than they are of me really. That's what we want to get the voice across, because all you hear about in the papers is "Paranoid schizophrenic, stabbed somebody", and so on and so forth and been arrested and they're usually down on the ground or something being manhandled by the police.*

And it's probably the voices telling them to do it. And they're more frightened of the police than anybody needs to be frightened of them. Cause I've been known to carry a knife but I didn't know that I was doing it. Do you know what I mean? Afterwards someone's told me and I couldn't believe it was me. It's like you're a different person, but you're very frightened. Cause hearing voices is frightening. (Anna)

Angie recounts an episode in which, faced with her brother's accusation that in periods of crisis she does not make sense, she reformulated her mental state as being "*unbalanced*", "*confused*" and "*not remembering things*" and argued that it is a state of mind that expresses aspects of her being ("*what I am about*") that should be understood and respected. Anna attributes both her and other voice hearers' "*abusive*" behaviour to the experience of hearing voices, which affects their state of mind. Moreover, she indirectly attributes some extreme reactions of voice hearers to their fear, caused by the voices and by other people overreacting to their altered state of mind and aggressive conduct.

Voice hearing constructed as a normal, ordinary experience

The discursive strategies employed to construct voice hearing as a normal and ordinary experience resulted in normalised accounts that minimised and reframed pathological notions of this experience. These are positive identity practices, because they seek to delineate what voice hearers are like, through asserting their proximity with the rest of the population, and thus ascribing to them the socially valuable identity of a 'normal' person.

Reframing

Reframing involves restating a situation so that it may be perceived in a new light. Wherever possible, participants attempt to reframe their experiences in ways that allows for a less problematic identity, for example by constructing themselves as atypical members of

pathological categories relating to the experience of hearing voices. The discursive strategy of reframing allowed participants to distance themselves from a position that is potentially problematic and particularly one that does not enable possibilities for action.

My voices have been more compassionate and reasoning and helpful as such on occasions, but I tend to be the exception to the case there, whereas most of the group their voices can be at times distressing, dark, aggressive, and cause them quite some distress. (Jack)

Well, a psychiatrist explained to me years ago, that because I could recognise my hallucinations as hallucinations they weren't true psychosis. Now I get delusions, which I believe are true. I don't see them as delusions, so if somebody, psychiatrists, wants to argue they are delusions, I would debate that with him or her. So, they could say I'm psychotic on that. But the hallucinations, I can see as hallucinations, so they're called a pseudo psychosis, not a total psychosis. (*Lauren)*

In the extracts above participants stress the difference of their experience from what is constructed as a 'typical' experience of hearing voices. They thus construct themselves as atypical members of the mental health diagnosis of schizophrenia or psychosis, repudiating the implied category entitlement.

Normalising

Participants used this discursive strategy to construct the experience of hearing voices as an ordinary experience. This strategy reduces perception of difference and otherness by establishing a degree of proximity with the rest of the population.

Well, it is normal but it's not seen that way, I don't think, by other people. [R: How do you think it is seen by others?] ...Either it's scary cause you might be dangerous or it's scary cause it's completely weird and people just can't understand what I'd be like, so

they're just kinda like "I can't relate the inside of my head to the inside of your head", which is really bizarre, cause the inside of my head works in a similar way to well everyone, the inside of everyone's head is pretty weird. And whenever you find out something about somebody's ways of thinking or beliefs and things, you're like "What? It doesn't make any sense!" So, everyone's different and weird and I don't think it, you know, I relate it quite often to my voices, are quite often troublesome to me in the night? That, you know, If I'm stressed they'll wake me up at like 3 in the morning, and kind of make lots of noise, but I know from other people that don't hear voices, that when they're stressed they wake up at 3 o'clock in the morning with their thoughts racing round in their heads. And that's completely normal. And I'm like "Well it's not so different from that! It's just like my body and my brain reacting to the fact that I'm stressed and disrupting my sleep. And for you it's your thoughts, for me it's the voices". (Neve)

Neve uses extreme case formulation ("*completely weird*"), direct speech quotes and generalisation ("*everyone's different and weird*") to construct an argument that her voice hearing experiences are more similar to other 'normal' experiences than others would be willing to acknowledge. She also uses personal footing, presenting her own experience and comparing it to that of others around her, in order to ground her claims to personal knowledge and experience.

Trivialising

Participants use this discursive strategy to minimise the distress they experience. These constructions allow participants to remain in control, save face and reassure others. One of the strategies adopted is to use humour to cope with difficulty (Gelkopf, 2011). The

alternative would mean participants having to acknowledge the sometimes very distressing and severe consequences that the experience entails for themselves and others.

> *One of my ways of kinda coping with things that have happened that have been really difficult, and this is my family's way of coping with everything, is with humour. So I've got like a collection of kind of hilarious stories about things that have happened when I've been in hospital, because hospital's been horrendously traumatic…but usually a few things happened that are quite funny, and they're particularly funny if it's something silly that I've done, cause I like making fun of myself so I'll maybe say to somebody "Oh like that time when I was in hospital and dadadadada happened" and then they'll laugh and someone might be like "Oh! what hospital were you in?" or something, and then I'll like make light of it. (Neve)*

Here, Neve uses direct quotes, extreme case formulation ("*horrendously traumatic*"), repetition and vague expressions ("*kind of*", "*like a*") to describe her deliberate use of humour to trivialise distressing situations and experiences.

Discussion

This study examines the effect of dominant discourses of voice hearing and psychosis, both lay and professional, on the identity construction of people who hear voices. It demonstrates that voice hearers are very aware of these discourses and are active in managing their positioning with respect to them. This is in line with other discourse analytic studies of mental health service users diagnosed with psychosis (Benson et al., 2003; Harper, 1995). Faced with the position of being severely mentally disturbed and potentially dangerous to themselves and others implicated in the diagnosis of a severe mental disorder, they can either accept it, with all the repercussions this has for their identity, or reject it and adopt a 'normal'

subject position (Georgaca, 2004). The polarity between pathology and normality constructed by the dominant biomedical discourse of mental illness leaves no room for any position other than being 'mentally ill' or 'being normal'. The price of adopting the 'being normal' position, is to deny the strangeness of voice hearing and to silence the distressing and disturbing aspects of this experience, as well as other psychotic experiences. There is no possibility of acknowledging, making sense of, and attempting to manage bizarre and disturbing experiences without adopting an unwanted pathological identity. Safeguarding a positive 'normal' identity implies rejecting the disturbing aspects of one's experience, leaving no possibility to acknowledge and deal with them. We see here the operation of power in the form of dominant discourses forcing individuals caught up within them into particular binaries of subject positions, which end up silencing, excluding and leaving unaccounted for significant aspects of their experience. Here, paying attention to what is left out, what is not talked about, is important in order to identify the discourses at play and their effects in terms of shaping individual experiences of distress.

Analysing, through the gaps, the operation of power of dominant discourses, also points towards strategies of resistance. In this case, resistance to the power of the biomedical discourse necessitates deconstructing the polarity between normality and pathology. This would involve a simultaneous process of normalising distress and de-sanitising normality, in other words acknowledging both the continuity between the two and the deeply disturbing and distressing aspects of 'normal' experiences (Parker et al., 1995). This is the direction that many self-help organisations in the field of mental health have taken (Campbell, 2013), and with regard to hearing voices the international hearing voices movement in particular (Longden & Dillon, 2013; Romme, Escher, Dillon, Corstens, & Morris, 2009).

Study three: Sanitising bodily processes

A biomedical discourse shapes human experience through defining, ordering and constraining what can be felt, also with regard to bodily processes. An example of the simultaneously productive and constraining role of the biomedical model is given in the work of Curran (2019) around childbirth, specifically women's accounts of giving birth, as they share them in groups and in social media. This study is rooted in a premise, born of an emerging social narrative (McNish, 2017) that childbirth is constructed in non-'woman-oriented terms' (Grosz, 1989), within dominant bio-medical and maternity discourses, and in turn the social contexts of naturally occurring talk between women. This study seeks to make sense of this absence of a subjectively female discourse in relation to what it says about a woman's power, positioning and sense of self in relation to giving birth. Twelve participants took part in three focus groups of 4. They were white or Asian women from the UK, Europe or the US, and all the women had given birth more than 12 months previously. All were currently living in the UK, in London. Some of the women had more than one child, and some were pregnant at the time of the focus groups. The emancipatory aim of this research prompted three research questions: What dominant discourses around childbirth are available? How do women take up or resist those discourses in their own construction of childbirth? What might that mean for both childbirth practice and a postnatal woman's subjective experience?

Analytic Procedure

Childbirth is both a practice and a process that is embedded within social, historical and institutional contexts. Explicit themes of gender, power, sexuality and medicine meant that a

Foucauldian Discourse Analytic framework was deemed an appropriate research method. Willig's (2015) six-step method (described above) was applied to texts produced from three focus groups, each comprising four postnatal women talking to each other about childbirth. The participants were recruited through mother-and-toddler playgroups, personal contacts and social media sites. Focus groups took place in hired private spaces in three different locations and facilitated with the aim of eliciting something as close as possible to naturally occurring talk. Helena, the researcher, offered participants her own stake in the research, through disclosing her own experience of childbirth, as Potter and Hepburn (2005) suggest.
A second analysis of visual images of childbirth posted on Instagram was also carried out; this will be summarised later.

Results

What follows are three examples of discourses elicited from the focus groups. They all serve to limit a woman-oriented discourse and the consequent subjective experiences of childbirth. Instead, a 'natural' maternity discourse, a biomedical discourse, and a masculine discourse are drawn on to construct childbirth as a perfect, natural process, and/or one in which women are the vessels for a healthy baby, and/or governed by a strikingly male lens.

'Natural' maternity discourses

In the naturally occurring talk of the focus groups, childbirth was intensely, and quite fearfully, constructed as part of the participants' sense of self. Participants talked of being justified or judged in relation to their capacity as a woman and a mother. Hannah described what the leader of an ante-natal group had told her:

"She said, 'Well you know what, I would just like to say that the ultimate childbirth experience and what you could all see as kind of a success story would be if you ended up having a home birth, because if you end up having a home birth, that just means you are awesome at childbirth'". (Hannah)

When asked to talk about their experience of giving birth, the participants positioned themselves quickly into split camps of 'natural' (vaginal) birth or Caesarean Section. The explanation around having a C-Section, particularly a planned one, was much more extensive and justifying. The ideal birth, as prescribed by Hannah's antenatal maternity group leader, was "*home birth*". "*Home birth*" is presented as the epitome of natural, which means you are "*awesome at childbirth*". This feeds into both a maternity discourse of natural as best, in which you are "more likely to feel satisfied with your labour" and "less likely to experience psychological problems like depression" (NCT, 2019), incorporating criticism of hospitals and medical intervention as overly controlling and therefore bad. By prizing the female 'naturalness' of birth this maternity discourse conversely constructs those who have navigated birth with anything other than natural ease as un-natural and a failure. The birthing woman is positioned as one to be observed and judged, as Sally experienced:

And I even overheard… and I shouldn't be critical, but it's something that happened and it sticks with me. I heard… someone came in to start their shift, and the lady said, "Oh, how is she getting on?", and she said, "Well [inhales] [pause], she is doing alright, when she does it properly".

To acknowledge childbirth as something emotionally and physically messy is made difficult by the 'natural' discourse of birth and the women described a need to tidy up their talk in their everyday lives when they talked about their experience of giving birth, into neat, clean, external and medicalised narratives of birth type, timings, location and pain-relief used.

Implicit in the 'natural' discourse was an expectation that women give birth independently, and without any (internal or external) fuss or mess. It was this absence of mess, chaos, gore – the 'not-said-ness' of childbirth – which was paramount; out of all the focus groups comprising over 5 hours of talk about childbirth, the word 'blood' was said six times, 'vomit' five, and 'vagina' just twice.

Through the not-said, and not-seen, and within a scrutinizing maternity discourse constructing childbirth as natural, women are positioned in a conflicting, eradicating and shameful way, where 'natural' is best but simultaneously unacceptable.

Bio-medical discourses: the mother as vessel for a healthy baby

> *This other poor lady, um… she was quite adamant, like, you know, "The baby is coming." And then the midwife who, like… you know, they, whatever, examined her, and they were like, "No, it's not." You know, "You're a first-time mum. It's not coming." And, um […], I think, like, somebody had told her to have a shower or… anyway, so she was in the shower. And she was like, "Can you get the midwife? The baby is really coming". And, um…, the midwife came, luckily, and it, kind of… it fell [laughter] out as she got out of the shower. (Renata)*

Another way in which women's subjectivity seems to be eradicated in childbirth links to the discourse that constructs the woman as a vessel for a healthy baby. All at once the birthing woman is constructed as a risky, threatening object and a passive, disposable entity. Renata recalls the story of the baby merely "*falling out*", and a 'lucky' one at that, as the vessel achieves its purpose and the baby survives.

That a woman is "supposed to efface her own subjectivity" (Bordo, 1993, p. 79) in childbirth evokes Foucault's (1998) thinking on discourses around women, their sexuality,

their reproductive function, and on the body as a site of disciplinary power. Taking up this discourse, Beatrice questions whether her subjective experience is even a valid consideration, given the baby was born healthy:

> *But it was those little things along the way that I hadn't really expected it and it, it did really take away from the kind of, the experience of childbirth. But then part of me sits here now and thinks, "Do I really care?" She came into the world, she's happy and healthy, um, does it, does it, any of these really matter, because it wasn't life and death at any point and it was quite controlled and, and carefully done.*

There was frequent talk about actual and feared loss or death of the baby through numerous miscarriages and ectopic pregnancies throughout all focus groups. Nothing was said, however, about the loss a woman may experience in the moment of birth, as if both ideas cannot exist together. The birthing woman is constructed as a vessel through participants' accounts of being monitored, restrained, told to lie down on their backs, get in the (birthing) pool or get out of the pool. Dominant medical discourses construct this control as necessary for the safety of the baby. This medicalisation of birth, in which women are constructed as a vessel for a healthy baby, might be considered to represent the operation of a technology of power (Foucault, 1988), a means to control and prevent obstetric negligence claims, which in 2018 represented a significant 48% of the total value of all medical negligence claims in the UK (NHS, 2018).

'Masculine' discourses of birth

When distress *was* talked about in relation to childbirth during the focus groups, it was often introduced through a third, absent person or through a male lens. Masculine metaphors of war or murder scenes were recruited into the women's talk. It was thinking about how her

husband saw and constructed their child's birth that allowed Sophia to re-construct what had previously been her "*great, really good birth"* to something that she definitely did not like and did not want to do again. The masculine lens was drawn on to allow her to construct a messier, more difficult birth in the absence of the not-said female-subjective one.

The masculine discourse was also constraining, as women describe its inability to accommodate either the physical or emotional chaos of childbirth. Sally described her husband's limiting, silencing reaction both to her being cervically examined; *"…my husband's reaction was to go to the toilet and throw up, you know"*, and of her wanting to talk about the birth afterwards: "*Like, "Move on", basically, in not so many words"*. The male lens constructs childbirth as intolerable and disgusting, needing to be curtailed and ended at the moment of birth. This suggests, as King (2004) argues, that "even in this supposedly equal, liberated society, femaleness is still disturbing enough to require supervision and containment by forms of discipline that men are not subjected to" (p. 36).

That discipline also manifests in repeated requests for pain relief to a male other, be it the husband, partner, or clinician. This has something of a protective yet withholding function, as if women need to be both sheltered from yet bravely endure childbirth, the most threatening of all bodily experiences in its otherness to the male standard.

> *So it was awful, the whole... I had my playlist, I had the candles, I had all these things that my husband laughed about and said, "You're just going to be begging for that epidural". "No, I'll be fine". I tried the gas and air, threw up, as in similar to you. It didn't work and there was no anaesthetist around, which didn't help. (Anya)*
>
> *My husband was very proud that I didn't have any pain intervention. (Sophia)*
>
> *And I remember [laughter] saying straight afterwards to my husband… I was like, "Don't ever let me not have an epidural again". (Renata)*

The notion of pain that is constructed as controllable by a male gatekeeper highlights something glaringly not-said in the women's talk about childbirth: the original sexual pleasure which creates the potential for childbirth, including any mention of sex, female sexuality and sexual organs. This can be contrasted with an image posted by the Empowered Birth Project on Instagram, with over 15,000 'likes', which shows a woman touching her clitoris for pain relief whilst the baby is crowning, accompanied by a caption, "Mammas, please don't be shy about touching yourselves!" (Empowered Birth Project, 2018a). This potential for the woman to relieve her own pain can be argued to be an example of an aspect of birth that a male discourse prevents, and which as Sophia says; "*…could quite easily be told to you and like…what is the myth about that that they can't say that to you?"* When birth is constructed as an event to be controlled by a male gatekeeper, woman's agency and sexuality is diminished at the moment of becoming a mother, kept as a shameful secret.

Visual discourse analysis: Birth as 'real' or 'unsee-able'

In addition to the textual discourse analysis, a second form of analysis was employed using images posted by postnatal women about childbirth on Instagram, aiming to pursue the emancipatory rationale of this study as well as consideration of the not-said. For the purpose of the study, Instagram is considered to be a space where women can communicate and construct birth in a way that has the potential to exist outside the dominant discursive framework. Machin and Van Leeuwen's (2016) discourse analysis framework for multimodal data was employed cyclically, to focus on meanings in relation to the signifier, signified and wider significance of the images selected. The first of the three stages of analysis focuses on the signifier, the visual evidence that is depicted, in terms of colour, objects or people within the image. The second stage focuses on the signified, the range of meanings that can be

contained within the signifier, and arguments for how potential for meaning is realised in the context in which the image is presented. For example, whiteness in an image depicting childbirth may be interpreted as indicating cleanliness, calm, or purity, and when contextualised as an image used by a hospital promoting its birth facilities, interpreting it as both clean and calm is plausible. The third stage of the analysis focuses on the wider significance of the image, particularly in relation to social theories, in which legitimisation or medicalisation, for example, can be argued to constitute, or disallow, particular identities, activities and values.

The disappearance of a woman's needs at the moment of birth found in the discourse analysis of focus group talk was also reflected in the visual discourses. A direct representation of what a vaginal birth actually looks like was in early 2018 actively censored by being removed from prominent visual social media platforms Facebook and Instagram along with "pornography, graphic violence, profanity and other subject matter deemed too offensive for the public eye" (Vigos, 2018). In contrast, posting an image of a dead foetus was permitted, because it was posted (to 1.6m followers) by a pathologist interested in the object as a medical curiosity (Hernandez, 2015).

Another image removed from social media in 2017 is worth considering (Empowered Birth Project, 2018b). The image in question does not show a vagina, a crowning baby, or a naked woman. It features centrally a woman, her breasts covered with her dark purple lace bra, her chest smeared with a little blood, holding her just-born baby over her bare, stretch-marked stomach, with the purple umbilical cord linking the not-yet-birthed placenta to her baby. In the image, there is an uncensored representation of the woman's intense emotional experience, which communicates horror and relief, agency and involvement in birth; unquestionably, this woman is more than a mere vessel. The setting is not within a medically

controlled and mediated environment; indeed it's a messy, cluttered darkly lit domestic bedroom, with a sexually dark red bedspread in the background, far from a clean, white, sterile hospital context. The removed image shows physical and emotional mess, together with female distress, alongside the birth of a baby, all actively communicated by the woman in the photo.

Discussion

In these accounts, like those of voice hearers discussed above, we see clearly the way women are trapped in the dominant discourses of childbirth, both as a natural process and as a medical procedure. Both discourses normalise and sanitise the experience of giving birth, excluding any non-linear, contradictory feelings and understandings that women may have. They also efface the woman-subject, turning her to a carrier, a vehicle for the safe delivery of a baby, making her subjective experience of the process secondary and irrelevant. The combined effect of these is that women have no way of expressing, acknowledging and ultimately fully experiencing the messiness, the physical brutality, the pain and the intense ambivalence of the birthing process. This is another example of the way in which discourses define reality and experience, silencing and making inaccessible to the people who are caught up within them aspects of physical, psychological and emotional experience. In this example, noticing and interrogating what is left out, in this case the sheer physicality, messiness and ambivalence of the birthing process, allows us to examine the operation of power in terms of dominant discourses shaping individual experience.

Uncovering the operation of power can point towards strategies of resistance. In this case, encouraging women to voice their experience, ideally in mutually supportive groups and environments, might open up possibilities of more varied and complex accounts of the

birthing experience. At the end of each of the three focus groups, the women taking part all independently agreed that a debrief with medical professionals about the birth would have been helpful in processing their experience. Consistent experiences of nobody asking, nobody wanting to hear about the birth within a medical context were reported. The women talked about wanting to voice their experience, have their distress validated, heard and held. This somewhat simple act might bridge the gap between the personal/female and the professional/male discourses, and be a way of disrupting the existing constructions of childbirth, so that a female-subjective discourse may be heard. Foucault (1998) claimed resistance is possible wherever normalization and domination exists, as power is always shifting and unstable.

The Empowered Birth Project's goal of normalizing the act of birth through showing it visually is one way that this resistance is contesting dominant power on what Foucault termed a 'micro level' (Foucault, 1998). The personal and female space of social media, showing actual childbirth, and with it a female-subjective discourse, which allows for a more mixed and messy, yet agentic expression and therefore experience of birth, is a way to do this. To this we might add the micro levels of resistance shown by the women taking part in the research; two of whom, it should be noted, specifically requested their own name to be used in the study, with five declaring feeling comfortable with either their own name or a pseudonym being chosen. This can be considered, perhaps, a micro act of resistance, which demands that they, and a woman-oriented discourse of childbirth, are both seen and heard in social, academic, and ultimately clinical spaces. Thus, encouraging women's voices and the physical impact of circulating visual representations might operate as acts of resistance to the medicalisation, normalisation, sanitising and silencing of the disturbing aspects of women's experience of giving birth.

Conclusion: Power, resistance and potential for action

The three studies presented here demonstrate how attending to the not-said and, most importantly, questioning the function of the not-said and its effects on the individuals affected by it, foregrounds the issue of power. Examining the operations of power can, in turn, open up possibilities for resistance. This, we contend, is one of the strengths of discourse analysis, and what provides it with its critical edge.

Attending to power is essential to the field of mental health research. Parts of experience that have been actively excluded through the operation of dominant discourses, such as a biomedical discourse in psychology, can be brought into the discursive framework and be thought about or spoken about in different, more empowering ways. The different purposes or reasons for the exclusion can be examined, limiting professional procedures can be questioned and strategies of resistance identified. These three studies all suggest different ways of uncovering the operations of power in what is currently dominant, deconstructing it and opening up gaps for other discourses and practices to emerge and gain ground. Discourse analysis seeks to "amplify the subjugated voices" (Miller, 2008, p. 258). It aims to identify and bring forth ways of talking and discourses that go against the grain of the dominant ones, and thus allow previously unacknowledged aspects of experience to be heard and felt.

At the beginning of this chapter, we briefly outlined some arguments that have been made about the place, or status, of the subjective experience of what it is that is not-said in discursive approaches. The limitations and criticisms of the methods described above depend on this status. If the not-said is considered to be outside discourse, discursive methods are limited to providing findings that must remain provisional. There is no way of either confirming or disconfirming what is being claimed when situated within a framework that

suggests some experience will remain inaccessible to language. Participants themselves may not recognise the claims that are being made on their behalf and for a research method that aims to draw out the workings of power, researchers must remain acutely reflexive and alive to the potential for the abuse of power that lies with their own role. If, on the other hand, all experience is considered to be the product of discourse, then the argument can be made that the method neglects the possibility that individuals do possess and exercise agency, even if this remains limited. It is difficult to give an account of the choices that are actively made by participants in their talk, and this too may seem to participants to be counter to their own subjective experience.

Moreover, as it has been rightly noted (Willig, 1999), discourse analysis is reluctant to move beyond deconstruction to make recommendations for improved social and psychological practice. Through deconstructing harmful professional views and practices and opening up alternative spaces and positions discourse analysis does not directly lead to possible interventions, but can inform them (Harper, 1999). It has been argued that, if discourse analysis is to move beyond deconstruction towards a more direct impact in the field of mental health, it would need to take some important steps, which would include placing emphasis on the links between research, implementation and interventions, forging alliances between discourse researchers, mental health service users and critical professionals, and making tactical use of research findings through utilising multiple forms of dissemination and consultation (Harper, 1999, 2006).

We argued above that investigating the not-said can be a valuable part of a critical agenda in mental health research and practice. Moreover, we would argue that attending to the not-said, alongside to that which is said, can be pursued regardless of the status one gives to the not-said, be it as pre-discursive or as excluded from discourse. We contend that

epistemological questions regarding the relationship between reality, experience and discourse, however important they might be, cannot detract discursive researchers from pursuing a critical agenda of problematizing constraining knowledges and practices, which are sustained by dominant discourses, and opening up spaces for more empowering modes of experiencing, understanding and acting. We hope we have demonstrated in this chapter that attending to the not-said can be a poignant strategy for pursuing this critical agenda, which is much needed in mental health research and practice.

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