

Patients, consumers and survivors: A case study of mental health service user discourses

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Abstract

This paper is an exploratory study of ways of talking about mental health. Drawing upon data collected from mental health service users in the Republic of Ireland, it employs discourse analysis within a case study approach to embellish three ‘types’ of service user identified in the sociology literature. Rather than being seen as specific types it is proposed that patient, consumer and survivor be regarded as a discursive typology which function as discursive resources for service users. The re-conceptualisation of these types, as discourses, allows the researcher to gain thicker descriptions of the ways in which service users socially construct their own perspectives on mental illness. Through a process of discourse analysis, discourses of patients, consumers and survivors are extrapolated out from interview talk with members of mental health social movement organisations or groups. The identified discourses contain intrinsically different ways of talking about mental illness and allude to different conceptions of agency on the part of the service user. It is argued that they offer an insight into bottom-up social constructions of mental illness. It is proposed that these discourses suggest that notions of patients, consumers and survivors have entered the service users’ discursive canon and that they are actively utilised by service users to socially construct their perspectives on mental health.

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Introduction

The sociological literature talks about users of mental health services as either psychiatric patients, consumers of psychiatric services or survivors of psychiatric treatment (see Barnes & Shardlow, 1996, 1997; Crossley, 1998, 2002, 2004; Crossley & Crossley, 2001; Everett, 1994, 2000; Kaufmann, 1999; McLean, 1995, 2000; Pilgrim & Rogers, 1999; Reaume, 2002; Rogers & Pilgrim, 1991). These three types are imbued with different conceptions of the service user. Patients may be regarded as passive recipients of care (Barnes & Shardlow, 1997), consumers as actively choosing care

(McLean, 2000) and survivors as actively resisting care (Crossley, 2004). Different authors define these types using different criteria. It is not the purpose of this paper to arrive at a consensus on these different types. Rather this paper considers these descriptions as discursive types. Many of the authors cited above talk about service users as patients, consumers or survivors, independent of each other. This paper considers these types in conjunction with each other, allowing for the discursive possibilities for socially constructing mental health across a range of typifications to be considered.

The tendency to talk about these types independently is problematic. For example, the term health ‘consumer’ may be regarded as superseding that of ‘patient’. Barnes and Shardlow (1997) attribute health consumerism to changes in citizenship, which are allied to changes in the

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UK public sector from the 1980s onwards. The development of the ‘consumer’ is often read as replacing citizen rights with market choices. This however begs the question of where does the arrival of the ‘consumer’ place the ‘patient’? Changes in nomenclature do not necessarily result in the eradication of prior ways of talking. Discourses are sites of continual acceptance, resistance or negotiation. The focus in the analysis that follows is on what impact structural changes (commodification) have upon ways of talking about being a service user. However, responses to processes of commodification are only part of the analytical frame. The key components are notions of acceptance, resistance and negotiation and how these can be shown to relate to the all of the different types, not just the commodified consumer.

This paper could be summarised as a comparative analysis of ‘classical’ medical discourses (patient), contemporary governmental discourses (consumer) and contemporary anti-psychiatry discourses (survivor) from data gathered by the people most readily affected by those discourses, the service users themselves.

Theoretical framework

A wider focus on types of service user can be justified on two counts. Pragmatically, the data were collected in the Republic of Ireland, where there is no universal ‘free’ health care provision, meaning that processes of commodification are not as significant in a historical context (though they are still present). Methodologically, the focus is on discourse(s) that have arisen to accompany new conceptions of ‘patient’. The distinction between the three types is based on notions of acceptance, resistance and negotiation. The patient, as the passive recipient of care, accepts their diagnosis. The patient can be summarised in the statement “I am a schizophrenic”. Antithetically, the survivor resists and rejects a psychiatric diagnosis. The survivor might be summarised by the statement “I am a person who hears voices”. The consumer can be regarded as someone who neither accepts (fully) nor rejects (fully) their diagnosis, but who vacillates between the two other discourses. The consumer may be summarised in the statement “I am a person with schizophrenia”. Acceptance correlates to the patient discourse, resistance to the survivor discourse and negotiation to the consumer discourse (see Fig. 1). It must be noted that all of the frameworks for the three discourses are ideal types.

Pescosolido, Brooks Gardner, and Lubell (1998) arrive at similar conclusions concerning patterns of service use. They identify a three-way typology of choice, coercion and muddling through. Choice is evident, if, “at any point, the person indicates that they want or at least, explicitly agree, to seek care” (p. 277).

Type	Discourse	Orientation
Patient	“I am a schizophrenic”	Passive acceptance
Consumer	“I am a person with schizophrenia”	Compatibilistic acceptance and resistance
Survivor	“I am a person who hears voices”	Active resistance

Fig. 1. Types, discourses and orientations.

This position is indicative of the patient discourse. The survivor is evidenced where “accounts of coercion reflect an active resistance to treatment throughout the story” (p. 277). The consumer can be seen ‘muddling through’, “where individuals end up in mental health treatment though they indicate neither an active choice nor any resistance in their stories” (p. 277).

Whilst the terminology is different, Pescosolido et al. (1998) have identified similar discourses in their study. Whilst their typology corresponds with the typology identified here, there is one important distinction. They state an interest in understanding the difference between “how individuals perceive and report what they do in the face of illness and what they *actually* did” (p. 277, emphasis in original). Within the current study the focus is only on what the respondent said they did, there is no way of knowing if what they said happened actually happened. The analysis is ultimately about social constructions of mental illness that are socially available for the service user to draw upon. For Pescosolido et al. (1998) the focus is on models of service use. Within the current study the focus is on discourses of service users.

Social movement organisations

This is not to say that these three discourses are the only way that service users have to talk about psychiatry. The data analysed were drawn from interviews with members of mental health user groups or social movement organisations (SMOs). Broadly speaking these can be typified as patient groups, or consumer or survivor SMOs. The basis for this distinction is the different organisations attitudes towards psychiatry. Patient groups passively accept the legitimacy of psychiatric knowledge (therefore they have no agenda for social change and are categorised as a group rather than an SMO). Survivor SMOs resist the legitimacy of psychiatric knowledge and have an agenda for social and political change. Consumer SMOs occupy a middle ground, challenging but ultimately accepting the legitimacy of psychiatric knowledge. This approach echoes the work of people such as Crossley (2004) and McLean (1995, 2000), who have considered specific social movement contexts. A key distinction is that consumer

SMOs tend to work with psychiatry, whilst survivor SMOs tend to work against psychiatry.

Another important feature is a temporal element. The three discourses have to be read as inter-dependent, they exist of and through each other, with each one serving as a definitive basis for the other two. The survivor discourse can be seen as a progression that builds upon the patient and consumer types. However, the endpoint is not necessarily the survivor discourse. There is progression both towards *and* away from this survivor discourse, which may (or may not) be influenced by length of time that someone is in contact with mental health services. These three types will now be considered in turn, starting with the psychiatric patient.

The psychiatric patient discourse

Estroff (1993) makes a similar distinction between chronic “I am” illnesses and chronic “I have” illnesses. Specific chronic conditions (such as schizophrenia) produce “I am illnesses”, where there is a “fusion of the self with the sickness, of diagnosis with identity...” (p. 257). I would argue that this “I am” component of schizophrenia is constitutive of the patient role, whereby patients are seen as repositories of pathology (Armstrong, 1983; Foucault, 1973). This discourse is indicative of a passive acceptance of a diagnosis and an active choice to seek treatment for that diagnosis. It requires compliant passivity in adherence to a prescribed medical regimen.

The consumer of psychiatric services discourse

Reaume (2002) describes how “people who identify as consumers want to work for reforms from within psychiatry and accept the medical model of mental illness” (p. 421). The consumer discourse allows the person to feature in conjunction with the diagnosis. It draws from anti-psychiatry discourses whilst vacillating between acceptance and rejection of the patient discourse.

The consumer discourse is negotiated. McLean (2000) identifies the National Alliance for the Mentally Ill in North America as a family consumer movement. She details how inclusion of family members reflected Canadian mental health policy to instigate community support programmes. Speed (2002) details how Irish consumer SMOs have similarly fostered the inclusion of family members in the treatment regimen. These studies highlight fundamental changes in notions of citizenship (and the role of state) in the provision of care. They mark a shift in the burden of care from state providers to voluntary and family led non-governmental organisations.

The survivor of psychiatric treatment discourses

The survivor type is the one which can most readily be delineated from the anti-psychiatry movement of the 1960s and 1970s (for analyses of the development of psychiatric survivor movement in the UK, see Crossley, 1998; Rogers & Pilgrim, 1991).

Pilgrim and Rogers (1999) characterise survivors as people “reluctant to enter or re-enter patienthood” (p. 201). They go on to add that “most wanted to establish their credibility as ordinary people with rights of citizenship” (p. 201). Crossley and Crossley (2001) argue survivors derive their status “from being an ‘active member’ of various mental health organisations and from personal experiences of belonging to an oppressed and exploited group” (p. 1480). There are two key (and relatively constant) elements of the survivor discourse, a resistance to medical hegemony coupled with a history of social exclusion. The survivor discourse can be seen to be political and oppositional to notions of both patienthood and consumerism.

In terms of medical hegemony, the survivor discourse rejects a medical aetiology replacing it with non-medical aetiologies. This may involve regarding the diagnosis as a spiritual crisis, a holistic issue or a familial issue. The survivor discourse arises out of a ‘claimed’ rejection of the sick role (and a rejection of exclusion) and involves survivors portraying themselves as active agents.

The utility of a discursive approach

The different discourses are not mutually exclusive; they function to offer different and overlapping pathways through or around social elements of mental health. Notions of patients, consumers and survivors are well established in the sociology literature and the service user literature. This paper identifies accompanying discourses that provide the analyst with an understanding of representations of mental health. The analysis identifies implications for the future analysis of service users’ talk and indeed for a sociological understanding of social constructions of mental health.

Three case studies are drawn from a sample of 12 interviews with mental health service users, drawn from either patient groups, or consumer or survivor SMOs. The discourses identified here were consistently found both within and across cases in the larger sample. The three key exemplars presented here were chosen to illustrate these discourses as they occurred in the talk.

Methods

The method of discourse analysis employed in this paper is taken from Gilbert and Mulkay’s (1984) study

of scientists' discourses. They offer a strategy that is based on a critique of traditional sociological approaches. This critique details how 'traditional' methods of qualitative analysis are predicated upon a 'univocal' (p. 2) interpretation of discourse. Gilbert and Mulkay identify a principle I describe as 'variable discourse'. Discourses are seen as "a diverse potentiality of acts which can be realised in different ways through participants' production of different interpretations in different social contexts" (Gilbert & Mulkay, 1984, p. 9). Variability is a positive feature of talk and an important analytical tool. It is variation in discourse that provides the rationale for analysis. The analysis considers differences in the discourses used by participants, depending upon the context they are discussing. For example, a participant may discuss a clinical encounter (a psychiatric context) through reliance on the patient discourse, but may describe a conversation with a spouse (a family context) through reliance on the survivor discourse. This adaptation of Gilbert and Mulkay's approach demonstrates the variability of discourse in relation to context and highlights the interplay between contexts and discourses. This particular approach demonstrates how structural aspects of different contexts might affect the type of discourses used within that context. In turn this suggests that service users are actively using different discourses to convey different constructions of mental health, dependent upon the context in which they locate their talk. This conclusion highlights awareness, on the part of the service user, of different social constructions of mental

health and an awareness of different discursive possibilities associated with these different constructions.

The discourses are linguistic resources, dependent upon the context of the talk. Harry, the first interviewee considered, utilises patient and survivor discourses in different sections of talk. He interpolates different discourses across different contexts. The discourses are used consistently and differentially and can be read as being indicative of different positions it is possible to take with regard to talk about mental health, mental illness and psychiatry.

Case study one: Harry and the patient discourse

Harry was 31 at the time of interview. His first breakdown was 2 years previously. He had been admitted to a psychiatric unit twice, both on a voluntary basis and both were for approximately 1 week. The interview begins with the interviewer asking Harry for the story of his involvement with psychiatry. In the first extract Harry discusses his first contact with psychiatry.

Of immediate interest in [Extract 1](#) are lines 127–9, where Harry talks (indirectly) about his psychiatric appraisal. He ascribes all agency to the psychiatrists where he is in a position of passive unawareness.

Harry only features in this extract of talk as a repository of pathology. Whilst Harry may actually be seen as an active agent here (he has decided that there is something seriously wrong and is actively pursuing a strategy to gain access to psychiatric services), the point

Extract 1

Harry:	so I was in hospital for a week	123
		124
INT:	okay	125
		126
Harry:	and in a general hospital for a week and they basically they they	127
	copped it that it ehmm from things I've said that eh I might need a	128
	psychiatrist	129
		130
INT:	okay	131
		132
Harry:	to talk to	133
		134
INT:	yeah	135
		136
Harry:	and ehmm so things like I said the radio is talking to me	137
		138
INT:	right	139
		140
Harry:	that was one of the phrases I said and I understood from that that I	141
	probably had psychiatric illness so the psychiatric professor came and	142
	two other the two different ones came one fo for the second opinion	143
	and they started me on medication and so on ehmm	144

most worthy of note is that he lets the psychiatrists identify a problem through things he says. In effect his active strategy to access psychiatric services is to become a passive repository of pathology, displaying symptoms that will be noted by staff on the ward. Rather than *drawing* directly from the patient discourse Harry would appear to be *endorsing* the patient discourse. Again he paints himself as a repository of pathology (line 137) and intimates that his understanding of this pathology was that he “had psychiatric illness” (line 142).

A final endorsement of the patient discourse is offered in line 144. Harry describes how “they started me on medication and so on”. Harry does not say that he started taking medication, he states that they started him on medication, utilising a passive discourse in the way he talks about psychiatry.

Extract 2 moves on in the interview to a stage where Harry is talking about aspects of disjuncture between psychoanalysis and psychiatry. He relates the different conceptions that psychoanalysis and psychiatry had of his pathology. In a move suggestive of being a consumer of services, Harry had started seeing a psychoanalyst as well as a psychiatrist. However, this action is only suggestive of a consumerist approach. As **Extract 2** illustrates Harry continues to endorse the patient discourse.

The start of **Extract 2** details Harry’s portrayal of the psychoanalytical interpretation on his ‘pathology’ (lines 437–8). Compare and contrast this portrayal with the portrayal that Harry offers of the psychiatric interpretation (lines 443–7). Harry offers a socially rooted (socially constructed) perspective (lines 437–8) and juxtaposes this against a biologically rooted (medically constructed) perspective (lines 443–7). At this stage it is unclear whether Harry supports one over the other, this does not become clear until lines 449–52. Here Harry offers a ringing endorsement of the patient discourse. His paranoia was not caused by the socially constructed

pathology of hatred for others; but was a product of the medically constructed chemical imbalance. This portrayal functions to make Harry a repository of pathology, a docile object upon which this chemical imbalance is enacted and it is a pathology over which Harry has no control. It constructs him as a clinical object, rather than a social subject. He elects to problematise his biological being as opposed to his social being.

Over the bulk of the interview Harry’s talk about psychotherapy is positive. However, in this instance Harry rejects a psychoanalytic frame and ‘very much’ accepts the psychiatric frame. It is activities such as these that lead to a tentative conclusion that Harry’s dominant ‘social context’ (Gilbert & Mulkay, 1984) is the patient discourse. Where contradiction arises in his talk, it is likely to be resolved by recourse to the patient discourse. Anything that problematises the patient discourse is likely to be portrayed in such a way that will allow the patient discourse to hold sway. This does not mean that Harry does not draw upon the consumer and survivor discourses. A pattern that emerged consistently over the analysis of all 12 interviews was that whilst other discourses were drawn upon, participants frequently relied upon a dominant discourse. It is suggested that these occurrences may identify which specific discourse most aptly ‘fitted’ the interviewee’s particular situation at that specific time. The analysis contained above demonstrates both the presence and the utility of the patient discourse.

Case study two: Ian and the consumer discourse

Ian was in his mid-fifties at the time of the interview. He reports that his first experience of psychiatry was in 1992, 9 years prior to the interview. The analysis of Ian’s talk begins with an extract where Ian is talking about his

Extract 2

Harry:	which I found out later the psychoanalysts thought that	437
	paranoia was a symptom of hatred for others	438
		439
INT:	mhhm	440
		441
Harry:	whereas the psychoanalysts think that paranoia is because not	442
	psychoanalysts but the psychiatrists	443
		444
INT:	the psychiatrists	445
		446
Harry:	think that it’s because of a chemical imbalance	447
		448
INT:	mhhm and what would you make of the chemical imbalance argument	449
		450
Harry:	I definitely agree with it I agree with the chemical imbalance	451
	imbalance very much you know	452

first experience of psychiatry. Ian begins by detailing issues associated with his physical (as opposed to mental) health (Extract 3).

In lines 17–19 Ian sets up the discussion to incorporate what can be generally described as complementary or alternative health strategies. He does not begin his talk of involvement via restitution to a psychiatric pathology; rather he portrays his psychiatric health in a context of his general health. In line 19, Ian states that he thought he had his ‘physical’ body covered, additionally in line 25 Ian draws a distinction between his ‘physical body’ and his mind.

In the next section of talk (lines 24–5) there are two key points to consider. Firstly, Ian introduces the idea that he did not have everything covered. He separates issues of physical health from issues of mental health, and accedes that all of his interests in alternative medicines had not prepared him for the events he describes. Secondly, in lines 23–4, Ian introduces another element, that of a relationship which ended. Ian’s portrayal of events is informed by biographical information relating to lifestyle and relationships. What is evidenced here is the importation of subjective information into the medical discourse. Consider lines 36–7 where Ian describes his situation after he was admitted to the hospital. The description of his ‘pathology’ places an emphasis on confusion (a far less clinical term than Harry’s ‘paranoia’) and reference is made to medication and the effects of that medication. This framing of medication may be tied back to his previously stated interest in ‘alternative ways of

medicine’. The emphasis is placed on medication (and hints of an attendant pathology) as opposed to being focussed exclusively on pathology.

The consumer discourse is all but confirmed by Ian in the next extract, Extract 4.

Ian’s response to the question regarding the necessity of medication is definite. Medication is the only option *because* it is the only option. Line 588 contextualises this statement as a broad societal (as opposed to medical) fact. Issues of deviance (not pathology) are then invoked, and are coupled with the inevitability of the consequences of this deviance. Ian outlines these consequences in terms of a reference to a psychiatric unit (“there’s where you’re going to go”). Medication, and by implication, pathology, are portrayed here as the only way that there is of dealing with mental ‘illness’ in ‘our society’. Ultimately, Ian has utilised a pathological model, i.e. the patient discourse. However, the portrayals and qualifications he has made in previous examples mean that he cannot be regarded as drawing predominantly on a patient discourse (although he does utilise it). Neither however can he be regarded as drawing predominantly on a survivor discourse (again however he does utilise it, but his assertion of the role, necessity and inevitability of medication precludes him from drawing upon it as a dominant frame).

Lines 602–6 demonstrate this feature to good effect. The interviewer asks Ian what would be his choice, given the option. He responds that “we don’t have the choice, there’s nothing else there” (lines 605–6). To talk of not having a choice, is to take on a passive discourse.

Extract 3

Ian:	and ehh I was interested in ehh I still am in macrobiotics and martial arts ^a and ehh all alternative ways of medicine and so on and ehh I felt that I had my physical body covered	17 18 19 20
INT:	okay	21 22
Ian:	and then I had a I went through a relationship where I was rejected by a woman and ehh I found that I didn’t have everything covered because there’s something else there’s the mind	23 24 25 26
INT:	mhhm	27 28
Ian:	and I ended up in ehh they don’t ca in I was living in Europe ^b they don’t call them mental hospitals they call them well I suppose they might be called mental hospitals but they they’re sort of ehhm I forget exactly what anyway I ended up in what would be termed as	29 30 31 32 33
INT:	mhhm mhhm	34 35
Ian:	mental hospital with ehh where confused and been sedated and ehh in other words on medication in 1992	36 37

^aActual form of martial arts practised by Ian has been omitted to ensure anonymity.

^bActual country in Europe has been withheld to ensure anonymity.

Extract 4

INT:	I mean well what's your attitude to medication then if I mean	578
	you've kind of medicated yourself it would seem right the way through	579
	all of this ehmm would you still see medication as something that was	580
	necessary	581
		582
Ian:	well you have to understand me what I'm saying is that's all we	583
	have	584
		585
INT:	mhhm	586
		587
Ian:	in the society we are living in	588
		589
INT:	mhhm	590
		591
Ian:	so if you're in the street doing something strange	592
		593
INT:	mhhm	594
		595
Ian:	you're going to be picked up and there's where you're going to go	596
		597
INT:	mhhm	598
		599
Ian:	right so	600
		601
INT:	but for you yourself ehmm if you had the choice between taking	602
	medication and not taking medication what would your choice be	603
		604
Ian:	but we don't have the choice because there's nothing else there at	605
	at the moment if you know what I mean	606

Survivors might argue that there are choices; the consumer sees that there may be choices, but ultimately not where medication and pathology are concerned. Choice can be exercised elsewhere within the clinical paradigm, but ultimately it is the medical model and passivity that hold sway with regard to treatment. It is ironic that Ian has been identified by the analyst as a consumer of services, yet here he is in this final extract talking about a lack of choice. This is a suitably grey area between the consumer discourse and the other two discourses. In some instances the consumer can be regarded as leaning more towards the survivor discourse, and in others, as leaning towards the patient discourse, but ultimately the compatibilistic nature of the consumer means that it draws from both of the alternative discourses. It is for this reason that many survivors reject the notion/ascription of consumer of services.

Case study three: John and the survivor discourse

John entered the psychiatric services in 1983. He spent the vast majority of the next 10 years in a psychiatric unit. Since getting out in 1993–94, he has had no

involvement in a 'client' context with these services. He has also not taken any psychiatric medication since 1993–94. John begins by relating his history of involvement and details very early on in the interview that he is no longer involved with services in a treatment capacity (Extract 5).

This section of talk serves to articulate the survivor discourse and simultaneously also to reject features of the patient and consumer discourse. Lines 133–4 are a verbatim rejection of the description of the patient discourse (I am a schizophrenic, see Fig. 1). John implies that he no longer sees himself as a repository of pathology. He offers a caricature of what psychiatry is, defining it by way of reference to the medical model. This characterisation functions, discursively, to place the survivor discourse above the medical model, in effect the survivor discourse is a lens which allows him to translate/understand psychiatric activity in light of this discourse. Another feature of the talk is that he no longer sees himself as subsumed under a diagnostic category. This statement is a rejection of the patient discourse. This statement is not a rejection or denial of the emotional distress (his term) that John experiences. The voices are not denied but the ascription of these voices to a classification as schizophrenic is denied. John

Extract 5

INT:	ehhm so how do you how would you see yourself in relation to psychiatry now then	130
		131
		132
John:	well for a start for a start I no longer class myself as schizophrenic	133
		134
		135
INT:	okay	136
		137
John:	I class myself just as John Knox ^a oh sorry you	138
		139
INT:	its grand I'll change	140
		141
John:	I just classify myself as myself again	142
		143
INT:	okay	144
		145
John:	ehh diagnosis means nothing I don't even really I I don't actually believe that it exists I don't even actually believe there's any scientific proof to	146
		147
		148
		149
INT:	mhhm	150
		151
John:	to back up a diagnosis of schizophrenia it's a process of the medical model	152
		153
		154
INT:	mmhm	155
		156
John:	and the medical model is a reductionist model so therefore ehh its its ehh I suppose its an easy way of them tagging a label onto somebody	157
		158
		159
		160
INT:	yeah yeah	161

^aName changed to assure anonymity.

goes on to detail how he does see himself before then outlining a critique of the ontological and scientific nature of psychiatry.

The placement of the word 'again' in line 142 functions to implicitly state that there was a period of time when John feels he was not classifying himself as himself. Even the word classify is suggestive of a clinical process, it is used here to subvert or contrast with the other classification he has mentioned, that of the schizophrenic. It contextualises the hegemony of the psychiatric classification and allows John to classify in a similar way that a psychiatrist might. Of crucial importance here is that John states he classifies himself as himself, and that before he did this, he was not classified as himself. This invokes a notion of passivity, i.e. if he was not classifying himself as himself, either someone else was classifying him, or he was utilising someone else's classification of him (and by extension was drawing from a patient or consumer discourse). John then moves into a full-scale utilisation of the survivor discourse (lines 146–59).

The next extract to be considered follows on directly from [Extract 5](#). It is concerned with John's detailed exposition of his experiences with psychiatrists, in terms of maintaining this survivor discourse against the hegemonic dominance of the medical discourse ([Extract 6](#)).

In lines 163–70 John states that he got involved in battles with his psychiatrist in order to stay off medication. John (as himself) features very strongly in this portrayal, the lone warrior (*I* and *my*) battling against the collective other (psychiatrists). Compare this statement made by John to the statements made regarding medication by both Harry and Ian.

Whereas the medical discourse created the passive body, and the subjective discourse was designed to enhance and maintain that passive body (through education and compliance) John reverses these features and explains how he took steps to educate and gain the psychiatrists compliance in terms of how he wanted to proceed (lines 168–70). He had to persuade them he had recovered and educate them about medication. Far from being a docile object, John portrays himself here as an

Extract 6

John:	I would have a lot of problems with psychiatrists trying to	163
	battle my way through staying off medication	164
		165
INT:	okay	166
		167
John:	and I'd have a lot of problems around persuading them that I had	168
	recovered I had a lot of problems around eh educating them that	169
	medicine wasn't an answer	170
		171
INT:	mmhh	172
		173
John:	that it wasn't didn't play a part even part of the answer you	174
	know that there was a whole lot of other basic components that were	175
	missing they were missing completely like instead of looking at some	176
	sort of brain disease or a biological disease that it was actually an	177
	emotional distress they were dealing with or or	178
		179
INT:	mmhh	180
		181
John:	they never took time to listen what cause what the life events	182
	were what the history was	183
		184
INT:	yeah	185
		186
John:	there was no time spent on that there was more time spent on	187
	trying to educate me to bec become compliant	188

active subject, directly engaged in challenging and changing the 'traditional' medical discourse.

In lines 174–8 John criticises psychiatry for 'missing completely' the 'basic components' of the issue. The approach to mental health as a 'repository of pathology' is critiqued in lines 177–8. Of additional interest in line 178 is John's application of the term 'emotional distress'. This description of 'emotional distress' resonates with Foucault's (1965) statements regarding the regulation of rationality in psychiatry. This term is offered up in this context as a direct polemic to the previously cited constructions of 'brain disease' or 'biological disease'. This highlights resistance to the medical discourse, positing a non-pathological description in opposition to a medical one.

In lines 182–3 the critique swings back to idiosyncratic experiential issues, they were not willing to listen to John's biographical narrative. By implication, John asserts here that the biographical narrative explains it all for him (this would also tie into his lack of medication and his stance on the aetiology of the distress). This experiential portrayal is the one that underpins John's use of the survivor discourse. Lines 182–3 portray the psychiatrists as being unwilling to listen to the survivor discourse. This point is echoed in the final section of talk, lines 187–8. Here John articulates the processes of the patient discourse, the professionals were, in John's portrayal, involved in

attempting to educate him and make him compliant in terms of the dominant medical approach to the 'condition'.

The last extract of talk that will be considered from John is a piece of talk where he talks about his own approach towards the four voices he hears. He details how he has dealt with these voices and what this approach has allowed him to do in terms of his relation to psychiatry and the medical model (Extract 7).

John does not deny the existence of the voices. He is not saying that he is not experiencing an emotional distress. He accepts the voices but rejects the medical explanation of these voices. In lines 336–7 he returns to an experiential frame to account for them, these three additional voices were "directly related to experiences in [his] life". In terms of this portrayal, John seems to be the origin of his own sense making regarding the voices. The services are then critiqued again (nobody talked to him about his experiences).

It was not until John himself understood what the voices related to that he was able to begin to make sense of what was going on. John features as an active agent within both of these lines of talk (lines 345/350). There is a process of working through (and sense making) drawn from his own frame, which is a biographical and experiential frame. It was when John was able to "make sense of what was going on", from his own perspective, that he was able to reject the medical frame. The

Extract 7

John:	so at 14 I heard one voice by the time I entered psychiatric services I was hearing four voices	331
		332
		333
INT:	right	334
		335
John:	and the three other voices were directly related to experiences within my life	336
		337
		338
INT:	right	339
		340
John:	but nobody talked to me about the experiences within my life	341
		342
INT:	mmhm	343
		344
John:	you know and it wasn't until I understood what the voices related to	345
		346
		347
INT:	yeah that you	348
		349
John:	that I could make sense of what was going on	350
		351
INT:	so would that be when you rejected your diagnosis then	352
		353
John:	that's when I rejected the the that's when I rejected the the diagnosis that's when I rejected the very fact that it was a brain dysfunction that's when I rejected if you want to say the medical model	354
		355
		356

consumer and patient discourse do not necessarily concern themselves with sense making; the pathology makes sense in light of the medical discourse. The survivor discourse, as stated by John in this last section of analysis creates a space in which ones own 'sense' of the issue can be made, and this in turn can then function to open up alternatives that are not predicated upon a medical model.

Conclusion

This study is an empirical validation of the three discourses that accompany the three identified types. The analysis demonstrates that the different 'types' of service users can be empirically demonstrated as discourses from which the service users draw to construct talk. The discourses of patient, consumer and survivor can be identified in the sociological literature, but they have not been consistently demonstrated through recourse to empirical data. This paper highlights how the passive accepting patient, the negotiated consumer and the active resistant survivor discourses have entered the discursive canons of service users, where they are used to socially construct talk about mental health.

The empirical analysis of the patient discourse illustrates that certain service users can be discursively identified as patients. It has been demonstrated that this patient discourse can be actively employed by the service user to support one particular perspective on their diagnosis, one that is founded in the biomedical model and which prioritises pathology. This can be regarded negatively in that it objectifies the service user as repositories of pathology. However, this discourse can be seen more positively, in that it absolves the 'patient' of any blame or sanction for their situation (in an echo of the [Parsonian \(1951\)](#) sick role).

The consumer discourse moves on from this passive patient role but is still in thrall to medical hegemony. The consumer discourse suggests a compatibilism between the objectified patient and the consumer (but where the objectified patient tends to dominate). It problematises but accepts the biomedical model. It is a negotiated discourse that utilises elements of the other two.

The survivor discourse can be seen to reject and challenge both of these positions, and indeed goes one step further by offering potential alternatives to these approaches. John's talk de-legitimises the biomedical discourse and *re*-legitimises a survivor discourse. It is founded in anti-psychiatric discourse and proposes alternative aetiologies (i.e. emotional distress).

These discourses are drawn from the sociological literature, and are also theorised from the sociological literature. However, the purpose of this study is to demonstrate their occurrence, in talk, across three different cases. The discursive frame is evident throughout the analysis and functions to allow for a consideration of different portrayals (both temporally and socially) across the research participants talk.

The key points for future consideration in regard to these discourses are the different levels of agency that each discourse may afford the incumbent user. Consider the enforced or intrinsic passivity that the patient discourse requires the incumbent to adopt, versus the compatibilistic consumer or the more active survivor. It is proposed that all of these discourses can be seen to have positive and negative features. For example, the impact of a passive patient discourse on what a service user is able to talk about 'doing' and not 'doing' (in terms of both their involvement with psychiatry and their everyday social interactions) offer an important insight into the impact of an acceptance of a biomedically constructed explanation of mental illness. The consumer and survivor discourses operate under these self same strictures, the compatibilistic consumer and the active survivor are all similarly constrained (positively and negatively) in terms of the types of accounts that the service users are able to offer regarding their mental health. This study presents an elucidation of these processes of action and agency in regard to service users talk, specifically in regard to how service users socially construct this talk in relation to their pathology. Any further research must move this focus on pathology on to consider the broader social impact of the acceptance or rejection of these processes of pathologisation.

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