A DISCOURSE ANALYSIS OF THE MENTAL HEALTH SURVIVAL KIT INFORMED BY POST-STRUCTURAL THEORIES

by

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Abstract

The purpose of this thesis is to undertake a discourse analysis, informed by post-structural theories, of the Mental Health Survival Kit to elucidate the ways it produces subject positions. Toward that end, I begin by developing a historical context that supports an understanding of the way psychiatric discourse emerged and continues to emerge through interlock with other socio-political discourses (i.e., biomedical discourses, neoliberal discourses). Through positioning my work within this historical context, I am able to illuminate the linkages between the production of subject positions and socio-political discourses that are found within the Mental Health Survival Kit. To further understand this rich constellation of relationships, I extend a theoretical apparatus informed by post-structural theories (i.e., governmentality and performativity) to approach the ways subject positions may be produced by the Mental Health Survival Kit. Thus, after completing a discourse analysis of the Mental Health Survival Kit, it is my position that, immanently, you, a subject, produce and are produced by the Mental Health Survival Kit through interpellation signified through a rich constellation of socio-political relations. These relations will be further explored in my thesis. Hence, in one way, subject positions are produced within the Mental Health Survival Kit.

Table of Contents

Chapter One – Introduction

> Where to begin in philosophy has always – rightly – been regarded as a very delicate problem, for beginning means eliminating all presuppositions. However, whereas in science one is confronted by objective presuppositions which axiomatic rigour can eliminate, presuppositions in philosophy are as much subjective as objective…
>
> Gilles Deleuze (Difference and Repetition, 1994, p 129)

Hospital Rounds – A Discursive Feast

It is 10:00am. I observe my list of ingredients; methodically, I note the steps of each recipe. Yet, I am a stoic at this ill timed meal. Preparation is nearly complete. Each morsel is prepared with a pinch of professional desire, a sprinkle of organizational agenda, and a touch of inter-disciplinary power. The menu is well known. The guest list is written then spoken aloud. As the guests sit at the table, corporeal arrangement speaks subversively to the head of the feast, soon to be carver of well prepared food. The dissections take place; it is led by the master of ceremonies. As if a bittersweet symphony of sound, some profess, some sing while others maintain chorus. I am among others but I cannot carry a tune, my voice is unheard. I am a witness to a ceremonial potluck; I am distant, flash frozen in place. It matters not; the meal is consumed despite philosophical absence. Future dinners are planned. What clinical recipe could facilitate such a well orchestrated performance? There are many sources, but placed firmly in the palm of my hand is the Mental Health Survival Kit. My exploration begins with…

1) What subject positions does the Mental Health Survival Kit produce? Particularly, how are neoliberal discourses and biomedical discourses implicated in the production of subject positions?
2) How does the Mental Health Survival Kit produce these subject positions?

Drawing upon post-structural theories (i.e., Michel Foucault, Judith Butler, and Derrida), this research aims to unveil some of the subject positions imbedded within Mental Health Survival Kit and some of the ways these subject positions are produced. In doing so, one can begin conceptualize and contextualize some of the social relations produced through psychiatric discourse. Toward that end, in this chapter, I intend to outline the development of post-structuralism. I then provide a discussion about the subject and subject positions to help the reader understand my use of the term 'subject position.' Next, I explicitly discuss the way interpellation can help understand how a text can produce subject positions. Finally, I provide an overview of the way I intend to develop my thesis to postulate an answer to my research questions.

What are Post-structural Theories?

For Hegel and Marx, history foretold an ever evolving dialectical process toward absolute reason (Singer, 2001). Yet, Nietzsche did not foresee absolute reason as the inevitable outcome of history (Horrocks & Jevtic, 1997). In contrast, Nietzsche examined the "historical effects, limits, and price" of reason upon humanity (Horrocks & Jevtic). According to Nietzsche, "reasoning discloses the typical prejudice by which metaphysicians of all times can be recognized; through this…they exert themselves…for something that is in the end solemnly christened 'the Truth'" (Nietzsche, 1988, p. 806).

With every incremental step toward ‘Truth’, the price is paid through human freedom (Leonard, 1994). In the progress toward ‘Truth’, marginalized peoples are forced to pay the price through imperialism, colonialism, exploitation, impoverishment, and cultural destruction (Leonard, 1994). Through a sophisticated linkage between knowledge, power, and discourse, ‘Truth’ serves to “exclude, reject, limit, and control” marginalized voices (Leonard, 1994, p. 13).

Following Nietzsche in the 1960s, a number of philosophers (i.e., Foucault, Derrida, Deleuze, Lyotard, and Kristeva), loosely referred to as post-structural theorists, produced a broad collection of literature, politics, art, cultural criticisms, history, and sociology (Williams, 2005). For some, post-structural theories began a dialogue that sought to understand the instability and contradictions within modern meta-narratives. For others, post-structuralism ushered in new-age nihilistic solipsism (Ajana, 2008). In either case, post-structural theories instigated a different way of understanding social realities.

In speaking about post-structuralism, it is important to emphasize a few points that underline the post-structural movement. To begin with, “the limits of knowledge play an unavoidable role at its core” (Williams, 2005, p 1). Basically, the aforesaid statement suggests that structuralism attempts to maintain and assert a secure understanding of knowledge. However, post-structuralism charts the differences, tensions, and contradictions within secure knowledge (Williams, 2005). Post-structuralism maintains an incessant attempt to place the limits of secure knowledge back on its core; knowledge cannot escape its limits. In this way, the limit is the core. Thus, ‘natural’ knowledge is only as secure as its limits. A limit is not defined in relation to its core; it exists on its

own. Yet, a limit cannot be identified, to identify a limit is to have established a core. Therefore, a limit can only be identified by the way it disrupts and changes its core. Consequently, post-structural theories attempt to graph the effects of a limit as it differentiates from a core. Williams (2005) provides an outstanding illustration of the way each of the abovementioned post-structural philosophers map the limits of secure knowledge.

> Put simply, Derrida follows the play of the limit at apparent more immediate and truthful core of language. Lyotard traces the effect of limit-events in language and sensation. Deleuze affirms the value of a productive limit between actual identities and virtual pure differences. Foucault traces the genealogy of the limit as the historical constitution of later tensions and problems. Kristeva follows the limit as an unconscious at work undoing and remaking linguistic structures and oppositions (Williams, 2005, p 3).

Under post-structural theories, human experience came to be seen as inseparably linked to language; as in Deleuze and Guiatarri's Captialism and Schizophrenia (1980), a human subject position is seen as immanent or 'becoming.' Once we speak, even merely affirm or deny existence, we must bring experience into the game of language (Deleuze & Guiattari, 2008; Wittgenstein, 1958). Thought is bound to a subject position, always ever within the bounds of linguistic semiotics. Hence, representation continues to present an ever more complex series of crises. As a result, many theoretical conversations were born. One such conversation among many focused on the subject; what is a subject and for the purposes of this thesis what is the relationship(s) to subject positions?

What is a Subject?

First and foremost, it would seem important to propose a position of reference for the term 'subject' within my thesis. For my thesis, I will borrow from Foucault's understanding of the subject. Yet, depending upon the essay, Foucault positions the subject in multiple ways. In some instances, it would appear the subject is largely neglected. Yet, in the second and third volumes of the History of Sexuality (1984), Foucault reflects upon the proliferation of discourse about the subject. In doing so, the subject is positioned as "constituted not constituent, an effect of structures rather than their cause" (Grosz, 1992, p. 411). In terms of humanism and anti-humanism, the humanist "privileges the self as the origin and destination of discourse" (Grosz, 1992, p. 411). In another way, Foucault positions the 'production of the subject' as tied to a mode of knowledge (Roberts, 2005); power may be understood as a medium whereby the 'production of the subject' is produced by a mode of knowledge. It is the anti-humanist subject, borrowed from Foucault's latter works, that informs my thesis. Drawing on this Foucauldian view of the subject, the term subject position refers to a space[1] produced through discourse that people may occupy. Thus, through an analysis of a text such as the MHSK one is able to unveil discourses that produce subject positions. With an understanding of the subject and subject positions, one can now begin to conceptualize the production of subject positions in relation to the analysis text.

[1] Space refers to a "mental space blending wherein structure is transferred from a representing space to the represented space" (Sweetser, 2000, p 1).

How does a Text Produce Subject Positions?

Drawing on the abovementioned understanding of a subject position, if one is to consider whether or not the Mental Health Survival Kit produces subject positions, one must first ask: do texts produce subject positions? To this end, I draw upon Althusser, Deleuze, and Butler in relation to 'becoming' and the act of interpellation. In doing so, I intend to show that texts are always already producing subjects and subject positions.

Althusser depicts the act of "interprellation" through illustration of a scene wherein an individual is walking a street (Althusser, 1970, p 162). As the person walks the street, the person is hailed by a policeman who shouts "Hey you there!" The individual responds by turning around and in that moment the person is transformed into a subject. The person being hailed recognizes him or her self as the person hailed; in doing so, the person knows to respond. While there is no reason to be hailed, he or she recognizes him or her self as the person hailed. However, the act of recognition is a misrecognition that functions retroactively. The person is *always already* an ideological subject. The subject has *always already* been transformed. In this way, the subject is a subject before the act of interpellation since the person recognizes him or her self as a subject before 'becoming' a subject. Hence, there is no transcendent subject as Kant suggests; instead, in appropriation of Nietzsche and Bergson, Deleuze suggests that a subject is 'becoming' (Due, 2007). Wherein, 'becoming' or immanence, as an ontology of the mind, means that the "mind is part of reality and unfolds as an activity within the force field of reality as a whole" (Due, 2007, p 21). In this way, a subject is part of reality as an activity of reality; a subject is immanent.

While a subject is ‘becoming’, ‘immanent’, a subject position is produced through discourse. Subject positions are spaces that subjects occupy and are produced through text. Butler situates language in place of institutions as a regulatory constraint on the formation of subjects. In the act of interpellation, power, available through the social order, is wielded as a means to signify discourse. Yet, the result of interpellation remains opaque since there are multiple conflicted subject positions that emulate from the act of interpellation. In a sense, the subject position hailed by the policemen is always already ‘becoming’ a subject; yet, the resultant subject position is produced through power relations signified within discourse. Since a text is a discursive product, it is always already producing subject positions through the power relations signified by discourse within the text. It is upon this basis that I intend to show that the Mental Health Survival Kit produces subject positions.

How will I Develop my Thesis?

In my thesis, I will use discourse analysis informed by post-structural theories (i.e., Derrida) to uncover empirical and theoretical threads (i.e., discourses) within the Mental Health Survival Kit to demonstrate that the Mental Health Survival Kit produces subject positions. Toward this end, I draw on post-structural theoretical constructs (i.e., governmentality and peformativity) to answer the first research question. It should be noted that I emphasize neoliberal and biomedical discourses because my theoretical framework develops a particular emphasis upon neoliberalism and bio-power thus informing the analytic lens that I applied in my analysis. However, I have not excluded the inclusion of additional discourses, as neoliberal and biomedical discourses interlock

rather than intersect with other discourses. Following this analysis, I will then provide a roadmap of my utilization of governmentality and performativity to show how the discourses, within the Mental Health Survival Kit, produce subject positions. In the process, I will answer the research questions and so, I am able to illustrate that the Mental Health Survival Kit produces subject positions.

Chapter Two – The Rise of Psychiatry

Introduction

The rise of psychiatry may be traced in many different ways for many different purposes. For example, the rise of psychiatry may be seen as a series of progressive medical developments, an evolving epistemological position or other ways. For the purpose of my research and as outlined in this chapter, I examine the rise of psychiatry as a series of interlocking, overlapping, and contested historical threads. In doing so, I trace psychiatry through specific historical points within pre-modern, modern, and anti-psychiatric eras. In the pre-modern era, I trace early theological and rationalist discourse to understand the ways people came to be positioned as mentally ill or mentally healthy. In the modern era, I trace the greater sophistication and refinement of psychiatric discourse to understand the ways psychiatry positions some people as health professionals (i.e., Pinel and Tuke) and others as people who are mentally ill (Foucault, 2006). At the same time, I draw attention to forms of knowledge production that sought to contest the modernization of psychiatry. Finally, in the anti-psychiatry era, I trace the response of some critiques of psychiatry to understand the ways psychiatry's power is subverted through subjects that engage in "discourse-based acts of subversion" (Watson, 2005, p 306). Through understanding the way people with mental illness are positioned within psychiatry, one can begin to conceptualize some of the possible subject positions produced within psychiatric texts.

Pre-Modern Psychiatry

Western beliefs about mental functioning can be traced back to the Greek and Roman eras. As seen in mythological stories, mental illnesses were often seen as enacted through involvement of the Gods (Merkel, 2003). People with mental illness were people who had lost favour of the Gods (i.e., due to moral infidelity) (Merkel,). Hence, there is a relationship that can be traced within Greek literature between moral failure and insanity. As a result, in early Greek and Roman eras there is an increasing emphasis on achieving reconciliation with the Gods in order to repair one's mental health (Rubin & Wessely, 2001). Early mythological ideological conceptions of mental disorder can be seen as forms of governmental rationality whose technologies were enacted through panoptic power and bio-power[2] (Georges, 2008). As such, people who were seen as deviant were disciplined through the transcendent eyes of the religious. At the same time, disciplinary measures ensured the vitality of a productive workforce. People who followed rules and regulations would be economically productive.

In the fifth and sixth centuries, there was an increasing emphasis on innate knowledge and a de-emphasis of the role of the Gods in mental illness (Merkel, 2003). For instance, Plato, a prominent early philosopher, saw the soul as immortal whereas the body was seen as a physical prison of the soul (Jenkins, 2005). The soul and mind were inseparable. Irrational behaviour was seen as an inevitable part of human life which could be overcome by reason (i.e., the mind) (Hooper, 2008). Mental illness came from a loss of balance between the soul and the body (Merkel, 2003). On the other hand, Aristotle recognized an interaction between the mind and body (Leder, 2005; Hooper, 2008). He

[2] There will be a more complete discussion of panoptic power and bio-power in chapter three

believed knowledge was the direct consequence of the senses, rather than innate. The senses exemplify the way the mind interacts with the body. As a result, he emphasized experience and empirical knowledge. In essence, while Plato thought mental illness arose from a disjunction between mind and body, Aristotle viewed mental illness as a conjunctive interrelated condition of the mind and body (Jenkins, 2005; Leder, 2005). Hence, for Aristotle, mind and body were interactional rather than separate entities. Both Plato and Aristotle's movement toward rationalism can be seen as a move toward greater refining of disciplinary power (Hooper, 2008). Power and control were beginning to be seen as rational fact rather than religious dogma, a step toward empirical differentiation and disaffiliation.

With the ascendancy of Christianity in the Roman Empire, Christianity became the basis of philosophical inquiry. Platonic ideas were combined with Christian principles (Merkel, 2003). St. Augustine championed Platonic conceptions of the mind, which included the dichotomy between body and soul. Psychological and social issues were seen through a theological and moral framework (Merkel). Under Christianity, the new regime theorized that individuals were responsible for their actions and had free will; mental illness was thought to come from sin. And so, mental illness was seen as a trial of faith. Since sin was central to mental illness, religious activity was central to cure (Merkel). Mental illness was seen as alienation from God, consequently a return to God was essential to cure mental illness. Furthermore, confession and penance were essential to the cure. With the introduction of Christianity, morality took up a stronghold within the etiology of mental illness. Hence, people who were ill were feared and despised since their mental illness resulted from sin. The inclusion of Christian theology created new

avenues for bio-power. The apparent ‘mental’ problems of others were not societal problems; people who sinned were mentally ill. As such, there was a categorical shift in defining who was mentally ill or healthy. In this way, discourses of Christianity served to constitute people as mentally ill or healthy through the production of binary opposite subject positions (i.e., ill vs. healthy).

Soon after the introduction of Aristotelian philosophy, the west shifted away from Plato toward a growing emphasis on empirical knowledge (Casey & Long, 2003). As a result, there was a growing separation of mind and soul. The mind was seen as a distinct entity separate, yet, interrelated to the soul and body. Through an effort to combine rationalism with Christian principles, the soul could not be seen as sick; hence, mental illness was seen as a somatic phenomenon. As rationalism displaced theological explanations, there was greater emphasis upon the theory of a deficient body as the cause of mental illness (Amsden, 2008). At the same time, morality, a remnant of Christian theology, played a significant role in the treatment of people with mental illness.

Modern Psychiatry

During the early modern era, there was an ever increasing emphasis upon urbanism and commerce (Bracken & Thomas, 2005). States became all powerful and world exploration and domination expanded exponentially. Industrialization increased and large segments of the population were displaced (Beabout, 1960). Poverty increased dramatically as former farmers lost land to industrial expansion. The early theological and brash rationalism informed frameworks could no longer adequately explain societal problems. The basic philosophical model of the mind underwent a significant change. Descartes,

using the new concepts of nature developed by Galileo and Newton, emphasized a division between the spiritual aspects of the soul and the mental aspects of the mind (Husserl, 1950; Rozemond, 1995). He also saw an interaction between mind and body, which was even more bi-directional than previously held (Baxter & Hughes, 2005; Rozemond, 1995). The mind, as opposed to the body, was seen as unbounded, non-material, and primarily limited to thought, consciousness, and will (Rozemond). He recognized a pattern of interaction in which physical sensations would create mental phenomenon, which in turn would result in a physical reaction (Rozemond). For Descartes, there were two types of ideas: derived, which developed from experience and sensation and innate, which developed out of the mind (Baxter & Hughes, 2005; Rozemond, 1995). Under the pressure of growing emphasis upon rationalism, there were a growing number of people recognized as mentally ill, poor, or criminals (Foucault, 2006). The ontological shift set the foundation for more expansive and complicated self-regulatory techniques; the Panopticon was born (Foucault, 1975). Prisons, almshouses, and other institutions expanded greatly to meet the threat that these people were perceived as demonstrating toward the rational movements of the state. Under the ever present Protestant Christian ethics, a person's value was based on their ability to be productive (Barnett, 2008; Becker, Lynde, & Swanson, 2008). Increasing wealth was seen as a sign of divine grace and that a person was chosen by God. Poverty and mental illness were seen as a sign of loss of grace.

After the French revolution, Philippe Pinel released many prisoners formerly held in institutions and prisons (Foucault, 2006). He believed that the people who were jailed only required freedom in order to be relieved of their ailments. After his appointment as a

physician, he attempted to develop therapies to treat mental illness. In doing so, he developed a system of morality that was connected to a dominant middle class; thus, mental illness was seen as rooted in the lower class people who did not conform (Foucault, 2006). Moral treatment was enacted through patriarchal 'caring' for people with mental illness to teach conformity (Foucault, 2006). Around the same time, Samuel Tuke began to set up rural retreats for people with mental illness (Foucault). Similar to Pinel, his retreats promoted moral reform (Foucault). He believed people with mental illness should be disciplined as children. His retreats sought to teach people with mental illness to become normal through punishing and controlling unusual behaviours (Foucault). Tuke's retreats were far from luxurious; they consisted of rigorous and constant tests of self regulatory power (Foucault). For example, he would set up tea parties through which he would test participants' abilities to conform to societal norms. Under his watchful eye, any deviant behaviour would be corrected (Foucault). As such, Tuke's retreats represented a greater intensity of panoptic power.

The influence of Tuke and Pinel contributed to a greater emphasis upon the treatment of mental illness rather than confinement. Benjamin Rush, influenced by Pinel and others, advocated for mental illness as a disease of the brain and for moral treatment (Foucault, 2006). Moral Treatment advocated cultivation of self-control, good habits, a quiet environment, a strong relationship with the doctor, activities to increase self-esteem, and re-education (Foucault). Beyond the elements of Moral treatment there was increased use of medications; he also utilized bloodletting, purges, and emetics. These efforts were designed to increase internal control. The term moral was used to infer emotional optimism for treatment of mental illness. At the time, hospitals claimed 60 to 70% of

people with mental illness could be cured (Merkel, 2003). However, these treatments were available only to a select few (Merkel). By the late 1800s, medicine was established as a discipline and psychiatry as one of its specialties (Merkel).

However, the reform movements of the eighteenth and nineteenth centuries were overwhelmed by the rapidly increasing demand for placement of the mentally ill. In the United States (1861), there were 48 asylums; each treated about 200 patients, all of whom were white middle class people (Merkel, 2003). There were about 8,500 hospitalized patients in the United States, with a total population of 27 million (Merkel). With increased industrialization, urbanization, and immigration resulting in increased poverty, disease and delinquency, hospitals for the insane became overcrowded and there was a proportional decrease in treatment (Merkel). Heredity, a form of bio-power, was emphasized etiologically over the environment (Amsden, 2008). The use of discipline and punishment increased substantially (Amsden). There was increasing acceptance of organic causes of mental illness as opposed to environmental causes. At the same time, there was increased pessimism as to the treatment of mental illness. Psychiatry focused on categorization and autopsy studies and less on treatment. The growing number of people with mental illness, and their increasing marginalization and condemnation, has been seen as the cornerstone of the modern stigma against mental illness (Merkel, 2003).

Yet, under modernity, no imperfection, ugliness or suffering could now claim the right to exist (Howe, 1994). The categories of mentally healthy and ill were more firmly rooted within psychiatric discourse. Hence, in the twentieth century, living in emotional and physical distress could not be accepted as it would jeopardize the vitality of a nation’s population. Distress was seen to disfigure the social order since it depletes and

consumes resources that would otherwise be available to advance the modern project (Hansen, 2005). In order to improve other's experiences, one must recognize and propagate principles that are found within a distress free life; afterward, one can begin to correct other's experiences (Gideon, 2008). Through systematic observation, experiment, and analysis, psychiatry claimed to reveal the underlying reasons for people's behaviour. In doing so, psychiatry could improve and fix people who were mentally ill (Howe, 1994). Yet, underlying the shift toward treatment was the realization that people who were confined were not economically productive. As a result, treatment of mental illness, once again, took up a prominent role in psychiatry.

In response to the increasing emphasis upon problematic individuals, theorists, like Marx (1848), suggested that rather than individuals, it was society that needed to be fixed. Marx saw that with the rise of capitalism, there was an increasing degradation of industrial workers who had control over their production (Marx, 1992). Industrial workers began to fall into poverty, insecurity, and sickness (Marx). On the other hand, capitalists began to accumulate enormous wealth. Marx rejected the capitalist system; instead, he favoured a complete and total overhaul (Mullaly, 1997). Yet, while Marx changed the site of analysis from individual to society, the goal remained the same – progress toward an ideal. Psychiatry, under the iron fist of capitalism (i.e., governmental rationality), exercised control enacted through legislative and moral systems to define the location of the problem within the individual (Mullaly).

As psychiatry continued to develop, Sigmund Freud, a prominent psychiatrist and historical figure, developed psychoanalysis. A prominent influence, psychoanalytic theories further shifted the psychiatric gaze toward understanding "the workings of the

individual" (Hick, 2002, p 49). In an attempt to understand the individual, psychoanalysis developed many distinct schools of thought. Due to the diversity within psychoanalytic thought, there are few principles within psychoanalysis that are wholly accepted without dispute. At the same time, the influence of psychoanalysis reached almost all areas within the Western world. For example, the concepts of repression, sexual desire, and the unconscious are widely incorporated into everyday languages and knowledges (Frosh, 1999). At the same time, psychoanalysis could been seen as an attempt to "produce a certain kind of knowledge, providing explanations of human conduct and experience by revealing the mental forces that underlie them and that are not dealt with by any other intellectual discipline" (Frosh, 1999, p. 19). Psychoanalysis, as a psychiatric enterprise, changed and continues to change the face of psychiatry. Other notable psychoanalytic theorists (i.e., Klein, 1960; Winnicott, 1963) drew upon Freud's insights to develop different theoretical threads (i.e., objects-relations theory).

> At the same time,
>
> a will to knowledge emerged which, anticipating its present content, sketched out a scheme of possible, observable, measurable and classifiable objects; a will to knowledge which imposed upon the knowing subject – in some ways taking precedence over all experience – a certain position, a certain viewpoint, and a certain function (Foucault, 1991, p. 137).

As a result of reason applied to the natural world, disciplines and professions transformed and exploited natural and social resources (Leonard, 1994). Simultaneously, the social sciences, guised as an effort to achieve emancipation, emerged to manage the inevitable side effects of exploitation (Leonard, 1994). Medicine was seen to be the solution to

mental illness. It was posited that through ever increasing medical sophistication, mental illness could be eliminated to allow for the population to reach peak production. Therefore, scientific rationalism continued to search for further efficient, effective ways to cure the undesirable effects of mental illness.

In 1952, the Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2000) developed as an attempt to categorize mental illness within North American populations, a pinnacle of panoptic and bio-power. While there were earlier attempts, the DSM (1952) is the first official DSM. The DSM was developed as a way to capture statistical abnormalities within the population (McQuaide, 1999). Yet, there are not steadfast boundaries for mental illnesses within the DSM (McQuaide). Instead, the DSM, in general, provides qualitative criteria that are used by physicians to diagnose mental illnesses (McQuaide). The DSM, in some ways, represents psychiatry's attempt to consolidate and legitimize its epistemological standpoint. Yet, it continues to struggle to find its footing as is evidenced by the continued revision of the DSM.

Around the 1950s, 60s, and 70s, a movement toward community care emerged through an increasing emphasis upon neoliberal discourse. In part, the community care movement, fueled by the ever increasing sophistication of modern medicine, attempted to free people with mental illness through de-institutionalization. Toward that end, aided by first generation anti-psychotic medications, people within mental illness moved out of long term psychiatric hospitals into the community to work, consume, and free state resources. Simultaneously, a movement of consumer advocates (i.e., CMHA) sought to advance the neoliberal rights of people with mental illness. People with mental illness were not necessarily a burden rather people with mental illness could consume like any

other. And so, consumer advocates empowered on the basis of consumption, 'freed' people with mental illness to consume. Yet, at the same time, consumer advocates also imbued greater emphasis upon the human experience of mental illness.

During the development of psychiatry in the late twentieth century, there has been greater impetus to develop a new medical model. In doing so, psychiatry sought to place greater emphasis upon the biological, psychological and social components of mental illness in order to develop a more comprehensive model to guide mental health practice (Johnstone, 2006). In 1977, George Engel proposed the biopsychosocial model (Johnstone). Ever since, the biopsychosocial model has been under constant development, revision, and adaptation. Yet, it is important to understand that the biopsychosocial model does not attempt to explain the interactions or causal influences between the biological, psychological, and social aspects (Johnstone). Instead, the model provides a general framework to guide theoretical and empirical exploration. The biopsychosocial model has been well integrated into the mental health field. In practice, the biopsychosocial model continues to remain a clinical centrepiece.

The Anti-Psychiatry Movement

Around the same time that psychiatry began to gain momentum in the modern era, some social theorists began to critically examine the role of psychiatry within modern society. Spurred by Foucault's major work, Madness and Civilization, an anti-psychiatry movement arose, which attempted to critique traditional psychiatric modalities, which emphasized the medical etiology of mental illness (Foucault, 2006). There were two main anti-psychiatric schools of thought. The first school of thought led, in part by Szasz

(1974), theorized that mental illness does not exist. The second school of thought led, in part by Laing (1995), theorized that "mental illnesses are reactions to unbearable stresses in life" (Double, 2006, p. 31).

Thomas Szasz (1974) argued that mental illness is a myth, whereby, mental illness is a metaphor whose physical etiology is used as a basis and justification for psychiatric treatment. Psychiatric treatment is used to control and enslave people. Secondly, he postulated that the state and psychiatry should be separate; if the state plays an active role in psychiatry, it inherently carries a political tone into psychiatric care. Szasz argued for reduced political influences in order to facilitate psychiatry as a voluntary activity. Thirdly, Szasz argued against the presumption of competence within mental illness, which affects an individual's legal capacity within society. In doing so, psychiatry is more open to corruption. Fourthly, he supported the abolition of involuntary mental hospitalization; involuntary treatment is violence enacted through disguised beneficence. Fifthly, he supported the abolition of the insanity defense since he believed that excusing a person of responsibility for their conduct on the basis of an inability to form coherent, rational thoughts is medical science's disguise of beneficence. Finally, he argued that psychiatry is a form of slavery (Double, 2006).

On the other hand, R.D Laing suggested that psychopathology is a social practice. If psychopathology is a social practice, the debate within psychiatry becomes about the social power and legitimacy of psychiatric practice (Double, 2006). Laing attempted to highlight the relationship between social disjunction and mental illness, which underpins psychiatric enterprise. Hence, a significant element of psychiatry, in treating psychopathology, centers upon social maladjustment. Thus, psychopathology is largely a

socially situated practice rather than a legitimate medical condition. In considering the aforementioned, Laing wrote:

> I began to dream of trying out a whole new approach without exclusion, segregation, seclusion, observation, control, repression, regimentation, excommunication, invalidation, and hospitalization…without those features psychiatry practice seemed to belong to the sphere of social power and structure rather than medical therapeutics (Laing, 1985, p. 48).

In a sense, anti-psychiatry's attempt to shift away from the notion of psychopathology could be seen as its essential feature (Double, 2006). Both Szasz and Laing stipulate the rejection of psychopathology as a necessary condition of the anti-psychiatric movement. Despite anti-psychiatry's attempt to critique psychiatry's role within society, medical based theories of mental illness continued to propagate.

While the rise of psychiatry occurred over several centuries, it did not shed its socio-politicized skin. Rather, like a young onion, it continued to add new layers. The theoretical peel of its origin perseveres, albeit in different tastes and textures, within psychiatric discourse. With an understanding of some of the possible subjects and subject positions that may be found within the pre-modern, modern, and anti-psychiatry movements, one can now turn attention toward the Mental Health Survival Kit to ask the research questions. In Chapter five, discourse analysis as a means to explore the research question is delineated.

Discussion

As one can see, I examined the rise of psychiatry as a series of interlocking, overlapping historical threads (i.e., pre-modern, modern, and anti-psychiatry). I traced psychiatry through specific historical points within these threads. In the pre-modern era, I traced early theological and rationalist discourse to understand the ways people came to be positioned as mentally ill or mentally healthy. In the modern era, I traced the greater sophistication and refinement of psychiatric discourse to understand the ways psychiatry positions some people as health professionals (i.e., Pinel and Tuke) and others as people who are mentally ill (Foucault, 2006). These discussions provide a socio-historical context for the development of biomedical discourse. In the anti-psychiatry era, I traced the response of some critiques of psychiatry to understand the ways psychiatry's power is subverted through subjects that engage in "discourse-based acts of subversion" (Watson, 2005, p 306). This discussion provides insight into the way subject positions (i.e., resultant from biomedical discourse) are unstable and contested. Through understanding some of the ways people with mental illness are positioned by biomedical discourse, one can begin to conceptualize some of the possible subject positions within the Mental Health Survival Kit.

Chapter Three – Governmentality and Performativity

Introduction

Through post-structural theories, one can begin to juggle interlocking social relations manifest in the Mental Health Survival Kit that produce and reproduce subject positions through discursive practices. In my research, post-structural theories related to governmentality (i.e., Michel Foucault) and performativity (i.e., Judith Butler) will provide a theoretical landscape for my use of discourse analysis. My use of discourse analysis draws upon Jacques Derrida's deconstruction. To illustrate some of the ways theoretical threads within my thesis relate to one another, it should be noted that Foucault, Butler, and Derrida develop theoretical constructs that build upon one another. For example, in Butler's early work, *Gender Trouble: Feminism and Subversion of Identity* (1990), she borrows the notion of regulatory discourses from Foucault's *Discipline and Punishment* (1975) to develop the performativity of gender, sex, and sexuality. In her later work, *Bodies that Matter: On the Discursive Limits of "Sex"* (1993), she draws upon Derrida's notion of iterability or repetition to develop her idea of repetition within performativity. While there is a relation between Butler and Foucault as well as Butler and Derrida, there is also a linkage between Foucault and Derrida. Despite a falling out in the 1960s, Derrida, a student of Foucault, draws both critically and supportively upon the works of Foucault. Most influentially, Derrida produced a critical analysis of Foucault's Maddness and Civilization (1961) (Flaherty, 1986). With a sense of the theoretical relations between theorists, I will discuss the purpose of this chapter.

In this chapter, I outline the ways post-structural theoretical constructs (i.e., governmentality and performativity) inform my research. In doing so, one can begin to

conceptualize the ways subject positions within the Mental Health Survival Kit are produced. In that way, this chapter provides the reader with a theoretical context for my research.

Governmentality

To approach governmentality is to approach a complex dynamic process, which is difficult to trace as one complete process. As a result, governmentality may be understood as multiple simultaneous threads that interlock dynamically for many differing, yet, interrelated effects. For the purposes of this research, governmentality may be understood as a relationship between technologies of power/knowledge and technologies of the self that together produce particular subjects who fulfill particular forms of citizenship (Bennet, 2003; Flynn, 2002). Central to the idea governmentality is governmental rationality (Bennet, 2003; Flynn, 2002). Governmental rationality is a set of practices that aim to exercise power/knowledge as a means to act out technologies of the self. “Govermentality, then, constitutes a way of understanding governing not as the intrinsic function of the state but as practices that are diffuse and heterogeneous” (Milklaucic, 2003, p. 327). Under governmental rationality, the underlying assumption is that rational citizens will govern themselves in ways consistent with expert knowledge (Thompson, 2008). As a result, expert knowledge is entwined with governmental modes (Thompson). Thus, expert knowledge is produced by power and power is produced by expert knowledge; in doing so, governmental modes draw upon panoptic power and bio-power to produce technologies of the self that produce specific subjects and subject

positions. For that reason, I intend to draw upon the theoretical concepts of panoptic power, bio-power, and technologies of the self.

Panoptic Power and Bio-Power

In the 18th century, Jeremy Bentham designed a new prison that he coined the Panopticon (Roberts, 2005). The Panopticon utilized "a central observation tower encircled by an annular building divided into individual cells" (Roberts, 2005, p. 34). The Panopticon allows for the continual observation and supervision of prisoners. Each prisoner "is seen, but [does] not see" (Foucault, 1991, p.200). As a result, the prisoners are aware of their continual surveillance and any indiscretion will be corrected (Roberts, 2005). Hence, prisoners begin to monitor their own behaviour; in doing so, it no longer matters whether someone is observing or not, the prisoners will continue to monitor and correct their own behaviour (Roberts, 2005). The result is the formulation of a power relation. The Panopitcon is not only limited to use in a prison; instead, it becomes a mode of power that can be utilized for governance in many institutions (i.e., schools, hospitals, work sites…etc). Through utilization in environments outside the prison, new forms of knowledge could be produced related to new disciplinary techniques (Roberts). At the same time, individuals are categorized and/or diagnosed; hence, in part, the Panopticon enabled the development of many modern human sciences (Roberts).

In contrast to modernity's claimed agenda of emancipation, the knowledge produced by human sciences exists to exercise greater disciplinary power. In turn, the greater disciplinary power produced through the human sciences refines and streamlines Panoptic power. As a result, Foucault (1975) came to see power as knowledge rather than

two distinct entities. In that way, Panoptic power functions to produce subjects and simultaneously control them (Foucault, 1975). Subjects that deviate are disciplined and punished. With the above understanding of power and knowledge, one may examine psychiatric practice as an exercise of Panoptic power.

An inpatient unit may be seen as a direct representation of the Panoptic prison design. Psychiatric patients are under varying levels of observation depending on the level and intensity of their deviant behaviour. There is an ongoing evaluation of the diagnosis and categorization of psychiatric patients as a means to refine psychiatric interventions (i.e., medications or therapies). At the same time, as Panoptic power attempts to create an environment of observation and correction, there is a continued effort to impart a sense of self regulation amongst psychiatric patients.

In the same way, psychiatry utilizes the Mental Health Act for the purposes of control not only within the psychiatric inpatient unit but in the community (Wynn & Myklebust, 2006). Under the Mental Health Act, a psychiatric patient may be put on extended certification (Wynn and Myklebust, 2006). Under extended certification, the individual is under continual observation or perceived observation in the community. If the person's behaviour deviates, the person may be brought back directly to hospital under the power of the Mental Health Act (Wynn). As a result, extended certification functions to produce a feeling that someone is under continual observation whether someone is watching or not (Wynn). Furthermore, psychotherapy may also be seen as a technique to enhance the monitoring of the psychiatric patient's thoughts and feelings. In doing so, the psychotherapist is able to enhance self monitoring and self observation. For example, Cognitive Behavioural Therapy (CBT) attempts develop mindfulness to allow

psychiatric patients to have greater ability to monitor their thoughts and feelings. At the same time, CBT attempts to utilize cognitive restructuring to change the thoughts of the individual to reinforce some behaviours while discouraging others.

With an understanding of Panoptic power manifest in psychiatry, one may now examine bio-power. In order to understand bio-power, it is important to define bio-power. Bio-power is the "subjugation of bodies and the control of populations" (Foucault, 1990, p. 140). According to Rabinow and Rose (2006), there are three elements essential to bio-power. Firstly, bio-power contains one or more truth discourses about the 'vital' character of humans (Rabinow & Rose). Secondly, strategies for intervention rest upon a collective existence of life (Rabinow & Rose). Thirdly, there are modes through which subjects are brought to work on themselves (Rabinow & Rose). With the aforementioned definition in mind, attention may be turned to the rise of bio-power.

In the 18th century, there was a shift in the way populations were governed. The shift recognized the importance of the health of a nation, which was, in part, facilitated by the rise of the human sciences (Verstraete, 2005). Life, a biological entity, was seen as a political object; a nation was not only a "sum of individual bodies but also the biological characteristics of a population" (Verstraete, p. 122). The bodies within a nation are essential to the establishment of a productive, wealthy state (Verstraete). While Panoptic power remained active, bio-power sought to regulate the collective life of a nation (Verstraete,). Verstraete (2005) illustrates an interaction between Panoptic power and bio-power through his recollection of a lecture at the College of France by Foucault regarding the local idiot Charles Joux:

> Charles was in his forties and served as a quiet, underpaid workman. He had a special relationship with a little girl named Sophie Adam. From time to time, Sophie masturbated the grown-up idiot Citing the reaction of a contemporary villager, Foucault argued that this behaviour was accepted by the local population. But when through a random inspection of the girl's underwear in 1867 the parents discovered what was going on, both the parents and the mayor requested a psychiatric investigation. Suddenly Charles Joux became a psychiatric patient and a danger to the population. Important to Foucault was this switch in attitude towards idiotic and imbecile children – a switch that could be explained by the emergence of an independent, global and invisible new form of power: bio-power…What mattered was no longer the well-being of one person but the welfare of the state, conceived as a population with biological characteristics…Scientific knowledge regarding the population become indispensable in order to discipline the individual body and to regulate the population. (Verstraete, 2005, p. 122-123).

The abovementioned situation provides a poignant example of the interaction between Panoptic power and bio-power in the observation, identification, and discipline of psychiatric patients.

Technologies of the Self

With an understanding of Panoptic power and bio-power as technologies of power/knowledge, one may now begin to explore technologies of the self. Technologies

of the self exist so that "individuals [may] effect by their own means or with the help of others a certain number of operations on their own bodies…and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality" (Foucault, 1988, p 18). In recent times, government rationality via technologies of the self has been linked to neoliberalism (Carney, 2008; MacEachern, 2000; Peters, 2001). Neoliberalism, a prominent ideological force in the production of policies in psychiatry, draws upon panoptic and bio-power to produce psychiatric patients and subject positions. In order to understand neoliberalism, it is important to understand some dynamic processes within neoliberal ideology (Carney, 2008; MacEachern, 2000; Peters, 2001).

Since the administrations of Ronald Reagan, Margaret Thatcher, and Brian Mulroney, neoliberalism has been a prominent force in the development of mental health policy (Fisher, 2006; Peters, 2001; Prince, Kearns, & Craig, 2006). Under neoliberal impetus, governments' began to constrict the flow of resources into social programs; in effect, neoliberalism attempted to shift social resources into new economic development (Kingfisher & Maskovsky, 2008). In essence, neoliberal ideology claimed that if capital (i.e., money) is able to flourish in a free unrestricted manner, it can provide for all persons within society (Fisher, 2006). Under neoliberal ideology in Canada, Canadians have seen the privatization (i.e., private-public partnerships) of health care services, the North American Free Trade Agreement, the privatization of Alberta's oil sands, and many other examples (MacGregor, 1999 & Vera, 2008). Through neoliberalism, Canadian policies have focused upon the "superiority of the market as an institution for optimal resource allocation, public choice theory, public burden theory of welfare,

government overload, superiority of individualism over collectivism, individual self-reliance, and moral responsibility are preferable to a culture of interdependency" (Ramon, 2008, pg. 1). The aforementioned underpinning principles took place in roughly two overlapping and interlocking forms, 'roll back' and 'roll out' neoliberalism. Both forms of neoliberalism drastically changed the face of mental health policies in Canada (Vera & Crooks, 2008).

In the early 1990s, the neoliberal policies enacted by the Mulroney government were largely referred to as 'roll back' policies (Vera & Crooks, 2008). In the 'roll back' processes, the free market took absolute precedence over social programs. Under 'roll back' policies, neoliberalism posits that an unrestricted flow of capital within the free market will create transfer of wealth from the wealthy to the poor. As the neoliberal 'roll back' took place, hospitals came under increasingly intense scrutiny to reduce costs. Persons who experienced mental disorders were viewed as a burden to the welfare system; as a result, neoliberal policies encouraged persons signified with mental disorder to seek independence via work programs (Curtis, Gesler, Priebe, & Francis, 2008). In order to facilitate the change, hospital budgets were significantly cut; thus, hospitals had to reduce capacity while serving an equal number of people. At the same time, under the community care movement, mental health services shifted away from institutionalized long-stay care toward short-term acute admission then re-integration into the community. As a result, in the United States, between 1991 and 1997 there was a 50% reduction in long-stay beds within hospitals (Merkel, 2003). By reducing the length of admissions, public resources were freed from burden. As a result, in part, through the community care movement, the focus shifted from long-term stay to acute short-term admissions. Yet,

without appropriate community resources, persons signified with mental disorder were discharged to re-integrate into the community (Johnstone, 2006). As a result, a large minority of persons signified with mental disorder moved between community care and the hospital at an alarming rate. Furthermore, homelessness began to become a growing concern.

In the last ten years, as the economic limitations of 'roll back' policies have been reached, neoliberalism was reconstituted and re-created into 'roll out' policies (Raco, 2005). Under 'roll out' policies, neoliberalism sought to focus on the "purposeful construction and consolidation of neoliberal state forms and modes of governance" (Peck & Tickell, 2002, p 37). Where 'roll back' policies were a deliberate often overt reduction of services, 'roll out' policies enacted a covert agenda that sought to subordinate cultural and non-market activities for broader economic capitalist gain (Raco, 2005). In a sense, a small hegemonic minority's interests were acted upon to control social activities in order to secure opportunities for economic gain.

For example, in the UK, after deinstitutionalization took place from 1985 to 2000, one hundred psychiatric hospitals were closed (Ramon, 2008). After closing many psychiatric hospital beds, community care initiatives, guided by neoliberal discourse, created new economic opportunities for profit which allowed for the emergence and revitalization of private sector psychiatric units. Yet, the new private psychiatric units have cost nearly three times the cost of government run hospital units (Ramon). Under private sector control, hospitals were more concerned with cost reduction and profit maximization (Ramon).

At the same time, ‘roll out’ policies shifted mental health care systems toward greater utilization of not-for-profit organizations. Not-for-profit organizations cost less to run, depend upon yearly financial renewals, and are more willing to conform to ‘unpleasant’ requests due to their dependence on financial contracts (Ramon, 2008). At the same time, there was a new emergence in work related programs for persons signified with mental disorder, in part, under the guise of self-determination. However, under ‘roll out’ neoliberalism, governments developed previously idle persons signified with mental disorder into contributing members of society (i.e., consumer advocacy programs). While storied as a shift toward self-determination, the shift also serves to free government resources for further economic development and create new sources of production (Raphael, 2008).

In a sense, the Mental Health Survival Kit may be seen as a neoliberalized text that through governmental rationality draws upon panoptic power and bio-power enacted through technologies of the self to produce the neoliberal subject position that is economically productive and does not burden public resources (Waring, 2007). At the same time, the Mental Health Survival Kit may be seen as a text that produces neoliberal subject positions and is produced by neoliberal discourses. In the following section, there will be an exploration of performativity in relation to the production of subject positions within the Mental Health Survival Kit.

Performativity

Introduction

In light of the surveillance, control, and self-discipline of governmental rationality within mental health, performativity offers a way to further understand the production of subject positions with specific attention to subjugation, agency and subversion. In recent years, state based welfare has been replaced by localized (i.e., neoliberal) welfare formulations (Perron, Fluet, & Holmes, 2005). In doing so, there has been a shift away from hierarchical regulation toward localized discourses that emphasize discourses of participation and social inclusion (Power & Gilbert, 2006). The Mental Health Survival Kit exists, according to its authors, as a means to help persons constituted as mentally disordered "navigate the mental health system" (Mental Health Survival Kit, n.d.). In a way, the Mental Health Survival Kit represents a participatory socially inclusive text. Yet, the neoliberal shift has created a social space wherein relations between professionals and clients may illustrate the potential for subjugation and subversion (Power & Gilbert, 2006). In years past, analyses of the relation between professionals and clients focused on the domination of clients by professionals (Power & Gilbert). The aforementioned analyses missed the nuanced relational dynamics that produce subjugation and subversion. Hence, performative acts do not exist in a single professional-client relation; instead, performative acts include many other people and objects (i.e., the Mental Health Survival Kit). Furthermore, the relation between professional and client is mutually dependent. Hence, performativity offers a way to understand complex interlocking social relations imbedded within the Mental Health Survival Kit.

Throughout the last two decades the works of Judith Butler (e.g., 1990, 1993, 1997, 2004, 2005) have had a significant effect on many debates about identity formation. Central to Butler's understanding of subjugation is that "regulatory power produces the subject it controls, that power is not only imposed externally but works as the regulatory and normative means by which subject are formed" (Butler, 1993, p 22). In a sense, rather than the violent oppression of physical restraint, performative acts subjugate people into a categorical social order via social discourse (Watson, 2005). As Butler (1993) argues, "performance acts are forms of authoritative speech; most performances, for instance, are statements that, in the uttering, also perform a certain action and exercise a building power" (pg. 225). Hence, Butler develops the theme of power within discursive practices as a productive force in the constitution of the subject (Butler, 1993). For instance, to speak or read a text is simultaneously to bring subject positions to the objects it intends to act upon; thus, the text enacts subject positions via wielding discursive power. Butler holds power to be a central to the processes of subjugation. Unlike many social theorists (i.e., Marx) who held institutions as the Other in relation to the subject, for Butler, 'power' is the Other. Power operates as a priori to the subject position (Watson, 2005). In a sense, power appears to "come from nowhere, to be embodied by no person or institution, and yet to exercise its authority relentlessly" (Watson, 2005, p 306). With an understanding of the way Butler situates power in relation to the subject position, one can now shift toward situating power as an operative within language. In developing performativity, Butler draws upon several linguistic influences, Foucault (1977), Althusser (1971), Austin (1962), and Searle (1969). For the

purpose of this research, Butler's revision of Athusser's the interpellated subject provides a way to understand power in the production of subjects and subject positions.

The Interpellated Subject

According to Althusser (1970), despite historical shifts, the function and structure of ideology have largely been unchanged throughout history; to this end, Althusser comments "ideology has no history" (p 150). Famously, Althusser depicts the act of "interprellation" or hailing (p 162) as described in the section titled *How does a text produce a subject position?* With this depiction in mind, I draw upon Montag's (1999, p 42) comment, "What happens when we no longer consider minds transcendent in relation to bodies, when mental decisions, acts of will, are viewed as entirely immanent in the physical actions of which they are said to be the causes?"

Drawing upon the abovementioned conception of the interpellated subject, Butler situates language in place of institutions as a regulatory constraint on the formation of a subject. Butler states that interpellation offers "a way to account for a subject who comes into being as a consequence of language, yet always within its terms" (1997, p 106). In effect, Butler attempts to situate the act of interpellation as a conflicted social relation of identity possibilities rather than an act of direct hierarchical ideological relation. To this end, Butler provides the following reflection:

> Consider the force of [the] dynamic of interpellation and misrecognition when the name is not a proper name but a social category, and hence a signifier capable of being interpreted in a number of divergent and conflictual ways. To be hailed as a 'woman' or 'Jew' or 'queer' or 'Black'

> or ‘Chicana’ may be heard or interpreted as an affirmation or an insult, depending on the context in which the hailing occurs (Butler, 1997, p 96).

In the act of interpellation, power, available through the social order, is wielded as a means to signify discourse. Yet, the result of interpellation remains opaque since there are multiple conflicted subject positions that emulate from the act of interpellation. For example, imagine an individual walking down the hallway in a hospital. In the act of interpellation, the individual may be hailed as “friend”, “family member”, “patient”, “doctor”, “nurse”, or “social worker” among many other possibilities. Each signifier may be interpreted in multiple conflicted ways depending on the source of the hailing. In this context, power is wielded through the utilization of socially charged signifiers found in the discourse of a particular social order in a particular context. The aforementioned form of power operates primarily through signifiers via language. In effect, if Butler’s account of interpellation offers “a way to account for a subject who comes into being as a consequence of language, yet always within its terms”, it’s also a prison to the production of subject positions (p 129). While there are many possible subject positions, one cannot separate the power of language from the way language limits a subject coming into being. Hence, if subject positions are produced in relation to Butler’s Other than the subject position is in a place of dependency. Thus, Butler stipulates “one cannot criticize too far the terms by which one’s existence is secured” because one subject position relies upon another (p 129). While one cannot extend beyond the confines of language, Butler emphasizes the importance of subversive acts.

Subversive Acts

While one can imagine a revolutionary Marxist approach to state based change (i.e., attacking or dismantling the state), one cannot envision a way to revolutionize an opaque conflicted apparatus like 'power' that operates through discourse. Where the revolutionary breaks the law, the subversive resists the law. Hence, Butler posits that the only way to confront "power is to repeat its signifiers disobediently, thereby engaging in discourse-based acts of subversion" (Watson, 2005, p 306). If power is primarily exercised through signifiers, the only way to combat discursive signifiers is through other signifiers. Hence, to respond performatively is to follow "logical progression:

> Your name brings me, as subject, into being, performatively, since you create me, the subject, by naming me; however, I can repeat that name, subversely, thereby performatively altering your act of performativity" (Watson, 2005, p 309).

In a recent paper by Rich and Evans (2009), the authors provide a rich illustration of the conflicted complex relation between subject positions and subversive acts. The authors describe the way white young middle class women experience eating disorders. The following is a snippet from the article:

> These young women are not simply adhering to a school's healthy guidelines but are in many cases dangerously thin. Here then, it is not just being thus but being anorexic…Finding a 'unitary self' within a relational construct is difficult. Thus only extreme thinness, with its accompanying label of anorexic appeared to provide the fictional subjectivity of 'who they really were' within a discourse where the reading of the body

> becomes a comparative project"… [Yet], it is never finished or fully complete as it is always context or 'other' specific… The body becomes a 'voice' through which to convey a message through which to ultimately subvert performativity, their embodied actions saying, 'look; now I have Nobody, now see and treat me as a person, for who I really am (Rich & Evans, 2009, p 12).

The abovementioned quote illustrates the way subversive acts (i.e., anorexia) may disrupt the power exercised through social discourse. The young woman must be recognized by others. In a sense, anorexia serves to display her struggle to construct a sense of self in relation to the individualization embodied in neoliberal discourses. Through subversion, she becomes one outside many rather than one of many. Her pain is seen as much as it is felt. For the purpose of this research, the young woman's struggle emphasizes the conflicted way subversive acts operate to produce alternative subject positions.

As one can see, performativity offers a way to further understand the production of subject positions with specific attention to subjugation, agency and subversion. In doing so, performativity will inform an analysis of the way the Mental Health Survival Kit produces subject positions. As one may recall, the interpellated subject situated as 'becoming.' Hence, I ask, "How does the Mental Health Survival Kit produce subject positions?" To answer the aforementioned question, discourse analysis will be implored. In Chapter five, I will provide an exploration of a utilization of discourse analysis as a means to answer the abovementioned question.

Discussion

In this chapter, I described the ways post-structural theoretical constructs (i.e., governmentality and performativity) inform my research. Specifically, governmentality and perfomativity provide a way to understand how discourses (i.e., neoliberal discourse and biomedical discourse) work through power (i.e., bio-power and panoptic power) within a text to produce subject positions. In this way, governmentality and performativity specifically allow one to show that the Mental Health Survival Kit produces subject positions. In that way, this chapter provides a theoretical organism for use in chapter five, six, and seven.

Chapter Four – Ethical Dialegesthai

> No philosopher was ever more worth, but neither was any philosopher more maligned and hated. To grasp the reason for this it is not enough to recall the great theoretical thesis of Spinozism: a single substance having an infinity of attributes, Deusive Natura, all 'creatures' being only modes of these attributes or modifications of this substance. It is not enough to show how pantheism and atheism are combined in this thesis, which denies the existence of a moral, transcendent, creator God. We must start rather from the practical theses that made Spinozism an object of scandal…
>
> Gilles Deleuze (Spinoza Practical Philosophy, 1988, p 17)

Introduction

During the rise of psychiatry, Christianity, in part, informed the development of pre-modern and modern ways of understanding mental health (Merkel, 2003). While modern forms of rationalism attempt to displace Christianity within Western ways of thinking, Christianity continues to hold onto its moral and theological position (Merkel). As such, moral discourse has informed the development of psychiatry. With Christian informed morality imbedded within psychiatric discourse, post-structural theories allow one to draw an important distinction between morality and ethics. In doing so, one can shift dialogue away from individual characteristics (i.e., transcendent values) toward a socio-political system of ethical relations that perpetrate specific discursive relations. As

a result, in this chapter, I intend to compare and contrast moral discourse in relation to ethics informed by post-structuralism. Then, I attend to possible ways ethics informed by post-structuralism may impact the production of knowledge through research. Finally, I provide implications, based on the aforesaid exploration, for the ethical development of my thesis.

During the enlightenment era, Immanuel Kant was one of the foremost philosophers in the field of morality. Through the *Groundwork for the Metaphysics of Morals* (1785), *Critique of Pure Reason* (1787), and *Metaphysics of Morals* (1797), he sought to translate a posteriori knowledge into a priori knowledge (Gardner, 1999). In doing so, he traced obvious rational experience back to categorical imperatives, which represent principles that are intrinsically good. From the categorical imperatives, he sought to articulate moral law (Gardner). Through emphasizing rational experience, Kant claims that only rational beings (i.e., humans) are subject to the categorical imperatives (Gardner). In essence, as rational entities, categorical imperatives represent moral obligations that people must follow regardless of their desires (Kant, 1993). By definition, the categorical imperatives are situated as transcendent philosophical knowledge that is knowable through reason (Gardner, 1999). After a complex intricate explanation of the categorical imperatives, Kant attempted to illuminate the ways categorical imperatives may be followed (Gardner).

Following Kant's assumptions about rationality and transcendence, it would appear that Kant's categorical imperatives provide some insight into moral discourse. However, drawing upon post-structural theories, what is ethics? In contrast to Kant's contributions, post-structural informed ethics would suggest that morality is irrelevant.

By drawing upon humanism, morality inherently positions the individual as a site of discourse production; hence, identity is seen as stable and fixed (Grosz, 1992). In contrast, post-structural informed ethics draws upon an anti-humanist view of the subject position (Grosz). The subject position is seen as a conduit of discourse; hence, identity is a product of discourse rather than a producer (Grosz). As a result, identity is fluid and unstable (Grosz). In effect, morality defined as 'personal character' is irrelevant since there are no stable identities. Ethics, unlike morality, emphasize singularities within a system of socio-political relations. Singularity refers to the uniqueness of human beings to which one can never fully know 'the other' (Ajana, 2008). By recognizing that one cannot fully grasp the singularity of 'the other', the other is not reduced to obscurity. Instead, 'the other' is seen as part of an interlocking web of socio-political relations. As such, Redwood and Todres (2006) contend that ethical dialogues emphasize a more explicit discussion…

> about the status of our knowledge and its context. So it won't be used to impose a kind of 'of course this how it is' rather than given this kind of researcher, given this moment in history in this kind of context, given these types of people and this kind of audience, these kinds of profiles (p. 4).

As a result, post-structural theories provide a strong ethical critique of transcendent, normative positions (Ajana, 2008).

In a sense, post-structuralism allows one to critically examine ethical systems without commitment to closure. Ethical systems do not necessitate well packaged answers; in effect, conflict and instability are features of post-structural ethical dialogues.

Post-structural informed ethical dialogues espouse critical reflexive questions to unearth transcendent, normative positions. For a moment, consider the below mentioned scenario as a means to reflexively examine one possible way a post-structural informed ethical dialogue may critically examine the role of representation within research.

Representation in Research

> "Suspend time and space for a moment, you are introduced to Miss Janet Tyler, who lives in a very private world of darkness, a universe whose dimensions are the size, thickness, and length of a swath of bandages that cover her face. In a moment, we'll look under those bandages, keeping in mind, of course, that we're not to be surprised by what we see, because this isn't just a hospital, and this patient, 307, is not just a woman. This happens to be the Twilight Zone…"
>
> – Opening narration from Eye of the Beholder, a Twilight Zone episode.

In the aforementioned scene, the viewer is presented with a woman whose face is bandaged. Only after the bandages are removed may the viewer grasp the truth of her grotesque disfigurement. Yet, as the bandages are removed; she is in fact not disfigured but beautiful. As the scene becomes clear, it is in fact the doctors and nurses around her who are disfigured. Yet, their expression is disappointment, to them, she remains disfigured. Instantly, the viewer is thrust into a reflexive debate about our socially constructed notion of normal and abnormal. Similarly, in qualitative research, paradigmatic positioning veils understanding. Hence, there must be a reflexive conversation about our socially constructed knowledges. What veils the beauty around us?

With a gaze tentatively fixed upon its' object of desire, poststructural methodologies aim to unveil the idiosyncratic social and power relations implicit to any regime of Truth. Through socially constructed interactions, sense based research creates Kantian a posteriori knowledge (Gardner, 1999). Yet, a posteriori knowledge, gathered through modes of visual transcription, relies upon a system of representation, which begs the question, how does research informed by post-strucutral theories ethically represent findings (Gardner, 1999)? Representation is, implicitly and explicitly, at the epicentre of the disjunction between claims of fact and fiction. Who may speak and who may not? What may be said and what may not? Poststructural methodologies, act to think then speak representation. What does it mean to think then speak representation? Thought, as a process, interprets and transforms (Williams, 2005). Thought occupies a space between the outside and inside, situated between seeing and speaking (Juniper & Jose, 2008). Thought presupposes an origin and destination wedged between words and things. In a sense, words represent things through a conduit known as language. Language occupies thought in relation to an origin (i.e., person) and destination (i.e., object); thus, thought occurs simultaneously outside oneself within oneself. In thought, "the thinking being problematizes itself, as an ethical subject position, thinking its own history (the past) only in order to free itself from what it thinks (the present), in order to think otherwise (the future)" (Juniper & Jose, 2008 p. 11). In this process, the transcendental subject position is absent, fixity is no longer; fluidity is placed in its stead (Juniper & Jose). Representation is unveiled; it is deconstructed. Permeated by thought, the problem of representation exists within the space between sensed experience and linguistic semiology.

For a moment, invoke Plato's simulacrum. The simulacrum is "a copy of a copy whose relation to the model has become so attenuated that it can no longer properly be said to be a copy" (Massumi, 2009). The process of its production, its inner being, is entirely different from that of the model; its resemblance is merely a façade (Deleuze, 1994). The production and function of a photograph has no relation to that of the object photographed; the photograph shrouds an essential difference (Massumi, 2009). It is that masked difference, not the manifest resemblance that produces the effect associated with the simulacrum (Deleuze, 1994). Where a copy is made to stand in for its model, a simulacrum has a different purpose. The simulacrum seeks not to become an equivalent of the model but to turn against it and its world in order to open a new space for the simulacrum's own proliferation (Deleuze, 1994). The simulacrum affirms its own difference; it is not an implosion, but a differentiation (Deleuze, 1994).

How is the simulacrum relevant to ethical representation? If we draw back to the original problem, in thought, the problem of representation exists within the space between sensed experience and linguistic semiology. Discourse analysis attempts to disrupt and unveil the representations of the thoughts of an-other through text. Yet, similar to the simulacrum, the text is not a copy; any resemblance the text bears to its origin is an illusion. Through differentiation, it exists to create space for its own proliferation. In effect it turns against its origin in order to differentiate and propagate itself. Hence, once the thought transforms from thought to written word, it is no longer a copy of one's thoughts. As Barthes contends, in *The Death of the Author*, the author is neither someone who can project an ultimate meaning nor an ultimate explanation of a text (Culler, 2002). Hence, the text occupies a space, created and enacted, separate from

its origin. Any claim of ownership, whether author, participant, or otherwise, masks the power a text possesses in its struggle toward simulacra differentiation. A possible balance lies in Deleuze's conception of immanence, a movement toward abstraction abandoning sense experience (Due, 2007). Yet, for visual research, one must seek some form of representation based in sense experience (i.e., available for others outside the inside) so that others may view it.

Haraway (1988) contends that "relativism and totalization are both 'god tricks' promising vision from everywhere and nowhere equally and fully" (p. 584). Hence, a text is neither no one's nor everyone's. Texts rely upon social and power relations conveyed through linguistic representation of a sensible world.

> The world does not speak for itself nor disappear in favour of a master decoder… [hence], situated knowledges require that the object of knowledge be pictured as an actor and agent, not as a screen or a ground or a resource (Haraway, 1988, p. 592).

Thus, a text must be approached as an agent rather than a passive object. A text is situated within my social, cultural, political, and historical influences; it is a text within a text. However, as with the simulacrum, it is not a text of a text. As posited before, thought occurs simultaneously outside itself within itself. Thus, our route to situating a text lies in abstract reflexive thought that is expressed, outside, as a text within a text. Research is the act of knowledge production (Guillemin & Gillam, 2004); knowledge production entails representation. Poststructural methodologies, act to think then speak representation. Therefore, ethical representation is struggled toward through abstract reflexivity; yet, it may not be possible to achieve in absolute terms.

As the opening scene depicts, the bandages are removed, but who can define the metamorphosis? The woman? The doctor? The nurse? It depends upon one's situated knowledges. Through post-structural theories, one can shift away from questions about whether or not an epistemological shift is right or wrong (i.e., moral discourse) toward questions about the ethical effects of an epistemological shift. Any attempt to appeal to a pre-existing or pre-given set of principles and rules to find one's way is doomed to failure if not even to violence (Ajana, 2008; Olofsson, & Jacobsson, 2001; Razack, 2005; Spencer, 2008; Widiger, 2006). And so, if transcendent representation of research, through moral discourse, is doomed to violence, my research, informed by post-structural theories that draw attention to a socio-political system of ethical relations, must be presented as positioned and localized. Therefore, my thesis is represented as my story of a story.

Discussion

In this chapter, I compared and contrasted moral discourse in relation to ethics informed by post-structural theories. I developed possible ways ethics informed by post-structural theories may impact the production of knowledge through representation in research. Specifically, the way research may be represented as a text within a text, a story of a story. Toward that end, I illustrated some possible implications for the ethical development of my thesis. In this way, the chapter provides an ethical framework, informed by post-structural theories, to guide the representation and development of my findings as an unfolding story about empirical and theoretical threads within the Mental Health Survival Kit.

Chapter Five – Discourse Analysis

Introduction

In this chapter, I intend to outline my research methodology, discourse analysis. Toward that end, I begin with an overview of the way language may operate to create space for social hierarchies to legitimize their position via *Semiotic Soup – a Word about Words*. In doing so, I outline what discourse analysis may uncover. I then describe the way I intend to utilize discourse analysis. Next, I discuss why I use discourse analysis rather than other available methodologies. Afterward, I discuss my position in relation to my research to understand some of the ways the discourses that produce me influence my research. Finally, I discuss the way my research may be validated.

Semiotic Soup – A Word about Words

Research informed by post-structural theories situates language as constructor of social reality. Within language, semiology draws attention to the process of constructing and mediating meaning through signification. Within semiology, there are three types of semiotics: syntactics, paradigmatics, and semantics (Belsey, 2002). Syntactics refers to the relation between signs (Belsey). Paradigmatics refers a vertical feature of language wherein one word may replace another related term (Belsey). Semantics refer to the relation between signifier and signified (Belsey). Together, signification is a complex process that is the relation between signified and signifier. To further explore the ways signification may operate, one can turn to the *Mythologies* (1957) by Roland Barthes (Culler, 2002).

In 1957, Roland Barthes's *Mythologies* presented an analysis of signification. For Barthes, the term myth refers to a form of political propaganda, which is presented as fact; yet, it masks contradictions within the social system (Culler, 2002). In Mythologies, the sign becomes a signifier, which creates a new semiological system (Culler). For example, if one were to think about a tree (signifier) and Christmas (signified). At Christmas, the tree is expropriated for a commercial or religious purpose. The tree is void of its original meaning; it is alienated from the signified. In *Mythologies*, a famous example depicted by Barthes takes place at a barber's shop (Culler). While at the barber shop, Barthes reviews a popular French magazine, *Paris Match* (Culler). On the cover is a young black soldier who is saluting, his eyes look upward, assumingly at the French flag. In doing so, it is conveyed that "France is a great Empire…all her sons, without any colour discrimination, faithfully serve under her flag…there is no better answer to the detractors of an alleged colonialism than the zeal shown by this Negro in serving his so-called oppressors" (Barthes, 1983, p 116).

A myth illustrates the way language can function to create space for social hierarchies to legitimize their position within society (Crowe, 1998). As is the case with some aspects of the research process, researchers may write in third person to mask the power of their social position (Fine, Weis, Weseen & Wong, 2000). In doing so, a researcher's text creates space for social hierarchies to legitimize their position. In this way, research may be positioned as objective fact rather than a partial socio-politicized text. Toward that end, I intend to write this research as my story; therefore, I will not refer to myself as 'the researcher' (Sandelowski, 1991). At the same time, discourse

analysis informed by post-structural theories may draw out 'myths that mask.' Yet, what is discourse analysis?

What is Discourse Analysis?

There are many forms of discourse and discourse analysis in the literature; in fact, discourse analysis maintains many different meanings for many different forms of research. Yet, pragmatically, the term discourse and discourse analysis must be defined so that a reader may understand the researcher's utilization of discourse and discourse analysis. Toward that end, this chapter provides a definition of discourse and discourse analysis, as used in this research. Discourse refers to "an interrelated set of texts, and the practices of their production, dissemination, and reception, that brings an object into their being" (Phillips & Hardy, 2002, p 3). For example, the discourses of psychiatry was brought about through the many texts developed in the early 19th century (Phillips & Hardy). Hence, a social world cannot be fully understood without reference to the discursive texts that give meaning to its existence. Thus, discourse analysis refers to the exploration of the relationship between discourse, texts, and social reality (Phillips & Hardy). At the same time, discourses are constituted and constructed in ways that exist beyond individual texts. A text may be considered as a material manifestation of discourse (Phillips & Hardy). Texts may take many forms which include songs, symbols, literature, newspaper articles, spoken words, and so on. Texts, on their own, are not meaningful; it is through connecting texts with other texts that the relationships between discourses illuminate the ways subject positions are produced, disseminated, and

consumed. As a result, discourse analysis is primarily interested in evoking the constitutive and constructive ways of discourse(s) (Phillips & Hardy).

At the same time, there are particular limits upon the research based on discourse analysis. Discourse analysis is not only a methodology; it is also an epistemological and ontological position. Hence, discourse analysis allows some aspects of the social world to be seen while obscuring others. As a result, a discursive analysis does not intend to claim to an omniscient omnipotent gaze. Discourse analysis, as applied in this project and informed by post-structural theories, is intended to illuminate specific theoretical and empirical threads within the Mental Health Survival Kit in order to understand the research questions. Toward that end, it is important to discuss the ways post-structural theories, specifically, governmentality and performativity, inform discourse analysis. Yet, first and foremost, it is important to discuss: why discourses analysis?

Why Discourse Analysis?

Discourse analysis, a product of the linguistic turn, has been thrust to the forefront of social sciences and humanities. Discourse analysis focuses attention on the processes that maintain and construct the social world. Furthermore, discourse analysis reflexively critiques academia by unveiling the production and maintenance of discourse through linguistic representation in research. But, why would one want to utilize discourse analysis over other available research methodologies? Toward that end, there are three critical reasons that support the utilization of discourse analysis.

In the past, language has been, to a greater extent, seen as a simple reflection of reality. Over the last few decades, there has been increasing emphasis upon the role language plays in the constitution and construction of social reality. As a result, there has been greater attention to a crisis of representation. As explored in chapter two, there was an exploration of some ethical dimensions of representation. The aforementioned discussion is only a small fragment of the vast area of academic interest that has been advanced by research utilizing discourse analysis. At the same time, some researchers are beginning to ask how and why the social world comes to have meaning rather than ask what the social world means to the subject positions that occupy it (Phillips & Hardy, 2002). In doing so, there are new categories of study that traditional research methodologies cannot address. Discourse analysis represents a methodology that can provide some answers to the aforesaid type of questions.

As mentioned, there has been an emergence of new categories of study. Traditional qualitative methodologies provide insight into the nature of the new categories and quantitative research provides claims about the relations between categories. Yet, neither traditional qualitative methodologies nor quantitative methodologies allow one to conceptualize how the categories exist or the mechanisms that maintain their existence. Contradictorily, traditional approaches tend to reinforce existing categories as natural and innate (Phillips & Hardy, 2002). Discourse analysis allows one to critically examine taken for granted categories.

With a greater emphasis upon post-modern pluralism, discourse analysis, a relatively new research methodology, provides theoretical and methodological revitalization (Phillips & Hardy, 2002; Wood & Kroger, 2000). While traditional research

methodologies recreate prior categories and ways of thinking, discourse analysis provides fresh reflexive insight into venerable avenues. In doing so, discourse analysis is able to spawn new questions and challenges. At the same time, discourse analysis may build on and complement other bodies of theoretical ideas by contributing new concepts.

As one can see, discourse analysis provides new ways of conceptualizing long standing areas of research, new challenges to former ontological and epistemological positions, build upon well established theories, and ignite new theoretical concepts. As a result, discourse analysis is likely to continue to be at the forefront of new research methodologies. For the aforementioned reasons, discourse analysis will be implored.

Discourse Analysis Informed By Post-Structural Theories

With a clear understanding of discourse and discourse analysis and the reasons discourse analysis will be utilized, it is important to discuss how discourse analysis is informed by post-structural theories. First and foremost, what is post-structuralism? Post-structuralism refers to a name for a movement in philosophy that began in the 1960s. In a general sense, it refers to a group of continental French philosophers who produced a wide array of literature, politics, art, cultural criticisms, history, and sociology (Williams, 2005). Yet, the movement is likely best spoke about with reference to its key philosophers (i.e., Derrida, Deleuze, Lyotard, Foucault, and Kristeva) (Williams, 2005). In speaking about post-structuralism, there are a few key points that underscore the post-structural movement. Firstly, “the limits of knowledge play an unavoidable role at its core” (Williams, 2005, p 1). Essentially, the aforementioned statement makes reference to the position structuralism attempts to maintain when it attempts to assert secure

knowledge. Post-structuralism charts the differences, tensions, and contradictions within the 'secure knowledge' purported by structural theories (Williams, 2005). Williams (2005) provides an excellent example of the way each of the five key post-structural philosophers trace the limits of secure knowledge.

> Put simply, Derrida follows the play of the limit at apparent more immediate and truthful core of language. Lyotard traces the effect of limit-events in language and sensation. Deleuze affirms the value of a productive limit between actual identities and virtual pure differences. Foucault traces the genealogy of the limit as the historical constitution of later tensions and problems. Kristeva follows the limit as an unconscious at work undoing and remaking linguistic structures and oppositions (Williams, 2005, p 3).

It is upon Derrida's post-structural influence that I develop a post-structural informed discourse analysis.

Discourse analysis that draws upon the post-structural influences of Derrida attends to the language of deconstruction (Czarniawska, 2004; Fairclough, 1995; Schiffrin, Tannen & Hamilton, 2003). Deconstruction unveils internal contradictions in language to confront suppositions and meaning (Cheek, 2000). In a sense, deconstruction looks for subtext to turn it into text (Cheek,). And so, deconstruction rewrites the text into a composite account of itself (Cheek,). A significant element in the deconstructive development is revealing binary oppositions; binary oppositions are "one term [that] is always prior or dominant to the other which is secondary or subordinate" (Cheek, 2000, p. 58). Binary pairs are socially constructed suppositions about meaning and worth

(Cheek, 2004). Within mental health, there are several key binary oppositions such as doctor-nurse, nurse-patient, body-mind, male-female, rational-irrational, order-disorder, oppositional-assertive, and cooperative-submissive. In substituting the dominant for its 'weaker' derivative, one can open the text to elucidation; the text no longer has perceived cohesive meaning. Through questioning the assumed meaning, one can begin to open up existential opportunities. Toward that end, there will be a series of reflective questions that will inform the analysis and will allow one to approach the research questions.

The discourse analysis used in this study involved five analytic readings of the Mental Health Survival Kit constituted as reflective sub-questions. First and foremost, discourse analysis sought to situate a text within social contexts. Thus, the analysis of the Mental Health Survival Kit is situated within a greater social context. I asked: what social contexts are found within the Mental Health Survival Kit? Next, discourse analysis pays close attention to knowledge as a means to produce power. Thus, the analysis of the text included an interrogation of the means through which some knowledges are legitimized over others. I asked: how do the authors legitimize the Mental Health Survival Kit? Next, since hegemonic discourses are constituted in relation to other discourses, tensions and relationships between hegemonic discourses and subordinate discourses were examined. I asked: how are contradictions/tensions produced within the Mental Health Survival Kit? Since texts speak not only what is written but also what is not, I asked: what is absent in the text? Finally, discourse analysis pays close attention to subject positions. Hence, there is a focused analysis of the ways the Mental Health Survival Kit produces subject

positions. Thus, I asked: what subject positions are found within the Mental Health Survival Kit?

While positing the above mentioned questions, as part of discourse analysis, textual themes are coded using NVivo 8^{qsr} a qualitative management software (Tuckett, 2004). Since discourse analysis is theoretically driven, the coding process is directly linked to the paradigmatic position. Theoretically relevant segments of text were coded by the abovementioned questions. Whenever a decision about whether or not a particular segment of text was relevant, the decision making process was recorded in a written journal. Thus, post-structural theories informed the analysis and the coding process. In doing so, themes were grouped by theoretical threads.

Who is the Researcher in Relation to the Researched?

In order to effectively carry out discourse analysis, the position that I occupy in relation to the object of analysis must be examined; more specifically, my position in relation to the discourses imbedded within the object of analysis. Hence, critical reflection upon my position is paramount. It is through explicit reflection that a richer understanding of the performative characteristics of the discourses in relation to the text and my position can be gained. Thus, in order to accomplish sufficient critical reflection, there is an immersion of self within the text through multiple close readings (Cheek, 2000). At the same time, there will be a discussion of my relationship to the Mental Health Survival Kit.

First and foremost, I intended to uncover the subject positions produced by the Mental Health Survival Kit and the ways these subject positions are produced. As any

analysis is, in part, gender constructed, it is important to discuss the ways gender may influence the analysis of the Mental Health Survival Kit. Women and men have distinctly different socially constructed perspectives. Gender disparity may inhibit my ability to see some discourse tensions and contradictions (Hamberg & Johansson, 1999). Furthermore, masculinity may have implicit gendered interpretations toward feminine voices and discourse which may silence female tensions that only women may access. Conversely, as I am male, I may over identify with masculine discourses leading to researcher blindness (Hamberg and Johansson, 1999). However, given that there is no cohesive 'woman' or 'man', discrepancies are difficult to identify.

Similar to gender position, socio-economic status may influence the analysis of the Mental Health Survival Kit. I may be more or less affluent than the subject positions identified in the text; as a result, I may be more likely to identify with specific language and power imbedded in the Mental Health Survival Kit. As a result, I may not recognize some linguistic and power relations. Hence, socio-economic status is a limitation upon the analysis. A linguistic and power disparity exists between people with lower and higher socio-economic status. People with a lower or higher socio-economic status have a unique socially constructed experience of the world. Since I am relatively well educated and affluent, I may not be able to detect some social contexts that privilege or similar socio-economic relations.

I must recognize professional authority. Since I am a registered social worker who works in adult inpatient psychiatry, I have psychiatric knowledge attained through partial possession of the discourse of psychiatry (Osgood, 2006). As a result, it is likely that I will not recognize all facets of psychiatric discourse. Some facets of psychiatric discourse

may seem natural or taken for granted (Johansson & Lundman, 2002; Osgood, 2006). In doing so, I may miss elements of discourse that contribute to the production of subject positions by the Mental Health Survival Kit. Yet, systems of power are extremely complex, multifaceted, and saturate our individual psyche and external environment; hence, one cannot predict all manifestations of oppression and systems of power (Spencer, 2008).

I must also recognize the unique experience of people with a mental dis-order. As Crowe (1998, p 1) comments, there is an "ideological assumption that qualitative researchers can directly represent lived experience through language." Post structural ideas challenge the aforementioned assumption in that the representation is not natural but politized (Crowe, 1998). In this way, I will take ownership over my story. My story is constructed through an analysis of the Mental Health Survival Kit. Hence, the culmination of the analysis is an interpretation and representation of a text that must be presented as my story rather than imposing a secure omnipotent representation of the Mental Health Survival Kit. My position should be owned. Speaking in third person, attempts to impart a sense of neutrality; hence, I have chosen to speak in first person. As an adult who has not been subjected to a diagnostic mental dis-order, I do not have any firsthand knowledge of the experiences of mental dis-order. I have never been subjected to psychiatric assessment or treatment. I have never been involuntarily or 'voluntarily' admitted for psychiatric observation. I do not carry the stigma associated with mental dis-order. Through hegemonic discourses about rational secure knowledges, I am privileged with an ordered experience.

While I acknowledge the aforementioned influences, there are unknown influences, which may impact research. Furthermore, my position is not fixed; my position continues to change throughout the research process and beyond. After the thesis is complete, the work is born; it no longer has residence with the author. As the work departs the author, the author's position departs via the work. As Barthes comments in the Death of the Author, readers must separate a literary work from its creator in order to liberate it from interpretive tyranny (Culler, 2002). For Barthes, the author exists to produce the work not to explain it (Culler).

Validity after Post-Structuralism

Finally, I will write up the analysis; in this process, validity is a centre piece. Research informed by post-positivist ideas tend to focus upon "transferability, credibility, dependability, and confirmability" as measurements of validity (Creswell, 2007, p 203). These criteria fit well with post-positivist ideas because the criteria assume a humanist subject position (i.e., identity is an epicentre rather than conduit) (Pratt, 2000). However, the humanist subject position may be seen as an ideological construct (Pratt). In contrast to humanism, post-structural ideas de-centre the subject position; the subject position is seen as an effect of complex power relations (Pratt). In doing so, the "boundaries that define identity are intertwined with processes of disidentificiation, such that the effect of identification is a fragile and contradictory achievement" (Pratt, p 802). As a result, subject positions are constructed within and through discourses. What does an anti-humanist subject position mean for validity?

If research informed by post-structural theories interrogates a humanist representation of the subject position then research informed by post-structural theories must reconfigure validity. As Richardson (1993, p 705) suggests, “reseeing and retelling are inseparable.” If the Mental Health Survival Kit is a text that is contradictory and unstable then the analysis must be presented in a way that illuminates the tensions and contradictions that are hidden by the representation of the Mental Health Survival Kit as uncontested. If the Mental Health Survival Kit is deconstructed in a way that unveils its contradictions then it must be evaluated by criteria that are expressive of those tensions/contradictions. What is validity after post-structuralism?

To this end, Lather’s (1991) rhizomatic validity fits well with a contradictory and unstable subject position. Rhizomatic validity draws upon the rhizome as a metaphor. Lather vividly articulates Rhizomatic validity:

> Rhizomes are systems with underground stems and aerial roots, whose fruits are tubers and bulbs. To function rhizomatically is to act via relay, circuit, multiple openings…There is no trunk, no emergence from a single root…Rhizomes are paradoxical objects…Rhizomatics are about the move from hierarchies to networks and the complexity of problematics…Rather than linear progress, rhizomatics is a journey among intersections, nodes, and regionalizations through a multi-centered complexity. As a metaphor, rhizomes work against constraints of authority, regularity, and commonsense and open thought up to creative constructions (p. 680).

Drawing upon Lather's rhizomatic validity, I will attempt to write an analysis that is an alternate story. Through a pluralistic, multi-faceted, contradictory analysis, I will attempt to present my story, a story about the Mental Health Survival Kit.

In order to facilitate the Rhizomatic validity, I intend to utilize a reflexive journaling process. In doing so, I will use a journal to track decisions made through the research process. The journal may enable the reader to see why I made each decision and will create a research road map for the reader. I will also utilize direct quotes and descriptions of the Mental Health Survival Kit to support my interpretation.

Discussion

In this chapter, I outlined my research methodology, discourse analysis. I began with an overview of the way language may operate to create space for social hierarchies to legitimize their position via *Semiotic Soup – a Word about Words*. In doing so, I outlined that discourse analysis may uncover the myths in a text. I then described the way I utilized discourse analysis to uncover empirical and theoretical threads. Next, I discussed why I used discourse analysis rather than other available methodologies. Afterward, I discussed my position in relation to my research to understand some of the ways the discourses that produce me influence my research. Finally, I discuss the way my research may be validated. This chapter functions to create a methodological roadmap for the reader; it explicitly outlines my research methodology.

Chapter Six – Empirical and Theoretical Threads

Introduction

In this chapter, I discuss the findings that were produced through my discourse analysis of the Mental Health Survival Kit. Yet, prior to moving forward, it is important to provide some discussion about findings produced by a discourse analysis informed by post-structural theories. For a discourse analysis informed by post-structural theories, theoretical threads are as much a product of discourse as are any other findings. As a result, findings refer to both explicit text and implicit theoretical threads. Theoretical threads refer to the linkages between empirical evidence (i.e., explicit text) and post-structural theories (i.e., governmentality and performativity). Therefore, this chapter is presented explicitly as a productive discussion of findings following a discourse analysis of Mental Health Survival Kit. Furthermore, in keeping with post-structural theories, there are no well packaged complete knowledges. Thus, I have made no attempt to conclusively answer each question. Instead, there are expansive postulations about ways to think about each question: there are many alternate ways to think about each question. In this chapter, I present four discourses resulting from my analysis: neoliberal discourses, biomedical discourses, discourses of normalcy, and discourses about caring. In the next chapter, I provide a discussion about possible ways the findings interrelate to provide a post-structural informed theoretical web that draws upon empirical evidence found within the Mental Health Survival Kit. In doing so, I posit ways one may come to understand the overarching research questions.

What Explicit Social Contexts are Found Within the Mental Health Survival Kit?

In the Mental Health Survival Kit, there are several recurring social contexts that interlock with one another. These social contexts are: mental illness, hospital, home/residence, crisis, reality, and treatment/recovery. For clarification, home/residence is referred to as such because it is discussed in both ways depending on its location within the Mental Health Survival Kit. As such, home/residence has different connotations; yet, it is explicitly linked because both terms reference the same physical structure. However, the two terms are applied in different ways. Home is referred to as a place of security and comfort while residence is referred to as a place to go upon discharge from hospital. Similarly, treatment/recovery are explicitly integrated through reference to a continuous interlocking process (i.e., treatment is part of recovery; recovery is part of treatment); both processes are ongoing. Mental illness is referred to within the Mental Health Survival Kit in several different ways. In one way, mental illness is referred to as a way to contextualize the other social contexts. Without reference to mental illness, in a general sense, the other abovementioned social contexts would have no meaning within the text. Reality is referred to as a cohesive collectively understood way to relate to the social environment. Crisis is referred to as a time of imminent instability.

In order to situate the use of the interlocking social contexts of mental illness, hospital and home/residence, crisis, reality, and treatment/recovery, one can envision a delicate dance between two sites of performance, the hospital and the home/residence. Within and across the hospital and home/residence, the other social contexts come into play. It is in transition, from one site of performance to another, that the dance is most

visible. As seen in the quote below, the hospital is explicitly linked to the home/residence.

> Not all people will have a home to return to once they are discharged from the hospital. Appropriate residential planning can help give people with mental illness the basic support they need to remain in the community and to avoid a relapse and the possibility of a re-admission to hospital (Mental Health Survival Kit).

In order to understand the transition between the hospital and the home/residence, one must draw upon neoliberalism, as a mode of governmentality that, in part, through a movement toward community care, transformed the hospital from a site of long-term exclusion to a site of short-term transition (Curtis, Gesler, Priebe, & Francis, 2008). Toward that end, I have found that neoliberal discourses permeate mental health praxis, thus, shaping and constituting possible subject positions. The next sections unveil neoliberal discourse within my findings to illustrate these relations.

Neoliberal mental health policies attempt to claim that there is no place in society for people who are unsuccessful (in a neoliberal state); hence, any dependence upon welfare is not to be tolerated (MacEachern, 2000; Ramon, 2008;). Under neoliberal ideology, long-term institutions are faux pas, persons with a mental dis-order are not to be idle; people who are idle are not economically productive. Hence, “when you are in hospital there is an eagerness to get out” (Mental Health Survival Kit). Furthermore, persons with a mental dis-order who are in a long-term institution are not self reliant and a burden to the welfare system. Hence, neoliberal mental health policies and practices (i.e., de-institutionalization and community care) opened the inpatient unit in order to

create a permeable space for acute short-term admission instead of institutionalization (Curtis Gesler, Priebe, & Francis, 2008). By reducing the length of admission, public resources may be freed from burden. As a result, the focus shifted from long-term admissions to acute short-term admissions.

During the acute phase, persons with a mental dis-order are supposedly at heightened risk to society and themselves; hence, the person must be confined. The Mental Health Survival Kit explains involuntary admission as follows:

> If you are admitted involuntarily to the hospital for care and treatment it is because two doctors have separately examined you and it is their opinion that: You are suffering from a mental disorder that seriously impairs your ability to react appropriately to your environment or to associate with others. You require treatment from this hospital so that you do not become more ill. You should be in hospital to prevent your substantial mental or physical deterioration or to protect yourself or other people. You probably would not seek help on your own. You may be admitted for just a few days or for up to one month, depending upon how well you respond to treatment. However, the law requires the doctor to automatically review your situation at the end of one (Mental Health Survival Kit)

However, as soon as the person is admitted, the person is thrust into the process discharge planning.

> Appropriate residential planning can help give people with mental illness the basic support they need to remain in the community and to avoid a relapse and the possibility of a re-admission to hospital. It is important that

> arrangements for your housing are made before you leave [hospital].
>
> (Mental Health Survival Kit)

In that way, an acute admission is a space of transition. Supposedly, the acute admission is storied as a place of refuge, a place to escape evildoers; it is represented as a 'fortress' (Curtis, Gesler, Priebe, & Francis, 2008). The Mental Health Survival Kit stipulates that "you may feel a sense of uneasiness about going home." As if to indicate that the hospital is a safe harbour. In doing so, the hospital is situated as a neutral place for persons with a mental dis-order who, through biomedical discourses, are paternalistically positioned as vulnerable, incapable, and dependent. At the same time, neoliberal discourses position community mental health consumers as potentially productive citizens. In this way, the two subject positions contest one another. Hitherto, neoliberal and biomedical discourses also support one another by continually encouraging consumer independence through biomedical advances. The hospital, a panoptic, provides a place for mental health professionals to discipline mental dis-order through surveillance, regulation, and control that extends through modes of governmentality (i.e., technologies of the self) (Simonsen, 1996). As such, "before leaving hospital, you and your family/support-ers should have good basic education about symptom recognition" (Mental Health Survival Kit). In this way, biomedical discourses operate through medical practices (i.e., symptom recognition). The biomedical discourses convey a script for psychiatric inpatient performances. The script locates the problem within the individual not within relational systems. Toward that end, the Mental Health Survival Kit indicates that "NO ONE IS TO BLAME. Never blame yourself. It can destroy your chances of coping. Mental illness is a

disorder of the brain/mind." As a result, the biomedical script continues to produce and reproduce problematic social relations.

While the biomedical discourses are performed, the person with a mental dis-order is transitioned into a home/residence. Within the community, the person with a mental dis-order is storied, through neoliberal discourses, as self-reliant, morally responsible, and able to contribute to economic production (i.e., a neoliberal subject position). As such, the Mental Health Survival Kit states, "there is abundant evidence of persons with mental illnesses returning to fulfilling lives." Furthermore, "today mental illness can be managed very successfully and people experience a full and meaningful life" (Mental Health Survival Kit). Drawing upon economic metaphors, neoliberal discourses position mental illness as a process to be 'managed.' "They have jobs, relationships, family, and hobbies and are active members of their communities" (The Mental Health Survival Kit). In this way, neoliberal discourses, in tandem with discourses of normalcy, position productivity as a necessary feature of a normal life. Now the person with a mental dis-order is supposedly no longer dependent upon the state; the person is now like everyone else. Yet, the person with a mental dis-order may not be easily assimilated into neoliberal social relations. As a result, the person may relapse (i.e., the assimilation did not hold). In doing so, a crisis may occur; yet, "following a crisis, family and other supporters can play an important role in helping you as you may be overwhelmed with dealing with feelings and thoughts" (Mental Health Survival Kit).

The relapse is identified through modes of governmentality. Governmentality may be understood as the ways governments attempt to produce citizens who best fulfill those

governments' policies (Bennet, 2003). Under modes of governmentality, technologies of the self are produced through and by neoliberal discourses (Foucault, 1988). Technologies of the self are the tools that people use to constitute themselves (Foucault, 1988). Through technologies of the self,

> individuals [may] effect by their own means or with the help of others a certain number of operations on their own bodies…and way of being, so as to transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988, p 18).

Once identified by themselves or family members through technologies of the self, the person is readmitted to the hospital for re-programming via biomedical and neoliberal discourses. At that point, the person is once again transitioned to a home/residence. In the community, the person is once again subject to modes of surveillance. Moral responsibility and self reliance, produced in relation to the psychiatric patient, is disciplined and regulated through community care based neoliberal discourses enacted through technologies of the self.

Through shifting the focal point of inpatient psychiatry to short term acute admission and enacting modes of governmentality, neoliberal and biomedical discourses, through a movement toward community care, opened a space between the hospital and the home/residence; a space of transition. The transitional space is neither here nor there. It is an abyss, a marginalized space that is no place. Yet, it is some space. Upon drawing back to the first question: what social contexts are found within the Mental Health Survival Kit? The interlocking social contexts of mental illness, hospital and home/residence, life, crisis, reality, and treatment/recovery interact in a way that is

unstable, contradictory, and under constant change. In perpetual flux, the transitional dance continues to produce and reproduce itself within social contexts produced and reinforced by discursive products like the Mental Health Survival Kit.

How do the Authors Legitimize the Mental Health Survival Kit?

In exploring the way the authors legitimize the Mental Health Survival Kit, it would be important to first situate the authors. In this instance, Interior Health Authority and the Canadian Mental Health Association Kelowna Branch collaborated to create the Mental Health Survival Kit. According to the Mental Health Survival Kit website, the Mental Health Survival Kit is:

> …designed to help you navigate the mental health system. It was created by the Consumer Development Project of the Canadian Mental Health Association with the guidance of people who have experienced mental illness, family members and service providers in the Okanagan region. Funding for this Kit was provided by the Interior Health Authority for its development. We believe this Kit will provide you with the basic information you and your loved ones will need to effectively deal with mental illness and focus on your recovery. There is a wealth of information available regarding specific issues and illnesses in addition to this Kit. We have included links to website that we believe will help you get started… (Mental Health Survival Kit Website)

In the aforementioned quote, the authors of the Mental Health Survival Kit clearly stipulate the purpose of the Mental Health Survival Kit. However, the authors do not

specify who, as part of CMHA and Interior Health Authority, took part in its development. As a result, it is somewhat difficult to fully and explicitly examine the position of individual authors or the extent of involvement of various interest groups. But, it is important to note that CMHA is a consumer based mental health organization. Through consumer advocacy movements, people with mental illness may be positioned as a neoliberal subject. Furthermore, Interior Health Authority is a government organization that is premised upon neoliberal discourse. Since the authors have explicitly stated the purpose of the Mental Health Survival Kit, one can situate the ways the authors legitimize the Mental Health Survival Kit's purpose. In doing so, one can begin to understand how the authors legitimize the Mental Health Survival Kit as a tool to navigate the mental health system.

Through a complex process, the authors use affiliation and disaffiliation in order to include hegemonic knowledge positions and exclude alternate ways of knowing. By affiliation, it is the colonization of a material/position to support an already conceived notion (Thompson, 2003). By disaffiliation, it is the rejection of a material/position to support an already conceived notion. Furthermore, disaffiliation and affiliation work synonymously to create distance from unappealing qualities while moving closer appealing qualities. There are several ways the authors utilize affiliation and disaffiliation within the Mental Health Survival Kit, such as, through biomedical discourses, referencing like-minded sources, statistics, and studies.

First and foremost, the authors reference professional biomedical discourses as a way to legitimize the Mental Health Survival Kit. For example, the authors state that "people from whom you may find support and advice in managing your recovery may

include: your family, your friends, your doctor, your psychiatrist and a mental health worker" (The Mental Health Survival Kit). Through drawing on professional biomedical discourses, the authors attempt to affiliate with transcendent objectivity. Transcendent objectivity promises "vision from everywhere and nowhere equally and fully" (Haraway, 1988, pg. 584). Hence, transcendent objectivity is silently problematic; it veils its masters' partiality. For example, if semiotics enacts epistemological languages and epistemological languages are one's situated knowledges, to toss aside one's epistemological languages is to toss aside one's selves or identities; it is nonsensical. As such, Haraway (1988, pg. 577) argues for a "partial, locatable, critical knowledges sustaining the possibility of webs of connections called solidarity in politics and shared conversations in epistemology." Following her logic, one must seek to situate the authors of the Mental Health Survival Kit; yet, without explicit disclosure, one can only partially situate an-other's utilization of epistemological discourses.

While the authors affiliate with professional biomedical discourses, the authors also attempt to affiliate through referencing like-minded sources, statistics, and studies. Through referencing like-minded sources, there is an imparted sense of cohesive, stable, secure, and uncontested mental health knowledge. For example, the authors cite several other sources that convey a similar message. As such, one can obtain "more information on mental illnesses and their symptoms log on to www.cmha.ca/english/info_centre" or "see www.mhr.gov.bc.ca for more information" or see the "fact sheets on mental health and addictions issues – BC Partners for Mental Health and Addiction Information" (Mental Health Survival Kit). At the same time, the authors utilize statistics, unsupported by specific citations, to impart a sense of normalcy on the experience of mental illness.

For example, the authors state that “one in five Canadians has or will develop a mental illness” or that “schizophrenia…affects one out of every 100 people” or “about 3 out of every 100 people experience a psychotic episode in their lifetime. It occurs equally in males and females and across all cultures and levels of socio-economic status” (Mental Health Survival Kit). Furthermore, the authors indicate that “studies estimate that up to 50% of people who use mental health services also report having alcohol and drug problems” and that “research has shown that people who experience mental illness have fewer relapses when their family or other support system is involved in their care and treatment” (The Mental Health Survival Kit). By affiliating with other like minded sources, statistics and studies, the authors are able to legitimize their use of professional biomedical discourses. Yet, as Thompson (2003) contends, “the purpose of such attributions is not to listen but to speak with augmented authority” (p. 12). In staking augmented authority, the authors do not expose their cultural, class, racial, historical, and social affiliations. Instead, through augmented authority, authors lay claim to a politically neutral text.

While the authors attempt to affiliate with several hegemonic sources, the authors disaffiliate from other problematic social relations (Wiegman, 1999). The Mental Health Survival Kit produces and is produced by a politized story that situates some experiences as normal and some experiences as abnormal; thus, the authors draw upon discourses of normalcy. In doing so, the authors state that “some people shy away from people with mental disorders, but in some cases it is not the person with mental illness we fear but our lack of knowledge about the illness” (Mental Health Survival Kit). Through the aforementioned statement, the authors disaffiliate from people who do not share

professional biomedical discourses. Furthermore, according to the Mental Health Survival Kit, people with mental illness are to "surround [themselves] with supportive people" (Mental Health Survival Kit). The authors allude to supportive people and sources as "found through self-help groups, family support, social support, adult education, meaningful employment, adequate housing and self-care" (Mental Health Survival Kit). In a sense, the authors situate professional knowledges as a natural reflection of reality; in doing so, the Mental Health Survival Kit excludes and alternative forms of knowledges.

Finally, the authors attempt to disaffiliate from a category specified as developmental disabilities. The authors stipulate that…

> Mental illness is not the same as being mentally handicapped or challenged, or what is now known as a developmental disability. People who are developmentally challenged as a result of a genetic disorder such as Down's syndrome are born with developmental delays that can affect a person's intellectual development and functioning. In contrast, mental illness affects a person's thinking, feeling and behaviour. It cuts across age, gender, economic, ethnic and political boundaries. Mental illness is treatable where most people recover to lead meaningful and productive lives. We know one in five British Columbians have or will develop a mental illness at some point in their lives (Mental Health Survival Kit)

Through disaffiliating with developmental disabilities, the authors attempt to situate professional mental health biomedical discourses as a distinct form of knowing not to be confused with developmental disabilities. At the same time, there is effort made to

affiliate mental illness with the general population. Hence, the authors attempt to indicate that developmental disabilities are largely a localized phenomenon while mental illness can affect anyone. As a result, mental illness is legitimized through situating mental illness in relation to a grander meta-narrative.

In the end, through a complex process, the authors affiliate and disaffiliate in order to include hegemonic professional biomedical discourses and exclude alternate ways of knowing. Thus, the authors affiliate and disaffiliate within the Mental Health Survival Kit through professional knowledges, referencing like-minded sources, statistics, and studies.

How are Contradictions/Tensions Produced Within the Mental Health Survival Kit?

Through revealing the ways psychiatric discourse interplays with neoliberal discourses, biomedical discourses, discourses of normalcy, and discourses about caring to produce contradictions and tensions within the Mental Health Survival Kit, one can understand ways subject positions are produced within the Mental Health Survival Kit. In doing so, one can see that discourses within the Mental Health Survival Kit did not evolve in transcendence; it is not a priori. Toward that end, there are several binary oppositions within the Mental Health Survival Kit that are unstable, contradictory, and under constant tension. While there are others, key binary oppositions that produce subject positions within the Mental Health Survival Kit are mental illness/mental health, idle/productive, objective/subjective, and rational/irrational. Through the aforementioned

contradictions/tensions, the Mental Health Survival Kit is revealed as producing subject positions.

Within the Mental Health Survival Kit, some people are positioned as mentally ill while other people are positioned as mentally healthy. And so, the Mental Health Survival Kit draws upon discourses of normalcy: discourses that assume a 'norm', a 'normal' human subject. For example, the Mental Health Survival Kit makes reference to "mental illness [as] one part of your life" and the "mental health professional or community mental health organizations" (Mental Health Survival Kit). In doing so, professionals are positioned as mentally healthy while the reader is mentally ill. Through positioning someone as mentally ill and professionals as mentally healthy, the Mental Health Survival Kit speaks to a power imbalance within discourses of normalcy.

In this instance, bio-power produces the power imbalance, within discourses of normalcy, through designating who is mentally ill and who is mentally healthy. As one may recall from an earlier chapter, bio-power is the "subjugation of bodies and the control of populations" (Foucault, 1990, p. 140). According to Rabinow and Rose (2006), there are three elements essential to bio-power. Firstly, bio-power contains one or more truth discourses about the 'vital' character of humans (Rabinow & Rose, 2006). The Mental Health Survival Kit indicates that "[mental illness] can affect anyone, regardless of age, ethnic background, income or gender" and "one in five Canadians has or will develop a mental illness" (Mental Health Survival Kit). By stating that mental illness can affect anyone, mental illness is positioned as a truth about the vitality of humans. At the same time, bio-power emphasizes strategies for intervention that rest upon a collective existence of life (Rabinow & Rose, 2006). As such, mental illness occupies a powerful

position within other meta-narratives like normalcy and neoliberalism, which focus upon productive, 'healthy' populations. Thirdly, there are modes through which subject positions are brought to work on themselves (Rabinow & Rose, 2006). Toward that end, bio-power acts through technologies of the self to allow people with mental illness to attempt to 'recover' or rebuild themselves as mentally healthy. Thus, the Mental Health Survival Kit claims that "many individuals with mental illness must also rebuild a sense of self-worth and recover from the side effects of unemployment, long periods in treatment settings and the stigma and discrimination attached to mental disorders" (The Mental Health Survival Kit). Yet, recovery is never complete. Mental illness is situated as "part of your life, you can still have other interests and participate in many activities" (Mental Health Survival Kit). In addition to bio-power and technologies of the self, neoliberal discourse acts within the Mental Health Survival Kit to create tension between idleness and productivity.

Through rollout neoliberal discourses, persons with mental illness are not to be idle; persons with mental illness must be productive citizens. In fact, the Mental Health Survival Kit claims that "most people with mental illness are productive members of society" (Mental Health Survival Kit). "They have jobs, relationships, family, and hobbies and are active members of their communities" (Mental Health Survival Kit). Under 'roll out' neoliberalism, governments developed previously idle persons signified with mental disorder into contributing members of society.

> Many individuals with mental illness must also rebuild a sense of self-worth and recover from the side effects of unemployment, long periods in treatment settings and the stigma and discrimination attached to mental

> disorders. Reclaiming these aspects of life are sometimes more difficult than recovering from illness itself. Crushed dreams may take a long time to mend especially if they are young and have had few opportunities to direct their life (Mental Health Survival Kit).

While storied as reclaiming their life, the story also serves to free government resources for further economic development and create new sources of production. The Mental Health Survival Kit goes on to claim that "some of the most exceptional and influential people in the world have publicly disclosed that they have a mental illness" (Mental Health Survival Kit). As one can see, the contradictions and tensions within the Mental Health Survival Kit are, in part, produced through rollout neoliberal discourses.

Through panoptic power and discourses of normalcy, the Mental Health Survival Kit positions some people as objective and rational while others as subjective and irrational. In doing so, panoptic power functions to produce subject positions and simultaneously control them. Subject positions that deviate are disciplined and punished. In essence, the Mental Health Survival Kit attempts to make natural that professionals are objective and people with mental illness are subjective. As such, the Mental Health Survival Kit suggests that people with mental illness should "try to keep a record of everything… don't rely on your memory – nothing is unimportant! Make copies of everything you mail" (Mental Health Survival Kit). Furthermore, it is advised that people with mental illness should "stick to the facts. Be concise and don't make conclusions. Try to describe what you observe objectively" (Mental Health Survival Kit). People with mental illness are also asked to "be on time for appointments. Be polite. Keep all conversations to the point. Ask for specific information" (Mental Health Survival Kit). In

contrast, persons with mental illness are supposed to identify professionals by their "ability to listen without judgment" (Mental Health Survival Kit). Who can listen without judgment?

While panoptic power produces subject positions (e.g., the mentally ill patient) and attempts to control, panoptic power also attempts to create an environment of observation and correction. Within this environment, the professional may see all. "As part of the therapeutic team in the hospital, [the nurse] ensures… that your progress in monitored and recorded" (Mental Health Survival Kit). Yet not all attempts to exert control are through overt forms of discipline or punishment. There is a continued effort to impart a sense of self regulation amongst those constituted as mentally ill. Toward that end, the Mental Health Survival Kit stipulates that "before leaving hospital, you and your family/supporters should have good basic education about symptom recognition" (Mental Health Survival Kit).

In another way, psychiatry utilizes the Mental Health Act for the purposes of control not only within the psychiatric inpatient unit but in the community. Under the Mental Health Act, a person constituted as mentally ill may be put on extended certification. Under extended certification, the individual is under continual observation or perceived observation in the community. If the person's behaviour deviates, the person may be brought back to directly hospital under the power of the Mental Health Act. As a result, extended certification functions to create a continual observation whether someone is watching or not. The Mental Health Survival Kit draws upon the Mental Health Act to enact an overt form of control. For example the Mental Health Survival Kit states:

> If you are admitted involuntarily to the hospital for care and treatment it is because two doctors have separately examined you and it is their opinion that: You are suffering from a mental disorder that seriously impairs your ability to react appropriately to your environment or to associate with others; You require treatment from this hospital so that you do not become more ill; You should be in hospital to prevent your substantial mental or physical deterioration or to protect yourself or other people; You probably would not seek help on your own. You may be admitted for just a few days or for up to one month, depending upon how well you respond to treatment. However, the law requires the doctor to automatically review your situation at the end of one month.

Through bio-power, panoptic power and technologies of the self manifest in neoliberal discourses, contradictions and tensions are produced within the Mental Health Survival Kit. Through tensions between binary oppositions (i.e., objective/subjective), psychiatric discourse, within the Mental Health Survival Kit, produces some subject positions while constraining others.

What Subject Positions are Found Within the Mental Health Survival Kit?

Prior to discussing subject positions within the Mental Health Survival Kit, it would seem appropriate to re-identify what is meant by subject position. As discussed in an earlier chapter, a subject is "constituted not constituent, an effect of structures rather than their cause" (Grosz, 1992, p. 411). A subject position is a space produced through discourse that people may occupy. Both the production of a subject and subject position

is tied to a mode of knowledge; whereby, power may be understood as a medium for the production of subjects and subject positions (Roberts, 2005). It is an understanding of an anti-humanist subject that informs this research. Drawing on the aforementioned definition, there are several subject positions produced within the Mental Health Survival Kit. They are: mental health professionals, person with mental illness, family and friends, and implicit subject positions.

By drawing on biomedical discourses, the Mental Health Survival Kit contains several subject positions within the position of mental health professional. These positions are: advocate, alcohol and drug counsellor, case manager or mental health worker, medical doctor, psychiatrist, nurse, occupational therapist, pharmacist, psychologist, social worker, therapist or counsellor, and support groups. The Mental Health Survival Kit readily identifies the aforementioned subject positions within the pamphlet titled Roles of Mental Health Professionals. Furthermore, it provides ways to identify each mental health professional.

An advocate "speaks or acts on behalf of an individual to ensure concerns they may have about the service they are receiving are addressed. In some communities, paid, formal advocate positions have been created. Each community has access to a Patient Representative who will help deal with concerns about the health care you or a family member receives" (Mental Health Survival Kit). An Alcohol and drug counsellor "has knowledge of symptoms and effects of alcohol and drug use, therapeutic approaches and counselling to support your recovery. May refer you to various services of the addictions' system of care - such as a residential treatment facility" (Mental Health Survival Kit). A case manager or mental health worker is "a general title for the professional from the

mental health system designated to help coordinate your recovery. Will help you access treatment, counselling, housing, social, vocational, and income supports. May have a background as a social worker or nurse" (Mental Health Survival Kit). A medical doctor "ensures you receive thorough physical and mental/ cognitive assessments and ongoing medical management. May refer you for specialist consultations and treatment when necessary. Assists you in addressing preventative health needs. The GP acts as the gatekeeper to accessing specialized care and treatment. They are central to managing your total health picture" (Mental Health Survival Kit). A psychiatrist is "a medical doctor who specializes in mental health and mental illness. This includes diagnosis and prescribing and monitoring medications. As a member of your team, he or she is also involved in your treatment and care plan. Some psychiatrists will do therapeutic counselling" (Mental Health Survival Kit). A nurse "ensures treatment and/or medication prescribed by your Psychiatrist and/or Medical Doctor is administered and that your progress in monitored and recorded. Will help to provide support when needed" (Mental Health Survival Kit). An occupational therapist…

> …has knowledge of activity analysis and promotion of self-care, productivity (work, school, volunteering) and leisure. Assists you in the enhancement of community living skills, including employment skills, social skills and appropriate behaviour. Works with individuals to enable them to pursue occupations and activities that they want or need to do. May include teaching skills, providing education and finding resources to do this (Mental Health Survival Kit).

A pharmacist “has knowledge of the outcomes and side effects of medications, their interactions and reactions, and what substances and foods to avoid with the medication you are taking. The Pharmacy can provide a great deal of written information to the public” (Mental Health Survival Kit). A psychologist…

> …has knowledge of developmental processes; mental health problems, disorders and needs; assessment, testing and test interpretation; therapeutic and behavioral management approaches to treatment; and provision of therapy, counselling and consultation. Will work with you to develop skills and strategies to manage thoughts, emotions and behaviours that impact on your mental health. Can be involved in helping you learn about yourself to aid your recovery (Mental Health Survival Kit).

A social worker…

> …has knowledge of family and social history; family functioning and specific areas of social work. (e.g., addictions, adoption, abuse, community living services, mental health). In a hospital, a social worker may coordinate the discharge planning process. Once you leave the hospital other community social workers may coordinate your recovery support to ensure you get the resources you need. May help you find solutions to problems you encounter in daily living (Mental Health Survival Kit).

A therapist or counsellor “has knowledge of counselling approaches, provides advice and counselling on behavioural management, development of skills and strategies to manage the thoughts, emotions and behaviours that impact on your mental health. Can become

involved in helping you learn about yourself to aid your recovery" (Mental Health Survival Kit). Finally, support groups are referred to as "group of people who have had some of the same experiences and may have helpful ideas on how to cope with your illness" (Mental Health Survival Kit).

Similarly to the subject position mental health professionals, there are several positions within the subject position people with mental illness, which are: person with depression, person with bi-polar disorder, person with an anxiety disorder, person with a personality disorder, person with an eating disorder, person with psychosis, person with schizophrenia, person with schizoaffective disorder, person who is voluntarily admitted, person who is involuntarily admitted, person with a disability, and person with a concurrent disorder. The aforesaid positions are identified within the pamphlet titled Major Mental Illnesses. The positions may be described as follows through text found in the Mental Health Survival Kit.

A person with depression "refers to severe and prolonged feelings of discouragement, frustration and even a sense of despair. Multiple causes such as specific, distressing life events, a biochemical imbalance in the brain or persistent psychological factors such as a negative or pessimistic view of life" (Mental Health Survival Kit). A person with bi-polar disorder "refers to the "two poles" of the continuum of mood with alternating periods or cycles of mania (highs) and depression (lows) as described previously" (Mental Health Survival Kit). A person with an anxiety disorder is a "disorder which affects behaviour, thoughts, emotions and physical health. Caused by biological and situational circumstances. Heightened and continuing response to a

perceived threat" (Mental Health Survival Kit). A person with a personality disorder may experience a…

> …Loss of energy and excessive fatigue. Physical aches and pains. Diminished ability to think and concentrate. Feeling bored and not interested in many aspects of your life. Imagining you have an illness such as cancer when there are no physical indications. Feelings of worthlessness, hopelessness, Possibility of suicidal thoughts, Changes in personal grooming, Isolation and withdrawal, Inability to experience joy or pleasure (Mental Health Survival Kit).

A person with an eating disorder may experience "distorted body images that make it difficult for people to nourish themselves in a healthy way. Most common in women and men under age 30" (Mental Health Survival Kit). A person with psychosis may experience "disorganized or confused thinking. Reduced concentration, attention, Reduced drive and motivation, lack of energy, Sleep disturbance, Anxiety, Social withdrawal, Behavioural changes, irritability, Hallucinations or delusions, Disorganized speech" (Mental Health Survival Kit). A person with schizophrenia may experience…

> …Hearing voices, hallucinations, may affect any/all the senses. Confused thinking, feeling ambivalent because you can't make a decision. Paranoia and other delusional thinking. Disjointed thoughts. Overwhelming thought – thoughts snowball, build until your senses are over stimulated. Thought withdrawal – your mind goes blank. Thinking that you can control someone else's thoughts or that someone is controlling your thoughts. Righteousness. Lack of motivation. Social withdrawal. Feeling that

> objects or events are meant as personal signs or omens. Religious preoccupation (Mental Health Survival Kit).

A person with schizoaffective disorder may experience "both a mood disorder and a psychotic disorder within the same period of illness. This does not mean you have two disorders but a combination of symptoms" (Mental Health Survival Kit). A person who is involuntarily admitted is…

> When you are involuntarily admitted or "committed" to a hospital for your mental illness, you come under the Mental Health Act of British Columbia. This means that you do not have a choice about staying in hospital. Under the Mental Health Act, the staff will see that you receive medication or treatment for your disorder even if you are against taking it. The Mental Health Act is intended to help people with mental disorders to obtain treatment and care that medical doctors believe is needed when a person does not recognize they are ill. The Act also is intended to provide safeguards for the rights of people who are involuntarily admitted to a psychiatric facility (Mental Health Survival Kit).

A person who is voluntarily admitted is someone who is not involuntarily admitted (Mental Health Survival Kit). A person with a disability is "developmentally challenged as a result of a genetic disorder such as Down's syndrome are born with developmental delays that can affect a person's intellectual development and functioning" (Mental Health Survival Kit). A person with a concurrent disorder refers to "people who experience a mental illness and use alcohol, cannabis, or other substances excessively" (Mental Health Survival Kit).

The abovementioned positions (i.e., mental health professionals and people with mental illness) are, in part, products of a modern refinement of categorization within psychiatric discourse that is evident in other psychiatric products (i.e., Diagnostic and Statistical Manuel of Mental Disorders) (Coyte & Holmes, 2006). Through greater categorization, there has been an explosion of health disciplines to produce knowledge to understand and treat the new categories of people with mental illness. As such, there is an interlocking feature between the positions of mental health professionals and people with mental illness produced by biomedical discourses. Furthermore, the interlock between the subject positions of mental health professional and person with a mental illness facilitate the ways family and friends are situated within the Mental Health Survival Kit. Within the Mental Health Survival Kit, the family and friends are referred to as follows.

Family and friends are referred to as people who may "support your recovery" and experience "your illness with you, only from a different perspective" (Mental Health Survival Kit). At the same time, family and friends may "play an important role in helping you as you may be overwhelmed with dealing with feelings and thoughts" (Mental Health Survival Kit). It is suggested that "research has shown that people who experience mental illness have fewer relapses when their family or other support system is involved in their care and treatment…if friends and family are knowledgeable and informed, they are in a better position to support you" (Mental Health Survival Kit). The Mental Health Survival Kit provides a detailed account of ways family and friends can relate to a mental health professional as well as their family member with a mental illness. Toward that end, the authors provide questions family members may have as well as answers. In doing so, the Mental Health Survival Kit provides a discursive framework

for people with mental illness and family members to relate to mental health professionals.

At the same time, there are four implicit subject positions that are produced within the Mental Health Survival Kit. These are the patient, the docile body, the loved one and the neoliberal subject position. The patient is produced in the Mental Health Survival Kit through a subtle process. As the text begins to speak about admission to hospital, it begins to refer to people with mental illness as patients. For example, "…in 2001 [rights were drafted] as a way of describing what people can and should expect…this is not law but intended to help service providers, patients, and family members to achieve the best of our mental health system" (Mental Health Survival Kit). The linguistic transition is subtle; it shifts from explaining a person's rights to the way rights are intended to help patients. In doing so, biomedical discourses are drawn upon to distinguish who is a person and who is a patient. Patients are to be helped and people need to understand how to help. As an object to be helped, biomedical discourses also produce discourses about the docile body. The docile body refers to the way the body is produced as an object to be acted upon.

The docile body is well illustrated through the involuntary admission process. Involuntary admission infers that "you do not have a choice about staying in hospital" (Mental Health Survival Kit). Through drawing on biomedical discourses, the Mental Health Survival Kit legitimizes the necessity of an involuntary admission.

> For example, "you are involuntarily admitted to hospital [if]…you are suffering from a mental disorder that seriously impairs your ability to react appropriately to your environment or to associate with others…[if] you

> require treatment from this hospital so that you do not become more ill…[if] you should be in hospital to prevent your substantial mental or physical deterioration or to protect yourself or other people…[and if] you probably would not seek help on your own. In doing so, the patient is also produced as a docile body.

In this way, the Mental Health Survival Kit draws upon biomedical discourses to legitimize the production of a patient who is also a docile body that needs to be helped.

While the patient is produced as a docile body, the patient is also produced as a loved one. Drawing on discourses of caring, a patient is referred to as a loved one. Toward that end, there is a pamphlet titled, *What is Happening to my Loved One?* Throughout the pamphlet, people with mental illness are referred to as loved ones. And so, discourses about caring are drawn on to position people with mental illness as loved ones. At the same time, family and friends are positioned as the ones who are caring. Yet, patients aren't called 'loving ones'; they are called loved ones. It is as if to say that "you are loved by your family and friends, but you're a docile body not capable of loving." In this way, discourses about the patient, docile body, and loved ones interlock to create implicit subject positions.

As my thesis focuses upon neoliberalism, it is important to note that the neoliberal subject position is present throughout the Mental Health Survival Kit. In one way, the Mental Health Survival Kit is, in part, the neoliberal subject position. It is given, by CHMA (i.e., consumer advocates) to people with mental illness and others to produce further consumer advocates (i.e., people who can effectively navigate an organization

based on neoliberal discourse). In this way, the Mental Health Survival Kit itself is produced by neoliberal discourses and produces a neoliberal subject position.

What is Absent in the Text?

Since the Mental Health Survival Kit speaks not only what is written but what is not, it is important to uncover some of the unspoken themes within the Mental Health Survival Kit. Within the Mental Health Survival Kit, there are several absent or unspoken themes: politicized relations (i.e., neoliberal discourses), privilege of the mental health professional, and alternate forms of knowledge.

Within the Mental Health Survival Kit, there are numerous examples of text that are consistent with neoliberal discourse. It appears that there is consistent importance placed upon unburdening the health care system, emphasizing personal choice, individual responsibility, and productivity. Toward that end, the authors state that "when you are in hospital there is an eagerness to get out, but you may also feel anxiety around this decision. You may feel a sense of uneasiness about going home" (Mental Health Survival Kit). In this instance, neoliberal discourse is drawn upon to suggest that people with mental illness are eager to unburden the mental health system by returning home. In another section, it is proposed that people with mental illness find a counsellor who "encourages personal choices" (Mental Health Survival Kit). In doing so, the 'right' counsellor is purported as someone who shifts responsibility onto the individual. Not only are the 'right' professionals ones who shift responsibility onto the individual, but neoliberal discourse situates the person with mental illness as responsible for their recovery. Therefore, it is posited that during recovery, "you become the person most

responsible for managing your recovery" (Mental Health Survival Kit). Thus, the person with mental illness is situated as individually responsible for their actions. Yet, in some ways neoliberal discourse is drawn upon to rationalize the worthiness of people with mental illness. Hence, it is suggested that…

> Most people with mental illness are productive members of society. They have jobs, relationships, family, and hobbies and are active members of their communities. Some of the most exceptional and influential people in the world have publicly disclosed that they have a mental illness (Mental Health Survival Kit).

At the same time, neoliberal discourse is drawn upon to emphasize the correction of anti-market behaviours. As a result, people with mental illness "must also rebuild a sense of self-worth and recover from the side effects of unemployment" (Mental Health Survival Kit). As one can see, neoliberal discourse is both drawn upon to support the worthiness of some people with mental illness (i.e., productive people) and support the unworthiness of other people with mental illness (i.e., unproductive people). Consumer advocates, constituted by and through neoliberal discourses, are also positioned as worthy people with mental illness.

While neoliberal discourses are one unspoken theme within the Mental Health Survival Kit, privilege of the mental health professional within the mental health professional – person with mental illness relationship is also unspoken. In the most overt way, mental health professionals have the power to involuntarily admit someone.

> When you are involuntarily admitted or "committed" to a hospital for your mental illness, you come under the Mental Health Act of British

> Columbia. This means that you do not have a choice about staying in hospital. Under the Mental Health Act, the staff will see that you receive medication or treatment for your disorder even if you are against taking it. The Mental Health Act is intended to help people with mental disorders to obtain treatment and care that medical doctors believe is needed when a person does not recognize they are ill (Mental Health Survival Kit).

As one can see, someone who is involuntarily admitted has very little control; in this way, a docile body is produced. Yet, in many ways, neoliberal discourse interacts with discourses about professional privilege. In this way, neoliberal discourse emphasizes personal choice and responsibility are drawn upon to produce a specific type of privilege within the mental health professional – person with mental illness relationship. For example, it is suggested that "if you choose to be admitted to the hospital for your mental illness, it means that you are fully aware of your situation and voluntarily enter treatment in the hospital" (Mental Health Survival Kit). Toward that end, it is suggested that "having a plan can be helpful in dealing with issues you can control" (Mental Health Survival Kit). It is also proposed that "being in control may reduce the stress you can feel when you have to deal with too many things at once" (Mental Health Survival Kit). However, people with mental illness should "focus on what you can control" (Mental Health Survival Kit). It is also suggested that people with mental illness not "let things beyond your control cause you undue stress and anxiety" (Mental Health Survival Kit). Through the aforesaid ways, neoliberal discourse is drawn upon to produce a form of privilege that focuses upon individual responsibility and personal choice in order to shift emphasis away from the mental health system onto the individual.

At the same time, the pamphlet, *Roles of Mental Health Professionals,* outlines the privilege of the mental health professionals by ascribing specific knowledges to each profession (i.e., pharmacist – medications, social worker – family, medical doctor – physical illness, psychiatrist – mental illness, psychologist – intellectual processes, nurse – medication administration, alcohol and drug counselor – substance abuse, occupational therapist – productivity, advocate – representation). In doing so, each mental health professional is positioned in some way as an expert; hence, the Mental Health Survival Kit provides a guide to a person with mental illness to recognize the foundation for professional privilege. In the end, through neoliberal discourse interacting with discourses of privilege, people with mental illness assume individual responsibility for their personal choices while mental health professionals claim professional privilege.

Within the Mental Health Survival Kit, there is almost no recognition of alternate forms of knowledge. In one section, there is reference made to finding a counsellor who is "willing to try alternative therapies, including those that are minimally invasive" (Mental Health Survival Kit). Yet, it is unclear what is meant by alternative therapies. It could be thought that it is reference to therapies like physiotherapy, massage therapy, psychotherapy, and other therapies. However, there is no reference to alternate forms of knowledge that challenge the way people think about mental illness/health. For example, there is no inclusion or recognition of the anti-psychiatry movement as discussed in an earlier chapter. By excluding alternate forms of knowledge, the Mental Health Survival Kit situates psychiatric discourse as an uncontested form of knowledge. As a result, psychiatric discourse is situated as the 'Truth' about mental illness/health.

As one can see, there are several absent or unspoken themes (i.e., politicized relations, privilege of the mental health professional, and alternate forms of knowledge), which function to speak veiled politicized, privileged discourse to readers of the Mental Health Survival Kit while excluding alternate forms of knowledge. By concealing politics, privilege, and alternate forms of knowledge, psychiatric discourse is able to further legitimize its position within broader social discourses.

Discussion

In this chapter, I discussed the theoretical and empirical threads that were produced through my discourse analysis of the Mental Health Survival Kit. I presented this chapter explicitly as a discussion of some of the theoretical and empirical threads produced by a discourse analysis of Mental Health Survival Kit. In keeping with post-structural theories, I have proposed no well packaged complete knowledges. Therefore, I made no attempt to conclusively answer each question. Instead, I provided postulations about ways to think about each question. In this chapter, I found neoliberal discourses, biomedical discourses, discourses of normalcy, and discourses about caring. The aforementioned empirical and theoretical threads will inform my discussion in the next chapter. In the next chapter, I provide a discussion about possible ways the empirical and theoretical threads interrelate to provide a post-structural informed theoretical web that draws upon evidence found within the Mental Health Survival Kit. In doing so, I posit ways one may come to understand the overarching research questions.

Chapter Seven – Discussion

Introduction

In this chapter, I provide a discussion about possible ways empirical evidence produced from a discourse analysis informed by post-structural theories of the Mental Health Survival Kit may interact. Toward that end, I draw upon Butler's interpellated subject to understand the ways my empirical evidence may interact to constitute/reveal particular subject positions produced by the Mental Health Survival Kit (Watson, 2005). In doing so, one may come to understand some of the possible subject positions in the Mental Health Survival Kit and the way these subject positions are produced by the Mental Health Survival Kit. Afterward, I postulate ethical possibilities for subversion. Finally, I propose some questions derived from my analysis in order to extend our knowledge. Yet, in order to begin, I must first outline some of the limitations of my research, which will help to contextualize my claims.

A Limitation of My Research

First and foremost, I do not claim that my research revealed all subject positions or the ways they are produced within the Mental Health Survival Kit. I imagine that if I were to utilize another discourse analysis following the same methodology, I may find different empirical evidence. It is possible that the difference between my research and future research using the same methodology could be the result of the tension between discourses that produce unstable subject positions. In this way, my research is, in part, a product of the tensions between discourses at the time it was produced, which are the

very discourses that, in part, produce my subject position. Yet, the research is not me nor am I it. And so, I draw attention to Plato's simulacrum to illuminate the differentiation my research and my subject position. The simulacrum does not seek to become the same as the model but to turn against it and its world to open a space for the simulacrum's own propagation (Deleuze, 1994). The simulacrum asserts its own difference; it is a differentiation (Deleuze, 1994). And so, a limitation of my research is not only a limitation but a way my research will disrupt the discourses that, in part, produced my research. With this limitation in mind, I draw Butler's theoretical concept of interpellation to understand the ways my empirical evidence may interact to produce subject positions in the Mental Health Survival Kit.

Hey You! – The Interpellated Subject

In order to understand the theoretical threads found by a post-structural informed discourse analysis within the Mental Health Survival Kit, one may draw upon Butler's conception of interpellation. In doing so, one can situate the reader as an always already ideological subject position within the Mental Health Survival Kit. Like the interpellated subject, the Mental Health Survival Kit claims at its start, "this kit is designed to help you navigate the mental health system." Upon reading the Mental Health Survival Kit, the reader responds; in that moment, the reader is transformed into a subject. Yet, the act of recognition is a misrecognition, which functions retroactively. And so, the person is always already an ideological subject. As Warren Montag (1999, p 42) comments, "what happens when we no longer consider minds transcendent in relation to bodies, when mental decisions, acts of will, are viewed as entirely immanent in the physical actions of

which they are said to be the causes?" For Butler (1997), interpellation offers "a way to account for a subject who comes into being as a consequence of language, yet always within its terms" (p 106). In effect, the act of interpellation is a conflicted social relation of identity possibilities rather than an act of direct hierarchical ideological relation. Hence, a subject is always already the subject; the Mental Health Survival Kit does not have to be read. You are always already; a subject is immanent or immanently becoming.

In the act of interpellation, power, available through the social order, is wielded as a means to signify discourse. Yet, the result of interpellation remains opaque since there are multiple conflicted subject positions that emulate from the act of interpellation. For a moment, imagine the reader is an individual in an office at a hospital. In the act of interpellation, the individual may be constituted as "friend", "family member", "patient", "doctor", "nurse", or "social worker" among many other possibilities. Each signifier may be interpreted in multiple conflicting ways depending on the source of the hailing. Within the Mental Health Survival Kit, power is wielded through the utilization of socially charged signifiers found in the social contexts of the Mental Health Survival Kit (i.e., mental illness, hospital, home/residence, life, crisis, reality, and treatment/recovery). The social contexts within the Mental Health Survival Kit are drawn upon to signify a subject position. Hence, the reader (i.e., 'you') within the Mental Health Survival Kit is signified by the social contexts of the kit itself. As a 'person with mental illness, the kit signifies 'you', in part, by its social contexts. For example, the authors declare that "appropriate residential planning can help give people with mental illness the basic support they need to remain in the community and to avoid a relapse and the possibility of a re-admission to hospital" (Mental Health Survival Kit). Then they declare that "it is

important that arrangements for your housing are made before you leave [hospital]" (Mental Health Survival Kit). In this way, the authors signify a social context (i.e., the hospital) then hail by stating "…your housing… before you leave" (Mental Health Survival Kit). As a result, a social context is drawn upon as a means to signify a subject position.

In unison, as seen in the previous chapter, bio-power and panoptic power through biomedical discourses produce some of the subject positions found within the Mental Health Survival Kit (i.e., mental health professionals, person with mental illness, and family and friends). Interpellation offers "a way to account for a subject who comes into being as a consequence of language, yet always within its terms" (Butler, 1997, p. 106); within the terms set through bio-power, interpellation is a prison to the production of subjects and consequently subject positions. For example, bio-power operates within language to designate who is mentally healthy and who is mentally ill. Hence, if subject positions are produced in relation to the Other then a subject position is in a place of dependency (i.e., mental health professional – person with mental illness). For example, if the Mental Health Survival Kit hails 'you' as a person with mental illness, it also hails the mental health professional. Thus, "one cannot criticize too far the terms by which one's existence is secured" because one subject position relies upon another (Butler, 1997, p 129). As a result, the person with mental illness cannot challenge the panoptic power of the mental health professional. Therefore, subject positions produced by the Mental Health Survival Kit are, in part, limited by the existence of subject positions within the Mental Health Survival Kit.

At the same time, through a complex process, the authors affiliate and disaffiliate in order to include hegemonic knowledge positions and exclude alternate ways of knowing. Disaffiliation and affiliation work synonymously to create distance from unappealing qualities while associating with appealing qualities. As explored in the previous chapter, through professional knowledges, referencing like-minded sources, statistics, and studies within the Mental Health Survival Kit the authors affiliate and disaffiliate. In doing so, the subject positions produced by the Mental Health Survival Kit are legitimized within psychiatric discourse.

Simultaneously, the subject positions produced within the Mental Health Survival Kit are, in part, constituted by not only what is written but what is not. As explored in the previous chapter, within the Mental Health Survival Kit, there are several absent or unspoken themes: politicized relations (i.e., neoliberal discourses), privilege of the mental health professional, and alternate forms of knowledge. The absent or unspoken themes (i.e., politicized relations, privilege of the mental health professional, and alternate forms of knowledge) function to speak veiled politicized, privileged discourses to readers of the Mental Health Survival Kit while excluding alternate forms of knowledge. By concealing politics, privilege, and alternate forms of knowledge, psychiatric discourses are able to further legitimize their position within broader social discourses.

All at once, immanently, you, a subject, produce and are produced by the Mental Health Survival Kit through interpellation signified through social context, subject position of the Other, power, privilege, and politics legitimized by hegemonic psychiatric discourses supported by studies, statistics, and like-minded sources, which veil alternate forms of knowledge (Miller, 2007; Morrissey, 2005; Nelson, 1999; Nikola, 2008).

Hence, in one way, subject positions, as described in the previous chapter, are produced by the Mental Health Survival Kit.

While one cannot extend a subject position beyond the confines of language, discourse analysis informed by post-structural theories allows one to unveil some of the implications of psychiatric discourses in the production of subject positions. One such implication is the way post-structural theories draw attention to dialogues about ethics, as seen in the chapter titled Ethical Dialegesthai. One possible way to approach interpellation within the Mental Health Survival Kit may be through Butler's conception of subversive acts. Toward that end, I offer an exploration of ethical subject positions.

Ethical Subject Positions

By drawing upon Butler's conception of subversive acts, one may confront the power of socially charged signifiers to ethically confront some of the signifiers in interpellation. One such way to confront "power is to repeat its signifiers disobediently, thereby engaging in discourse-based acts of subversion" (Watson, 2005, p 306). In a sense, if power is primarily exercised through signifiers, the only way to combat discursive signifiers is through other signifiers. In this way, people signified as mentally ill may find ways to ethically subvert subject positions.

As discussed in an earlier section, Rich and Evans (2009) provide a rich illustration of the contested relationship between subject, subject position, and subversive acts. In a similar way, people signified with borderline personality disorder may operate through subversive acts to disrupt and redirect the power exercised within biomedical and neoliberal discourses. In one such way, people signified with borderline personality

disorder may utilize suicide, as a signifier, to subvert neoliberal discourse. Neoliberal discourse attempts to constantly unburden the public health care system; as a result, there is constant emphasis upon moving people out of hospital. Yet, within biomedical discourses, a person must be admitted to hospital if they intend to end their life. In this way, a person signified with borderline personality disorder may subvert neoliberal discourse that attempts to move them out of hospital by drawing upon the 'preservation of life' signifier within biomedical discourses. Therefore, the person signified with borderline personality disorder is able to remain in hospital. As a result, the person signified with borderline personality disorder is able to say, "look at me! Value me! I am more than a number; your attempts to save my life tell me so" As such, through subversive acts a space for alternate subject positions is opened by drawing on competing aspects of biomedical and neoliberal discourses.

Through drawing on Butler's conception of subversive acts, I have shown that some subjects find ways to ethically subvert the power of biomedical and neoliberal discourses. In doing so, these subject open spaces within the tension between competing discourses. It would appear that the way subversive acts may ethically confront some of the signifiers in interpellation is a possible avenue for further research.

In Pursuit of Extending Knowledges

With knowledge of some of the subject positions produced by the Mental Health Survival Kit and ways these subject positions are produced by the Mental Health Survival Kit, future research may focus upon the way discourses within the Mental Health Survival Kit interlock with other discourses to produce subject positions. Toward this

end, I would ask several questions: In what ways do subject positions, produced through neoliberal, normalcy, and biomedical discourses interlock with child welfare discourses to produce subjects (i.e., the unproductive mentally unstable parent)? In what ways do subject positions, produced through discourses of racism interlock with biomedical discourses to produce subject (i.e., the unpredictable psychotic Asian)? In what ways do subject positions, produced through normalcy, biomedical and neoliberal discourses interlock with discourses of gender to produce subjects (i.e., the hard working man who cares for his depressed wife)? Through extending knowledge of the ways psychiatric discourses within Mental Health Survival Kit interlock with other discourses, one may begin to open spaces for alternate subject positions. Through unveiling subject positions within the Mental Health Survival Kit and the ways these subject positions are produced, my research is an initial step toward understanding this space.

Discussion

In this chapter, I provided a discussion about possible ways empirical and theoretical evidence produced from a discourse analysis, informed by post-structural theories, of the Mental Health Survival Kit may interlock. Toward that end, I drew upon Butler's theoretical concept of interpellation to understand the ways my theoretical and empirical evidence may interlock to produce subject positions in the Mental Health Survival Kit (Watson, 2005). In doing so, I have shown some of the possible subject positions in the Mental Health Survival Kit and the way these subject positions are produced by the Mental Health Survival Kit. Afterward, I provided ethical possibilities for subversion.

Finally, I proposed some questions derived from my analysis in order to extend knowledges.

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