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## **Narrative approaches in mental health: preserving the emancipatory tradition**

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Pamela is a sociologist in the School of Healthcare at the University of Leeds. Her work focuses on critical understandings of 'resilience', 'vulnerability' in relation to communities which are marginalised, for reasons of mental health, disability, social disadvantage, political and social stigma. Her work often analyses 'spaces' (both physical and metaphorical) in which collective forms of resilience are developed. Recently, she has been developing work which considers emerging ways of working in health and social care based on the principles of democratic professionalism. Pamela is widely published in sociological and health-related peer-review journals.

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John has edited or co-edited four books and has published widely in peer reviewed journals in the field of anthroposophy, transformational research methods and counselling and psychotherapy.

## **Narrative approaches in mental health: preserving the emancipatory tradition**

### **Abstract**

Narrative approaches have exercised an emancipatory influence within mental health. In this paper it is suggested that there is a risk that the emancipatory tradition associated with narrative may be co-opted through contemporary mental health strategy by a narrow agenda which promotes a particular western and neoliberal form of citizenship. This may limit the way recovery can be imagined by equating it solely with the future-orientated individual who strives, above all, to be economically independent. To resist this, it is suggested that narrative in mental health should be approached with recourse to therapeutic thinking which promotes a relational ethos of 'recovery together'. The 'recovery together' model is subsequently considered in relation to narrative research on temporal understandings which have been conducted in disability studies and in the area of chronic illness. These studies point towards the value of a relational orientation towards wellbeing in the present, rather than fixating on future goals. It is suggested that a relational philosophy of the present might be usefully incorporated into narrative approaches when working therapeutically with people suffering from mental distress. It is argued that this might enable users and practitioners to extend the available narrative templates and to imagine recovery in diverse ways which support personal transformation and, ultimately, contribute to social change.

Key words: narrative, mental health, recovery, IAPT, managed care

### **Introduction**

The key principles defining recovery [from mental distress] were first established in a number of seminal papers which shared the view that recovery is principally a social rather than a clinical process (see Deegan, 1993; Anthony, 1993; Coleman, 1999, Dillon, 2011). For Deegan the main concern was to critique narrow understandings of rehabilitation in order to encourage more open understandings of hope. Coleman (1998) explicitly argued for a political understanding of recovery, and Dillon (2011) emphasised the importance of both individual and collective approaches to recovery which challenged oppressive structures. Despite a slightly different emphasis, recovery is based on a rejection of the view that the symptoms of mental illness define a person's identity. What is particularly important in relation to this paper is

that recovery has the potential to open up diverse stories of hope which may or may not involve the restitution of 'normality'.

Given that a major challenge for people with mental health problems has been to have their perspective viewed as legitimate, narrative approaches have provided opportunities for people suffering from mental distress to gain a previously denied authorship of their own biography. Whilst this is a welcome development, it is suggested in this paper that there is a risk that the possibilities for envisioning recovery in mental health may be limited through the influence of contemporary and historical metanarratives which locate success according to an *individual's* perceived ability to master future uncertainty. More specifically, the traditional moral quest to determine future events, associated with the modern era since the 18<sup>th</sup> century, is increasingly morphing within liberal/neoliberal societies into a preoccupation with an individual's ability to flourish in the context of market relations. The assertion that approaches to mental health have been colonized by a neoliberal agenda is now well rehearsed (for example see Ramon, 2008; Teghtsoonian, 2009; Morrow, 2013; Esposito and Perez, 2014; Henderson, 2014). This paper adds to this literature by considering how neoliberalism is a continuation and reworking of a narrative of identity which emerged with the birth of the modern age. We consider how this narrative, which emphasises an individual and linear life trajectory, is currently enacted in mental health care strategy. Whilst we draw mainly on the example of the UK, this paper is equally of relevance to comparable liberal/neoliberal states, such as the USA, Canada, and Australia where mental health care systems have been shaped by a similar move towards evidence-based psychological therapies (Shera, 1996, Teghtsoonian, 2009; Henderson, 2014).

Our aim is to alert the reader to the possibility that current approaches to mental health care in liberal/neoliberal societies may encourage service users and practitioners to think of recovery in normative rather than imaginative and empowering terms. In response we suggest an approach of ‘recovery together’ which dismantles the binary between service users and practitioners, thereby offering the potential for the positive transformation of both parties. It is suggested that ‘recovery together’ requires a rediscovery of the ‘sociological imagination’ associated with the survivor movement, and an openness which can imagine recovery in ways which differ from dominant templates of citizenship. In short, the paper, which reflects the authors’ respective backgrounds in sociology and psychotherapy, seeks to raise awareness about the importance of protecting the emancipatory potential of narrative approaches in mental health.

## **Background**

The ascendancy of the recovery movement within mental health has been accompanied by a growing popularity of narrative approaches in research and within therapies which, in various ways, have challenged biomedical understandings of mental illness whilst illuminating the personal experiences of people suffering from mental distress (see for example Grant 2006; Short, et al, 2007; Grant, et al, 2011). It is at least partially thanks to these accounts that personal testimonies are being increasingly regarded as key within therapeutic interventions (Place et al, 2011). As a result, the symptoms associated with different forms of mental distress are viewed by some as meaningful responses to environmental and cultural stresses rather than as biological dysfunctions (Hornstein, 2013, Johnstone. 2014). Whilst biological

definitions of mental illness indisputably persist they have forfeited some of their former largely uncontested legitimacy. This is partly attributable to the growing popularity of narrative approaches in health care contexts which are characterised by the ascendancy of patient-centred care (King's Fund, 2011; Keogh, 2013).

Despite the advances which have been made, the contemporary field of mental health in liberal/neoliberal states is being significantly shaped by a policy movement towards managed healthcare which has been identified as aligned to the techniques associated with neoliberal governance (see Fullagar, 2008; Teghtsoonian, 2009; Esposito and Perez, 2014; Henderson, 2014). Neoliberalism emphasises a particular form of individualism consistent with a market-based economy (Rose & Miller, 1992; Dean, 1999). Within this context the focus is on 'recovery from' specific symptoms which prevent integration into the market economy, with mental illness framed as a problem of the individual whilst the cultural, economic and social dimensions which underpin much mental distress are ignored (Ramon, 2008). Implicitly this reduces the horizon of possibilities for enacting recovery (Fisher and Freshwater, 2015) whilst reinstating professional power. What tends to be overlooked is the notion (associated with emancipatory narrative traditions) that recovery is a unique experience for each individual which is aided by solidarity and collective resistance (Howell and Veronka, 2012: 4).

'Recovery from' is manifest in quantifiable evidence based practice and in a publicly accountable 'managed care' stream of research and practice (see Henderson, 2014). Above all, it is characterised by a persistent emphasis on diagnosis and on 'recovery from' symptoms. As Freshwater et al (2013, 4) put it, '...diagnosis

underpins every aspect of a patient's therapeutic journey and sets the parameters of their mental illness...so in this sense, the patient's mental illness, through diagnosis, is literally written into existence.' Recovery is principally associated with the eradication of symptoms which pose obstacles to the individualistic principles of responsibility and self-determination. Success is subsequently measured through quantitative method (see Clark et al., 2011).

Managed care systems in mental health which have become associated with neoliberalism were first introduced in North America (Shera, 1996). In the UK they were introduced into the National Health Service in 2007 (NHS) in the form of the Improved Access to Psychological Therapies (IAPT). This scheme was driven by financial considerations in view of the fact that it addresses the problem that 'between 1995 and 2005 about half a million extra people registered for Incapacity Benefit (IB) ....because of a mental illness, taking the total to about 1.1 million' (O'Brien, 2013). Its adoption by the NHS was preceded by a report which argued that psychological therapy had the potential to reduce the cost of IB 'for those unable to work due to psychological distress' (Layard, 2006). Subsequently the then UK Coalition Government stated that it would support the scheme financially until at least 2015 (NHS, 2012). Driven by a top-down technical rational principle of 'recovery from', the intention was primarily to enable service users to resume their involvement in the job market for the alleged benefit of society (Layard, 2006). Consistent with neoliberal ideology, policy-informed definitions of recovery tend to be those which are aligned with economic participation whilst the social conditions, which might have contributed to the psychological problems, are neglected.



According to the British Association of Counselling and Psychotherapy, IAPT is increasingly defining the debates within mental health (BACP, 2014).

There is a risk that the models of recovery which are upheld by managed care systems in liberal states may surreptitiously infiltrate understandings which shape the landscape of mental health, seeping even into the most emancipatory narrative approaches. It should be pointed out that this will rarely occur as a result of a conscious and deliberate strategy. People tend to reproduce social structures and dominant cultures mainly through inadvertent actions. As Bhaskar (1989: 80) puts it, ‘. . . people do not marry to reproduce the nuclear family, or work to reproduce the capitalist economy. But it is nevertheless the unintended consequence.’ In other words, emancipatory agendas can be inadvertently undermined in ways that can go largely unnoticed. This is discussed in more detail below in relation to Raymond Williams’ (1977, cited in Gray, 2008: 937) concept of a ‘structure of feeling’.

### **Structure of feeling and ‘recovery together’**

The term ‘structure of feeling (Williams 1984, cited in Gray, 2008: 937) was coined to refer to the emotional landscape which at a particular time and in a specific location shapes the way people apprehend the world. In short, the structure of feeling of any given time and place is comprised by the social relations, social organisation, the dominant ideas, and the material conditions, and yet it is something more than the sum of these dimensions. The structure of feeling shapes people’s responses to the world, sometimes at pre-reflexive levels. Within the UK and comparable states, the structure of feeling is significantly constituted by the ‘numinous image’ of the market economy. A ‘numinous image is an image that has captivated people, consciously

or pre-reflexively (Samuels, 2001: 142). Whilst Samuels does not directly address how the potency of a numinous image comes about, Foucauldian scholars have argued that neoliberal governance is internalised through specific technologies of rule which ostensibly avoid coercion but instead encourage individuals to subscribe to a particular view of personhood shaped according to market imperatives (Rose & Miller, 1992; Dean, 1999, Teghtsoonian, 2009). As Teghtsoonian (2009) points out, managed care systems within mental health care constitute subtle technologies of rule. As such they are likely to have some influence in shaping the development of people's understandings - service users and providers alike – in relation to how recovery may be envisioned.

To combat the tendency towards the narrowing of narrative horizons which are open to diverse understanding of recovery we are in favour of maintaining and reinforcing the connection between narrative and psychodynamic, humanistic and integrative traditions based on critical reflection, innovation and theory-building (Lees, 2010) in order to supplement cognitive behavioural therapy which is the primary therapeutic approach in managed care. This may at first seem a curious strategy in view of the aims of this paper. These traditions have, after all, traded off the western notion of the autonomous self, often placing ontological separation at the top of a hierarchy of values. Ideas of connectedness have been under assault in western societies since the emergence of the modern period in the 18<sup>th</sup> century and, for the most part, psychology has colluded in this. However, in their more contemporary forms, psychodynamic, humanistic and integrative approaches are based on a relational and intersubjective model which does not privilege the atomized and individualistic self. Relational approaches instead see the field of interaction between the therapist and the client as shaped by the inner worlds of both (Mitchell, 1998; Aron, 2014;

Orbach, 2014). Ideally, the relationship involves a dyad of exploration and imagination which defies the more traditional healing binary of healthy expert and ill patient. Perhaps rather than thinking of it in terms of 'recovery in', thinking in terms of 'recovery together' may be more apposite. This *potentially* offers the space to imagine recovery as a process of growth and development, enabling recovery to be found in ways that could not be anticipated at the outset. Crucially, it involves a democratic relationship between service users and practitioners. The benefits of self-transformation do not accrue solely at the level of the personal or the interpersonal. Locked up in people's narratives of their experiences in the world are critiques of that world, and the development of psychologically informed and innovative self-transformation coexists with political and social awareness (Taylor, 1989; Samuels, 2001; Crossley and Crossley, 2001 Fisher and Freshwater, 2015).

This is not to assert that paid employment is not, or should not be, important to many people with mental health problems. People on the margins would undoubtedly often benefit from greater financial and economic resources, but narrative approaches in mental health should, we believe, facilitate and unleash aspirations and energy which extend beyond the imperatives of economic participation. This is only likely to be achievable if narrative horizons are not inadvertently circumscribed by a hegemonic understanding of what constitutes successful personhood.

### **A sociological imagination**

Whilst the idea of remaining 'open' may seem like an easy appeal to make, after all few would advocate being 'closed', we want to emphasise here is that it is extremely difficult to do so. Crucially, we suggest that maintaining openness involves, among

other things, being open to dialogue and a readiness to evaluate critically the prevailing common sense as well as one's own personal assumptions. In other words, it requires, among other things, a 'sociological imagination' (Mills, 1959). It was after all a sociological imagination which gave rise to the survivor movement in mental health, a political awakening in the field of mental health which is described by Crossley and Crossley (2001) in a paper which provides a poststructural analysis of two studies of narrative testimonies of mental health patients. The first entitled *The Plea for the Silent and Speaking our Minds* dates back to the 1950s. This study is atypical of its time in the sense that it provides patients in mental hospitals with an opportunity to 'speak out' about their experiences. Nevertheless, the testimonies are entirely typical of their time in the sense that they are essentially stories of individualized suffering which tell of lives lost, opportunities missed and the absence of hope for future progression. In contrast, in the second study *Speaking our Minds* which was published in the 1990s, service user (no longer patient) narratives point to a strong sense of survivor identity which has developed as a result of a *collective* response to institutional oppression. In other words, the personal suffering characteristic of mental distress in the 1950s had been reconfigured as a political issue within narratives which establishes the link between internal mental and exterior social conditions. What the two studies powerfully demonstrate is that whilst a person's sense of self can be undone by injustice and isolation, it can be repaired through solidarity with others, and that solidarity can be established through shared narratives which lead to unanticipated forms of individual and collective forms of empowerment. We suggest that the importance of solidarity and of openness to understandings of recovery may be overlooked within the mental health strategy underpinning IAPT. In stating this, we recognise that the aetiology of mental health

problems is in many cases likely to defy any simplistic separation of social and personal factors. However, the current focus on IAPT does not necessarily provide the space to enable new ways of thinking to emerge through a process of critical evaluation that comes through an attentive engagement to others' perspectives (Taylor, 1989). Instead it tends to reinstate professional power and place the obligation on the service user to comply with the advice they are given in order to recover (see Clark et al, 2011).

We identify a risk here that managed care systems in general, and IAPT in particular, may reinforce a structure of feeling, which emerged in the modern period, but which persists in a reworked version in western cultures saturated by the neoliberal agenda. Whilst the trope of linear time significantly predates the advent of neoliberalism, it has assumed a particularly limiting guise within neoliberal discourse in which progress and success segue with the ability to flourish financially. In the discussion below, we consider linear time in relation to western personhood, and, and subsequently discuss how this narrative, in its current neoliberal form, is embedded in mental health policy.

### **The future-orientated individual**

The starting point for narrative approaches tends to be that good mental health is associated with the ability to tell a coherent life story. Recovery is frequently equated with the ability to develop a revised sense of self through a biographical re-write which provides meaning within and through the illness experience. As Roe and Davidson (2006) explain, narrative is a tool which people use to weave back together a sense of self, which is based on and yet extends beyond who they were before

they were ill. In other words, story-telling enables people to attribute meaning to their lives which supports the development of a positive sense of self. As Kearney (2002: 152) says,

Storytelling invites us to become not just agents of our own lives, but narrators and readers as well. It shows us that the untold life is not worth living. There will always be someone there to say, “tell me a story,” and someone there to respond. Were this not so, we would no longer be fully human. (p. 156)

Being fully human is thus equated with the ability to link past actions with experiences in the present, and equally anticipate how present actions will be lived out in the future. This linear understanding of time and of life trajectories is related to the Enlightenment project and the emergence of modernism at the end of the eighteenth century (Ezzy, 2000). Since then understandings of temporality as a linear process have become central to narrative constructions of identity in western societies. From a sociological perspective, Elias (1992) argued that the introduction of clocks and calendars led to forms of self-regulation which prompted the development of moral concepts of individual responsibility which encouraged people to take control of time by utilising it as productively as possible. Actions in the present came to be assessed ‘in terms of the efficiency of means in achieving ends’ (Siegel 1988: 130) and progress was to be achieved by ‘rugged individuals’ who sought certainty and strove to become architects of their own futures (Dudley-Marling 2004: 489). This has resulted in an orientation whereby behaviour and actions in the present tend to be evaluated according to their impact in shaping future events.

This position is reflected in influential (western) philosophical thinking. In *Sources of the Self* the philosopher Charles Taylor (1989) argues that the ability to see oneself as an unfolding story is bound up with the development of moral identities. To have no moral framework enabling a person to orient herself to the good is, for Taylor, tantamount to having no sense of self. Since there is no sense of self without an orientation to the good, and since our place relative to the good is something that changes over time, our sense of the good has to be incorporated into an understanding of our lives as an unfolding story. As Taylor (1989: 47) puts it, 'The issue for us has to be not only where we are, but where we're going'. The view that the good life is always future-orientated has been contended by Strawson (2004) who takes issues with the view that a narrative of linear progression is essential to a moral life and to a well lived life.

The protagonist within linear narratives is under a moral obligation to steer their life trajectory down a positive course towards the future. Similarly, practitioners and researchers engaging in narrative approaches may assume that recovery involves biographical reconstruction, with the person with a mental illness learning to reconfigure themselves as 'the protagonist, the hero of her own story' (Roe and Davidson 2006: 91-92). Whilst helpful to some service users, this may be disabling for many others, particularly if aspiration is defined narrowly according to a person's ability to flourish within market conditions. As Bourdieu (1984) noted (in relation to unemployed people) the internalisation of dominant notions of commodified linear time can have profoundly damaging effects on individuals.

Within this discourse the market itself is imbued with certain moral qualities. In relation to this, it is worth noting that whilst mental health policy discourse in the UK acknowledges the material and environmental conditions which can adversely impact on mental health, this is invariably accompanied by a strong discourse of responsabilisation which identifies mental health problems as a fiscal burden. The individual citizen is identified as primarily responsible for his or her economic autonomy. In *No health without mental health*, recovery is described as ‘central to our economic success and interdependent with our success in improving education, training and employment outcomes...’ (DH 2011, 2–3). In *Closing the Gap* (DH, 2014:4) the link between mental health and economic self-sufficiency is expressed in the introduction,

All too often, for example, poor mental health precipitates premature job loss. This is a waste for individuals and for the economy. In addition, we know that not having a job is too often associated with the onset or recurrence of mental health problems and being out of or away from work can sustain the symptoms of mental ill health.

Although health policy discourse is embedded in the idea of the ‘Big Society’, the Department of Health is arguably promoting a narrative which assumes that recovery is manifest when people are assimilated into market relations. The discourse underpinning UK mental health policy is reflected in comparable liberal/neoliberal states. In *Healthy Minds and Healthy People*, a policy document produced by the Ministry of Health Services and Ministry of Children and Family Development (2010) in British Columbia, the fiscal burden of mental health is addressed on the first page. One of the key aims is identified as ‘promoting the healthy social and emotional



development of British Columbians in order to maximize their investments and yield long-term positive outcomes and economic gains for individuals, businesses and government' (p.2).

Whilst assuming paid employment is clearly a desirable object for many, questions need to be asked about the consequences for mental health users who are unable to conform to this model of citizenship. The most acute form of social suffering can occur when those on the margins internalise denigrating narratives which undermine hope and a positive sense of self. Suffering is internalised into a person's identity and the resultant sense of abjection leads to a lack of agency (Bourdieu, 1984)

In the discussion which follows we draw on narrative studies taken from the field of chronic illness and disability studies which offer an alternative temporal and relational understanding, 'the philosophy of the present' (Ezzy, 2000; Fisher and Goodley, 2007) which directs attention to alternative transformative possibilities. In contrast to the linear narrative of progress, the philosophy of the present appears to be aligned with a relational rather than ontological separate understanding of the self.

#### *Another perspective in narrative studies of disability and chronic illness*

Apart from the occasional exception (see Beresford, 2002) there has been a general reluctance to engage in ongoing dialogue between survivor activists and representatives of the disabled people's movement in order to develop a 'social model of madness and distress'. However recently there has been as a small body of scholarship (see Howell and Veronka, 2012) which has opened up new ways of

thinking through the connections between social justice and mental health, precisely by challenging the norms that underpin the very value of 'mental health' or 'mental illness' as useful categories or ways of thinking about people. This scholarship takes inspiration from the mad movement (Morrison, 2005; Fabris, 2011), which is exploring the positive valuing of madness as a form of difference. This literature resonates with critical disability studies which reject the biomedical interpretations of disability.

It is beyond the scope of this paper to articulate an argument which develops significant links between mental health and critical disability and/or chronic illness. Nevertheless, we draw on specifically narrative studies taken from the field of critical disability studies (Fisher and Goodley, 2007; Gibson et al., 2009) and narrative studies of chronic illness, specifically HIV (Davies, 1997; Ezzy, 2000). These studies are discussed because they demonstrate that individuals are sometimes able to resist the hegemony of the dominant time culture.

In a study relating to parents with disabled babies, Fisher and Goodley (2007), observed that parents who broadly subscribed to a linear narrative, premised on an understanding of selfhood as ontologically separate, were most likely to view disability essentially as a personal tragedy. Interpreting disability as a personal trouble, the parents identified medical expertise as offering the best hope for their child to achieve greater normality in the future. The realisation that the desired outcome was unobtainable led, for some parents, to a sense of hopelessness and self-imposed isolation. This finding resonates with an earlier study on people living with HIV by Davies (1997) who describes some people as living in an 'empty

present', characterised by a lack of hope and meaning. Similarly, Gibson (2009) has noted that young men living with the life-limiting condition Duchenne often resorted to aggressive and anti-social behaviour in dealing with the uncertainty of the future in a cultural context which emphasised the importance of linear progression over present wellbeing. Failure to meet normative milestones, Gibson et al. (2009) argue, can create a sense of failure and entrench marginalization among disabled people who do not progress according to hegemonic notions of linear time.

Related to the linear narrative but in a slightly different guise, Fisher and Goodley (2007) identified a narrative of challenge which was more critical of the medical model of disability and generally less deferential towards medical expertise. That said, in common with the linear narrative, meaningfulness within the narrative of challenge was achieved by moving towards future goals or a *telos* (MacIntyre 2007: 202), with parents on a journey of equipping themselves to 'fight' for their children's future wellbeing. Whilst this approach brought its own rewards, particularly when it came to accessing material and resources, the ongoing 'fight' was exhausting for many. These parents tended to remain wedded to the idea that future wellbeing was more or less contingent on the ability to overcome the obstacles associated with disability. Whilst often heroic, this could be limiting. As Walker (1998: 127) has argued from a feminist perspective on stories premised on integrative coherence,

I picture tired stories being dutifully tended and maintained because they are integral to an existing plot. I picture something especially onerous for those who feel that others have had a disproportionate hand in writing stories for them that are limiting, cruel, oppressive, or alienating to some things they sense but do not (yet) have stories available to express.

The problem with placing one's hope in a particular future-based outcome is that it is often highly precarious. Ontological security is related to an understanding that there is one good way of leading a life (Ezzy, 2000), a view which, as argued above, tends to be reflected in current mental health strategy.

In contrast, however, to the linear narrative, Ezzy (2000) identified a different temporal understanding among some of his interviewees who had been diagnosed with HIV. This was a temporal orientation which appeared to enable people to enjoy the present for what it is by investing future uncertainty with hopefulness. Rather than being focused on a particular outcome, hope was 'continually open to the possibility that reality will disclose as yet unknown sources of meaning and value' (Barnard 1995: 48, cited in Ezzy 2000: 607). Similarly, Davies (1997), in a study which addresses the existential problems faced by people living with HIV, noted that in a curious way some participants sensed that their diagnosis liberated them from the need to fight for the future, giving them permission to build a meaningful life in the present. Again in Fisher and Goodley's (2007) study on parents with disabled babies, some of the interviewees appeared to engage in a 'philosophy of the present' based on the valuing of relationships with their children and with others, particularly other parents who had a disabled child. This focus on present often involved a distancing (although not rejection) of materialist values (Davies, 1997; Fisher and Goodley, 2007), and a collective move towards a political challenge to deficit-based understandings of disability (Fisher and Goodley, 2007; Fisher, 2008). This appears to be aligned to Diprose's (2002) understanding of 'corporeal generosity' as a type of embodied and relational generosity based on openness to alterity. Corporeal

generosity not only encourages people to be open to others - but sees this very openness as a constituent of identity. The subject on the linear life trajectory towards individual success is substituted for one who is other-related. To use Frank's (1995, p. 35) term, the 'dyadic' subject is created who recognises that 'even though the other is a body outside of mine ... *this other has to do with me, as I with them*' (original emphasis). Far from closing down agency, this view of the relational located within an open future appeared to encourage people to see themselves as active and evolving. If anything, agency was promoted by at least partially by overcoming the fear of an uncertain future.

Acceptance that the future is not entirely controllable appear to open people's horizons regarding what is possible (Ezzy, 2000, Fisher and Goodley, 2007), a perspective that is often rejected by health and social care professionals (Fisher and Goodley, 2007; Fisher, 2008). In response some of the parents of disabled babies sought out alternative spaces in their homes and local communities, and via social media, in which they were able to collectively develop counter-narratives which challenged neo-liberal understandings of citizenship by emphasising the transformative aspect of relational and collective identities (Fisher and Fisher, 2007). Some practitioners, however, continued to assert that parents had not 'taken on board reality', a position which can be interpreted as a form of parsimony which dismisses alternative ways of envisioning human flourishing (Diprose, 2002). Similarly, we suggest in this paper that narrative approaches in mental health should not be foreclosed by unquestioned acceptance of dominant narratives of personhood and citizenship.

### *Recovery together and co-production*

The relational orientation to the present discussed above resonates, we suggest, with psychological understandings of ‘recovery together’. From this perspective, the goal is no longer solely to ‘cure’ the ‘patient’ but to engage in a process which may lead to mutual transformation. This said, we do not wish to set up a new binary between temporal orientations towards the present and the future, but we suggest that an engagement with the present which is relational and based on an openness to alterity can be a source of wellbeing whilst providing the space for emancipatory and transformational possibilities – a point which is well-expressed in Daniel Stern’s (2004) notion of the moment as an experience of *kairos*:

*Kairos* is the passing moment in which something happens as the time unfolds. It is the coming into being of a new state of things, and it happens in a moment of awareness. It has its own boundaries and escapes or transcends the passage of linear time. Yet it also contains a past. It is a subjective parenthesis set off from *chronos*. *Kairos* is a moment of opportunity, when events demand action or are propitious for action. (Stern, 2004: 7)

The transformational and emancipatory possibilities of such a moment of meeting are connected to the fact that they exist both beyond time but are also connected to the passage of time. Such an event ‘has its own boundaries and escapes or transcends the passage of linear time’ and yet is ‘in some kind of dialogic equilibrium with the past and future’ (Stern, 2004: 28). It is both a personal and a political experience which can begin within a therapeutic encounter based on ‘recovery together’.

Whilst it is clearly unrealistic to imagine that each therapeutic encounter is likely to result in a moment's epiphany, recovery together might be viewed as at least creating the potential for this to occur. We have previously questioned Taylor's (1989) view that the moral life is necessarily future-orientated, nevertheless, we remain persuaded by his perspective, developed in the *Sources of the Self*, that each person has a distinct and authentic way of being human. On this basis, Taylor (1989) argues that everybody should have the opportunity to grow towards their best self rather than being obliged to follow an externally imposed blueprint. We suggest that this is a view which could usefully form 'recovery together' by replacing the focus on the pathology of the service user to one which opens up a conversation which potentially provides the space for the growth and development of service user and practitioner alike.

Such an approach would require the notion of ontological separation to yield to a view of the self as relational and embedded, who achieves autonomy within relationships of interdependency, as reflected in narratives of the parents with disabled babies and people diagnosed with HIV discussed above (Fisher and Goodley, 2007; Ezzy, 2000). Similar strategies are reflected in some community mental health groups which work on collectively developing mutual support, often in innovative ways. Here, the focus is often on activities which develop relational wellbeing in the present through engaging in social and creative activities (Alderdice and Fisher, 2015). It is perhaps worth pointing out that the philosophy of the present is always relational and other-orientated, a key point which distinguishes it from the pursuit of immediate and often self-centred gratification associated with

consumerism. The ability to flourish meaningfully in the present *requires* attentiveness, responsiveness and openness to others (Ezzy, 2000, Fisher and Goodley, 2007), an ethos which is often less well supported in managed health care systems. Paradoxically, though, there are policy initiatives which potentially encourage ‘recovery together’ whilst possibly opening the space for understandings of recovery which may incorporate the philosophy of the present. This is discussed below in relation to contemporary policy shift towards co-production in mental health.

Co-production, currently an important policy objective in mental health in the UK (NHS England 2013, CQC 2014, DH 2014a), involves working across organisational boundaries, (that is between third sector, community and public and statutory organisations,) and through genuine partnerships with service users. Admittedly a key limitation of the term co-production is that it can be easily co-opted to mean quite different approaches, and it lends itself to being adopted as an adroit tactic which enables ‘lip service’ to be paid to patient involvement whilst maintaining normative understandings of ‘recovery from’ approaches. However, at its most transformatory (see Needham and Carr, 2008), co-production entails the development of equal partnerships between service users and practitioners in therapeutic encounters and, equally, in shaping mental health practice, management, governance, commissioning and policy. In other words, co-production and, we suggest, ‘recovery together’, are ultimately concerned with authentic power-sharing which can enable personal transformation and shape practices and services in mental health – thereby ultimately contributing to social transformation (Needham and Carr, 2009). Co-production may potentially offer a way forward for ‘recovery together’ approaches.



## Discussion

Whilst narrative approaches are often seen as investing people with mental health problems with epistemic authority, this paper attempts to alert readers to the risk that dominant narrative templates may insidiously weave their way into people's *lifeworlds* where they furtively close down our ability to imagine diverse understandings of recovery and alternative ways of being. We are the most persuaded by the 'recovery together' model which avoids setting up false binaries between service users and professionals which pathologise the former and invest power in the latter. We see 'recovery from' as potentially consistent with the current policy focus on co-production. Equally, we alert the reader to the fact that stories of survivorship emphasise relational approaches which are respectful of service users' frames of reference and, crucially, do not foreclose narrative horizons (see Grant et al, 2011). The extract below is a particularly telling plea in this respect, which underlines how therapeutic relationships should seek to open up new freedoms:

When you work with people, treat people with regard and respect ... Be real. Be human and you might just connect with 'us'. ... You will have used your skills but more importantly you will have allowed yourself in your scientific world to access your humanity and through empathy you can give hope to others and a freedom in life – a freedom of mind for which we all strive (Jamie James, 2011 in Grant et al., 2011: 143-144)

Practitioners who apply narrative approaches need to be mindful that their own perspectives are not limited by tropes of linearity which reflect and reinforce a political agenda of individualism based on narrow economic autonomy. This is not to downplay the importance of economic autonomy, but we take the view that the

process of recovery should at least support the potential for moments of epiphany when people create something new or unanticipated. This may be prompted precisely as a consequence of resistance to the norms which reinforce marginalization (Ezzy, 2000, Fisher and Goodley, 2007). Whilst this may involve a rejection of linearity in favour of a philosophy of the present, it may be something entirely different from this. As Deleuze & Guattari (1988, p. 216 cited in Tamboukou 2008, p. 288) argue, there can be moment when something flows or breaks free, and a new unanticipated perspective emerges. This experience is particularly associated with subordinated groups such as women, youth and 'the mad'. This is, for example, how hearing voices came to be seen by some as a sign of sensitivity or an attempt at meaning-making rather than as a symptom of biological dysfunction.

Hendry (2007) goes so far as to argue that listening to people's narratives should not be directed towards a search for narrative coherence which can foreclose people's identities. Instead the focus should be on non-judgement and on an open horizon of possibilities. Put differently, narrative approaches, if approached with a mindset which has managed to remain relatively unfettered by narrow political agendas, offer the opportunity to see, as Bourdieu and Wacquant (1992: 40) would have it, the 'unthought categories of thought which delimit the thinkable and predetermine the thought'.

## **Conclusion**

In this paper we have argued that although narrative approaches within mental health have emancipatory potential, there is a risk that narrative templates may be narrowing. This is at least partly attributable to normative understandings of

citizenship within neoliberalism which appear to be supported by the growing ascendancy of IAPT. For this reason, we have suggested that narrative approaches should remain connected to psychodynamic, humanistic and integrative traditions, particularly those based on a 'recovery together' model which appreciates the personal and the political. We have considered the 'recovery together' model in relation to a relational focus on present wellbeing. Finally, we have argued that narrative approaches should be seen as potentially opening up possibilities for unanticipated and innovative forms of recovery which may lead to personal and social transformation. Personal awareness and development is linked to emancipatory social change which arises when dissonance between mental and social structures prompts a questioning of 'natural' and common sense expectations (Bourdieu and Wacquant, 1992). In brief, rather than allowing narrative to be co-opted by a neoliberal political agenda, there is a need to build on the collective and transformative legacy of the survivor movement and to extend its achievements by creating therapeutic contexts in which people in mental distress may imagine their recovery ways not yet anticipated.

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