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Pluck, acceptance, defiance and fortitude: telling mental illness stories to change the world

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***Pluck, acceptance, defiance and fortitude:
telling mental illness stories to change the world***

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Genesis

This piece was originally written as a literature search on consumers using story in the clinical education of mental health nurses. The more the idea of story was explored the more interesting (and complex) it became. By following the literature trail we found ourselves exploring ideas that moved far beyond the concept of individual story as an account of personal experiences. We explored the business literature which is where most of the energy about using story seems to be at the present. We looked at story in relation to the history and philosophy of knowledge and a critique of the way the word has been abused in ideas about 'storying'. It was an interesting journey which ended up producing a document that was long.

Editing:

Working through the piece over a period of time we decided to emphasise the idea of 'story-enacted'. That is, to think about stories as derivatives of our lives. We tell them as part of living (and teaching or being more or less public). That is, consumers teach with story even when they don't do it intentionally.

As we sorted through the material it appeared that there were certain consumer story plot lines (we called them narratives) that seemed common and could be analysed. These intrigued us and we explored how these had multiple and sometimes contradictory meanings and messages that matched the dominant motifs of the day. Are these co-opted scripts? That's one of the questions this paper addresses.

In the pursuit of what became the most important questions about a complex idea of story we made the decision to edit out much of the original material on clinical education. It has not been discarded and will appear, in a different format, soon.

{ *pluck, acceptance,
defiance and fortitude:* }

*telling mental
illness stories to
change the world*

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Introduction

This booklet is written for all people who are interested in the way people with 'lived experience' (consumers) enact and use story as a means of understanding their world. The most obvious manifestation of story is seen when consumers take on paid and unpaid roles in the mental health workforce. As we tell and retell our own stories, meanings change; but active storytelling is only a small part of enacting our own stories of our experiences. Even as we attempt to educate others our stories change and are moulded by social circumstances.

This booklet is also useful for others. It is important reading for people, perhaps recently diagnosed with mental illness and who are looking for reasons. What do different people make of this life and how it is lived and interpreted? It is important for all of us to know that we are not alone and to understand, therefore, that the dominant ways people have chosen to tell their stories to themselves - and then others - is important. This booklet can help people with 'lived experience' and who are asked to be involved in public awareness campaigns, talk to school children or support their involvement in Mental Health Week.

The booklet is not about using story per-se; rather, it is about the larger narrative most of us pin not only our stories on, but also about the way we relate to our own distress and want to understand it.

Section One is about the social and political context of story; stories are never told separated from the social world we are connected to; we

look at stories as fundamental building blocks to successfully pass-on culture from one generation to the next in small-scale social settings. We also examine how stories have been abused by business, using 'storying' for their interest in the market or even by politicians and how mental health consumer-storytellers may have been and may have felt abused when their stories have been 'stolen' or misused for purposes different from their intent of telling them. What do people learn from us as consumers and is this what we set out to teach or share or intend to use our stories for?

Section Two identifies the ways 'others' try to silence the voices of consumers through:

- demanding representation when representation is impossible;
- demanding 'standards' which belong to discourses that are 'other' and more powerful than the consumer discourse;
- creating tokenistic categories which simply 'categorise', divide and dilute consumer stories and come from a skewed understanding of who is actually on the 'inside' of this mental illness endeavour and whose opinions should, therefore, be seen as central to it.

Section Three looks at the dominant biomedical story of mental illness and the various narratives people with 'lived experience' have constructed to either support the thrusts of this story with stoic inevitability or counter it with narratives of heroic survival, recovery, hope or passion.

Life is story and "humans are storytelling animals"
(McLachlan 2006:1154).

Stories are a valuable, rich and accurate way to pass on culture, experience and wisdom. Oral histories and traditional story telling form the bedrock of all cultures and continue to be the most reliable way to convey knowledge from one generation to the next. However some stories are more valued as accurate and offering crucial messages and insights than others. Our community upholds the value and wisdom of the consumer story.

In First Nations (First Australian people; Aboriginal or Indigenous Australians) communities the significance of storytelling as a vehicle for wisdom and culture transfer is valued beyond the traditions of Western culture (Murray R. 2009, Phillips G. 2004, Platt J. 2012; Jackson V. (not dated); Williamson J. 2007; Wright M. et al 2015, Williamson J. & Dalal P. 2007, Gardiner G. 1999, Augustine JA (not dated), Yunkaporta T. 2009). Nonetheless, in reality, we all tell and retell stories throughout our lives. (Riedl M. 2010; Yiannos G. 2008; Sirhan N. 2014; Leitch A 1986). Telling stories is a significant way to translate experiences. Once told, they become impossible to ignore or repress.

"Under the almost infinite diversity of forms, narrative is present in every age, in every place, in every society; it begins with the very history of mankind and there nowhere is or have been a people without narrative. All classes, all human groups, have their narrative, enjoyment of which is very often shared by men with very different, even

opposing, cultural backgrounds. Caring nothing for the division between good and bad... ...narrative is international, trans-historical, trans-cultural: it is simply there like life itself". Barthes R. (1964) Translation in Bal N. 2004:64)

The stories we tell about our lives change historically, politically and culturally as we move through different interpretations of our own life circumstances. However the story or explanation and transmission of meaning might be very different at different phases of our lives and in different life contexts. In the context of living with a mental illness Grey discusses "unstable identifications" to describe how people come and go from identifying as mental health consumers, as part of their ongoing life narrative (Grey F. 2014).

We tell stories for different purposes. Stories assist us to understand ourselves, explain difficult paradoxical or challenging situations, transfer culture and form friendships. Stories are both personal and relational (Epstein M. & Grey F. 2011; Radden J. 2012, Ward M. 2012). Their importance may change with time or they may be exactly the same as the problems and challenges they address have not been resolved. (Wadsworth Y. 2001). Some stories represent metaphors that are versatile and can be applied to many different situations (Northcote M. 2006, Wright A. 1999). They survive intact. However their meaning cannot be isolated from the relationships in which personal accounts are constructed (Radden J.

2012; Ward M. 2012). They are not necessarily a personal testament.

Experience, confidence and competence influence storytelling delivery and affect the way that the audience relates to the narrator as well as to the content. Education and mentoring of consumers who use story, however, is somewhat perfunctory. Its focus is to maintain confidentiality, protect one's reputation and deflect intrusive questions (Watson S. 2014; Epstein M. & Grey F. 2011), to warn the storyteller rather than sharing techniques and expertise (Watson S. 2014). Much tutoring is based on the following assumptions:

- Storytelling is about personal testament;
- Storytelling is always an individual act;
- Consumers are likely to need rescuing from their own need for recognition and acclaim;
- Without intervention from others (e.g. trainers, therapists), story-telling by consumers will become addictive catharsis even if *intending* to educate;
- Stories are not meant to be and should not be political, angry, ungracious or emphatic;
- Those listening to 'the story' are absolved of any responsibility to hear generously and then act accordingly, including changing their own and others' stasis.

Not necessarily a healthy set of assumptions, although there is a need for care, knowledge and tempered enthusiasm. Stories are couched within a social and relational context. Story methods exist and provide the best service to

both the story and the student. Metaphor, legend, storylines and communal stories (Epstein M. & Grey F. 2011, Wright A. 1999, Sirhan N. 2014) not only create a more abundant learning environment but they also protect the story technician. Stories that are sophisticated and purposeful can be used and reused because they have been so skilfully woven that they both endure and can speak to multiple and very different audiences.

The story plots are never completely discreet *nor* completely whole and many individual stories wind around several plot lines or narrative archetypes. These are generous stories. They allow for personal testament but also enable story to be used in many other creative ways. Story can be oral fiction often used to draw important truths unable to be reached with reality account alone. Story enables colourful word pictures, prophesy, illumination through playing with language, metaphor, improvisation, traditional myths, legends and fairytales, caricature, pithy anecdotes, role-playing and different forms of humour.

Science, economics and story

The dramatic potential of story has been captured by business (Gotshall J. 2014; Girard J. 2014; Sole D. 2014; Reidl M., 2010; Buchanan D. 2007, Yannia G 2008). Less burdened by traditions of "science", business thinkers and academics have explored the use of story with some enthusiasm. They have an authority to do so that accompanies their status and thus a freedom to explore the potential of story to teach in ways mental health consumers have not. Whilst consumers are captive

Context

to the history of the bio-medical model of healing in which their endeavour sits:



This scientific prism of evidence-based authority is represented as a triangle of assumed inferior rising to assumed superior forms of knowledge (Oxford Centre for Evidence-based Medicine). Stories, in the green sphere or even one rung below, are not considered important ways of knowing in medicine nor in mainstream culture. Furthermore, consumers who overtly use story to transfer knowledge may have more hurdles to jump to be accepted as valued educators than consumers who can claim academic excellence, rhetorical acceptability and a convincing didactic logic to explain all things. In reality, a combination is always used to interpret and teach.

Several writers argue that stories have entered the market place (Costa et. al. 2012 :99; Beresford P. 2007). This suggests that story has become a commodity for sale and that the necessity to tell stories that are in demand reduces the capacity for story to fulfil a charter to 'bring down oppressive forces of social control' (Poole J. et.al. 2012; Morrison 2006; Canning C. 2006; Stastny P. & Lehmann, P. (Eds.) 2007; Cresswell M. 2005;

Grey F. 2012). Consumers at the more radical end of the consumer/survivor continuum aim their guns at story as a technique as well as critiquing the lack of critical content.

However, many oppressed groups have taken up the medium of story. The potential power of story is understood intersectorially across diverse (and sometimes competing) areas of disadvantage. Despite challenges of emphasis and ownership, it has potential to be creative as well as reactive; dramatic as well as testament; group-owned as well as individually accounting; real time or reflecting on the past.

People often begin to collectively claw back social regard by individuals refusing to be silent. This includes those fighting sexism, racism, heterosexism, body image prejudice and discrimination (Nguyen B.2011; Kasardo A. 2009; First Do No Harm: Real Stories of Fat Prejudice (2013); MacDonald J. (2008); Atkins C (2010); Rice C. (2006), Lucero, S et al (2014) MacDonald J E. (2008) Kumashiro K. (2004). (Terrorism Survivors Storytelling Project: Freire P (1970); c4c Torture Project (2014); Hovey, R.B. & Amir N. (2013); Hunter D. (2013). Story is valued by many as part of a collective cache of resources for change.

Techniques of using story have been co-opted along with the content of the stories; for example Salmon (2010) argues that story telling has been captured by the powerful in both politics and in the economy, used to manipulate ordinary people and processes by utilising the public's need to identify with a story. Salmon notes that this intentionally abuses power, rendering the innocence of story as benign. Razack (2007) talks about people 'stealing others' pain' through story.

In addition the words 'story' and 'storying' have been used and misused. Whilst the Heroic

Survivor narrative is a central tenet of radical social change movements (Morrison, L. 2006; Canning M. 2006; Grey F. 2012), is a very different from narratives co-opted by the business sector. In business the main reason for storying is as a motivation tool: more sales, more contracts, better message control, more efficient workforce, better numbers, bigger profits, staff working harder, selling more, capturing new markets, thinking outside the box and any number of metaphors for business success (Gotshall J. 2014; Girand J. 2014; Sole D. 2014; Reidl M. 2010; Buchanan D. 2007).

Consumers have a radically different agenda but it is testimony to the utility of story. Skilled, story can enlighten clinicians and students about their political agency. Thus the practice of story can engender powerful and potentially regenerative sector as well as personal change.

In any setting consumers who use story also have much to learn from First Nation story traditions where story-method is widely accepted even by medical science as not only valuable but essential (Williamson, J 2007; Yunkaporta T. 2009). Why, therefore, is it not acceptable for mental health consumers? First nations' stories are about ancient meanings meeting and in the context of a recent history of oppression and conflict. This is a very familiar archetype for contemporary consumer experiences (Chamberlin J. 1997; Morrison L. 2006; Holley L. 2012; Wilson, 2000; Beresford P. 2000). The reluctance of the more radical end of the consumer movement, sometimes described as survivor movement, to embrace story as a method is interesting in light of this.

Traditions of story emanate from pre-industrial Europe as ways of sharing wisdom. Handed down from generation to generation, they provide us with an historical tradition that is important to preserve and pass on. Thus stories can never belong solely to individuals. Remarkably they resonate with others. They become cultural truths. Traditions of epochal storylines that repeat through time are central to our collective and multigenerational knowledge. (Thyl Ulenspiegel; The Bible; Gilgamesh; ANZAC; 1066; Captain Cook)

Story and social science

Narrative has become a distinct discipline as defined by Tzvetan Todorov 1969) and his academic disciples (Kindt T.3003; Meister J. 2003) as narratology. It is argued, however, that this is an attempt to capture stories and make them more palatable and scientific. This trend would please many in the *mental illness industry*.

However Ricoeur, (Time and Narrative,!984) introduced the term "narrative turn" (or, return to story) in social science and other humanistic studies. He suggests that the positivistic and reductionist illusions of clear causality, linearity and objectivity [scientism] do not explain the complexity of social and personal realities. He argues that since the widening of the phenomenological understanding of social reality and the post-modernist rejection of simple, purely psychological explanations something much more, sensitive, nuanced and tentative has emerged. [including the re-honouring of story as *real* rather than simply perceived knowledge]. (Gergen K. 2009; Czarniawska B. 2004).

Story and politics

Writers from various medical disciplines recognise that story does not sit above politics but resides within it (Poole J.2012; Costa L. 2012).

Costa (2012:99) states that stories "...have suddenly been understood as useful by dominant hegemonic orders and incorporated into neo liberalist mental health agendas in order to support and sustain the validity of health service systems", and need to be protected. Shee argues that cultural awareness training for those who teach with story is not enough. Does this highlight a shortfall in the training of consumers who use story techniques or that story itself is a fatally flawed mechanism for radical, or for that matter, incremental change?

Even those clinicians and academics who believe they are teaching anti-oppressive studies reproduce the content of consumer stories and appropriate their knowledge and experiences; Beresford (2000) and Wolframe comment on the lack of intersection and combined politics of oppression, where mad stories are not informed by:

...other forms of oppression which we might not have experienced. Sexism, racism, heterosexism, cissexism, ableism, ageism and classism have an impact not only on many mad people, but many of our allies and potential allies as well." (Wolframe P. 2013:14)

Authors writing from within the dominant discipline refer to this politico-social reality:

"Another way to emphasise the outsider's perspective involves how....medical schools, hospitals and clinical role models both enable and constrain their learning and moral

development. Such an account might assist them to make better sense of where they find themselves in the medical system, so that, for example, they have ways to explain their failure to 'speak out' against unethical or inhumane treatment of patients (Braunack-Mayer A. 2011:4).

This could be achieved by utilising politically aware story techniques.

"...personal narratives are always dialogic in that individual subjectiveness contains a multiplicity of other historically and culturally situated voices, which are more or less resorted [to] or embraced at the level of personal story" (Grant A. 2012:846).

Stories are told both overtly and covertly. And others can misconstrue them. Bakhtin in *The Dialogical Imagination* (1975), discusses the primacy of context in the construction and reconstruction of meaning. The context is created in a dialectical moment where the exchange of meaning takes place - 'an utterance' takes place. In his understanding of 'utterance', Bakhtin describes that interaction where one person appropriates the words of another and... "populates them with one's own intentions" (Holquist M. 2004).

Bakhtin argues that individual people cannot be completely understood, known or labelled. He suggests that it is possible to treat people as if they are known, introducing the concept: 'unfinalizable' - that a storyteller can never explain to the audience comprehensively. And even if their story includes almost everything about them, the audience still wouldn't know them. He is concerned, however, that the audience may believe they **do** know and the

transference of knowledge is dependent on that belief. In this sense the act of using personal testament is risky.

Some stories emerge as belonging to outcast groups and remain the story of the other. The "other" is a concept first coined by the philosopher Georg Hegel. The practice of othering leads to a polarization of people into two groups: An **us** group (the in-group) which normally includes the proponent of an idea, and his or her intended audience, and a **them** group (the out-group) who are the people used as objects of derision or mistrust. The idea of 'otherness' is central to sociologists' understanding of how majority and minority identities are constructed. Those who are understood to be 'other' represent groups who are controlled by those that have greater political power. For example:

"Woman is the other of man, animal is the other of human, stranger is the other of native, abnormality the other of norm, deviation the other of law-abiding, illness the other of health, insanity the other of reason, lay public the other of the expert, foreigner the other of state subject, enemy the other of friend" (Bauman 1991: 8).

Rather than talking about the individual characteristics or personalities of different people this analysis reflects on the way individuals and groups establish social categories such as cultural, ability, gender, class and other identities. These shape our ideas about who we think we are, how we want to be seen by others, and where we belong.

Sociologists, radical economists and other critical theorists have critiqued using story as neo-liberal and an excuse for social control and oppression (Salmon C. 2010). Some of this critique has

been a response to what Salmon describes as an explosion of storytelling particularly in the US and particularly in relation to business. It can be seen as a 'weapon of oppression'.

Preparing consumers to use story in the most effective way is for all stories to be understood, in part at least, as opposing the oppressive narrative of social control, deviance control, economic determinism and all that politically justifies inequality (Beresford P. 2007). Consumers who use story can retell incidents of bad (or good) practice in such a way that hooks into a larger political framework. In such situations their narratives are more plausible if they are experienced, prepared, sophisticated and political, presenting content as well as process.

Story, community and culture

"...experts by experience" have something very important to teach. One of the main lessons is around the struggle between personal and cultural meanings. Invariably, mental health users and survivors must negotiate spaces between lay and professional discourses... the struggle is therefore personal, relational, cultural and political." (Grant 2012: 847)

Beyond the relationships found amongst consumers, it is important to locate consumer narratives within mainstream culture, contextualising the message and selection of a story, the way it is told, its perspectives and conclusions.

All stories are born of a particular discourse and cultural life. Inevitably a cultural product, storytelling, with all its caveats, becomes a significant way to ensure that consumer and survivor culture is preserved and broadcasted.

Consumer storytellers can weave multiple stories intricately; however, these may not be culturally translated into meaningful mainstream understandings (Grey F. 2014). To do this successfully depends on the institutional power of competing meanings. Consumers can also be culture carriers (Wadsworth Y. 2001), deliberately or subconsciously, taking a critical consumer perspective (Grey F. 2011) and disseminating it, rescripting dominant narratives along the way. Stories, whether they are those of mad people or any other oppressed group, offer (Understanding and Involvement (U&I) 1994) new ways to understand society. Consumer stories challenge larger social messages including a modern Western cultural response to madness: a mental illness industry (O'Hagan M. 1994).

Ways of Silencing

Media portrayals

Susan Sontag (1978) famously drew attention to the larger narratives in medicine that held the victim responsible for their own ill health. Her critique drew heavily on the role of story in the public media - selling non-facts, exaggerations and judgements to ordinary people, particularly people with cancer (and later HIV AIDS). In her gaze were mystical healers, wonder curers, gurus and other 'non-qualified' purveyors of stories about people's health. As Clow writes of Sontag:

"She believed that wrapping disease in metaphors discouraged, silenced, and shamed patients." (Clow B. 2001: 293)

Her analysis of misuse of story is sound but her solution, which was straight from the dominant discourse, may not be. As Clow (2001) points out, the story can be used in multiple ways and Sontag's analysis was problematic.

"Other writers disagree with her (Sontag) saying that metaphors and other symbolic language helps affected people form meaning out of their experiences." (Clow B. 2001: 294)

Following the publication of '*Illness as Metaphor*' (Sontag S. 1978), western medicine has become single minded, confident, sceptical, cynical and ever more vigilant about denouncing experiential wisdom (Grey F. 2014), particularly aiming at the least scientific which is seen as anecdotal, 'just story' and, at best, the metaphor Sontag condemned.

Spurious scientific claims can instantly come to life on social media; however, the conflation between stories-that-make-profits, cook-up-weird remedies or that-sell-products to desperately sick

people are perhaps different in intent and form to 'insider' stories about health.

The traditional mass media has a problematic relationship with consumers. Invariably there are two groups of consumers who participate, prejudice is mediated through privilege. The first group is very small and includes consumers who, may for a variety of reasons (social capital, class, education, senior positions in consumer organisations etc.) are enabled to comment on service provision, mental health policy, legal matters, mental health law and so on. Whether members of this class of consumers project their personal story privilege seems to give them licence to talk for and about others. Mostly they defend this with claims of representation rather than acknowledgement of personal power. This dignity is afforded few. Most consumers seen in the media are there only to tell their story and be *brave* (see section on the military metaphor). They are at the mercy of editorial decision-makers. This can be catastrophic when consumers' need to be heard leads them into a trap.

The electronic age has brought greater democracy. Blogs and other forms of communication enable all consumers, who have and understand this technology, to comment. This empowers and enables many consumers but terrifies those who profess orthodox authority; both members of the medical establishment and some consumers (Epstein M & Grey F. 2011:48).

Not representative

One way of silencing storytellers is to accuse consumers who tell stories of not being representative. (Happell B. 2013; The Health Foundation 2010; Fadden G. 2005)

"Patients who teach are unrepresentative of the majority of patients, because they have by definition an interest in becoming involved in insuring that others have what they regard as good treatment from health professionals" (Livingston G. 2014 p. 3)

There is a good argument that consumers can never be representative and should not be asked to be so. (Happell B & Roper C. 2006; Happell B. 2013; Grant A.2012; The Health Foundation, 2010; Terry J.2012). Happell B & Roper C. 2006); a better concept being the idea of consumer leadership.

Consumers, sometimes in partnership with clinicians and clinical academics, (Epstein 2005; Grey F. et.al. 2011; Bennetts W. 2013; Happell B. & Roper C. 2006) have proffered arguments as to why the cry for representation is simplistic. Epstein (2005) suggests that representation without the means to actually represent is flawed. Resources, time, technological competence and an income are needed to even approximate representation of a diverse constituency: economically, educationally, geographically, diagnostical/experientially and culturally. Often without organisation and little social and economic capital, representation (including tokenistic representation) is impossible.

Further, too often the action of representation is interpreted as the expertise in and of itself rather than others appreciating consumer knowledge, wisdom, experience and areas of specialty as their contribution. This idea of 'expert in representation' is rarely expected of others involved in education. Their expertise lies in the sanctity of their knowledge, name and status in the sector. Rarely is their representativeness called into question. Meehan and Glover argue

that in order to be seen as expert (and therefore not a representative), consumers are required to divulge aspects of their personal life that other educators are not required to divulge (Meehan T. & Glover H. 2007).

Bennetts argues that no consumer can speak for everyone and that different people and different organisations have very different ideas about what constitutes representation. Little thought, however, is given to exploring what representation might mean in practice. She suggests that representation is applied very loosely and sometimes as a "snap solution to the task of trying to get learned heads around the concepts of consumer participation and leadership" (Bennetts W. 2013). Raising ethical issues, she questions whether consumers should even seek to represent and notes that speaking for other consumers silences their voices.

The difference between representation as a key concept for committee membership and for jobs allocated specifically for consumers, for example, as compared to consumer representation in the role of story-using educators is that in the latter it is the story that is expected to represent the consumer experience. What is deemed to be that particular experience is dependent on the political framework. The choice of content, by virtue of the course structure and/or the choices made by the individual consumer educator, is never culturally or politically neutral, as discussed previously. Interestingly two groups identify a lack of representation: those who adhere to the dominant medical narrative and supporters of the Heroic survivor narrative (Morrison L. 2006). Thus the question of who is setting the agenda by which the lack of representation is being judged is a reasonable one.

The specialist - universal dichotomy

The critique questioning the validity of the consumer story continues. One body of literature critiques the clinical stereotype of active consumers only pushing their own agenda or having an axe to grind (Happell B. 2013; Livingston G. 2014; The Health Foundation 2010:25). That clinical educators nearly all have areas of speciality interest and expertise is rarely considered when consumer representation is critiqued.

Clinical specialisation emerges from experience and so does consumer specialisation. It also comes from passion, fascination, anger, relationships, hurts, acts of kindness, ambition, bad practice, practice experience, excitement and inspirational others (Lowenstein, G. 1994). By saying consumers have only personal experience and no expertise and that "others" have all expertise and no personal experience is to diminish the value of both.

Consumers who use story are somehow expected to tell the universal story, or, at least, stories strongly adhered to the various counter-narratives rather than being specialists who just happen to use the skills and techniques of story. Much of the consumer work around specialist expertise or leadership pits critical consumer perspective/ body of knowledge as separate from and different to story. This is conflating content with process. Using story form is a process issue. Critical content is imperative for all consumers who wish to inform debate regardless of preferred method.

Other critics identify the rise of the professional patient (McGarry J. 2004:38) and call for a solution by operating through local organisations to locate grass root experiences i.e. *real people* with

non-politicised stories of *real practice* (Fadden G. 2005). *Ourcommunity* is concerned that this reductionist, non-politicised, individual story as invited to be told further individualises and glamorises the powerless perhaps in the same way that stories of anti-psychiatry heroes are being glamorised by survivors. The scripts are poles apart and yet, to some extent at least, they share some parts of the same narrative and disquiet about the use of personal story and, perhaps, the surprises and challenges to belief and rhetoric these might bring (Costa L. 2012; McGarry J. 2004; Fadden G. 2004).

Attempts are made to juggle the competing discourses in relation to many stories, silencing many storytellers with only a relatively few continuing to tell them.

"This makes sense particularly if we think about the image people might have of a 'real consumer' or a 'typical consumer' - in reality consumers are extremely diverse and complex, with all sorts of different opinions and life experiences, which can change over time ...if we ignore this diversity and complexity, acting as if 'consumers' are a clear-cut, homogeneous or easily represented category then we are misrepresenting consumers." (Grey F. 2014)

Grey notes that this massive complexity of the consumer voice doesn't mean that consumers cannot speak but it "pushes us to be more transparent in how we are presenting our understanding." (Grey F. 2014) This is an argument about diversity and generalisation rather than representation, however as Morrison argues:

"The consumer/survivor/ex-patient voice is not a singularity, and neither are any of the lexical parts." (Morrison L. 2006: 4)

Although there is an echo of critique in the survivor writings about storytelling, it does not offer an analysis of story method per se. It is a criticism of the way personal account is used and its content (Beresford P. 2000, Morrison L. 2006, Costa L. 2012). Perhaps this is an argument for better, consumer-run, education and training for consumer educators. Such training should include: how to tell story in the context of a willingness to do so; how to not generalise unless under specific conditions and for a justifiable educational purpose (Morrison L. 2006); perhaps how to tell story that is a counter-narrative to the dominant consumer narratives (and has to be said louder in order to be heard).

No matter whether individual consumers deliberately use story as a method, all consumer educators tell story and have a narrative script. Some deliberately dress up and some dress down. Some present as scholarly, some worldly, some pragmatically. Some feel the need to validate - deliberately trying to be seen as a "real", with serious experiences as compared to a professional activist.

Indeed sometimes consumers feel cornered into telling something of their personal narrative to prove they are "real", have experienced the most awful or are the most vulnerable. Any number of categories is thus used to sift out the genuine from the imposter. This is unfortunate and directly feeds simplistic stereotypes. Many form the basis of media attention. Some of these remain unchallenged by consumer (VMIAC) and advocacy organisations (Victoria Legal Aid, Mental Health Legal Centre) and are to some extent coopted by the dominant narrative of most need in order to secure funding. Some influential consumer groups promote the

stories from those they identify as real, vulnerable, non-elitist, public and community sector clients in order to stay viable in a competitive sector. Labels such as: serious mental illness, the most vulnerable, high and low functioning consumer, just the worried well and genuine illness may be bureaucratic sleights of hand (Olsen 2007; Epstein 2012) but "Within this model of consumer leadership, the issue of ensuring that the voice of all consumers is heard by mental health services becomes the responsibility of all leaders, not merely that of those consumers who choose to participate" (Happell B. & Roper C. 2006)

On the other hand, stories told by famous people seem to get public airplay anyway particularly through organisations like beyondblue that script these encounters into their business plan. Very often these fit well with the organisation's mantra about a difficult but eventually triumphant ascent from hell, medical solutions, dogged determination, discipline and inspirational ambassadorship. Even the stories of everyday people seem to get airplay when they ascribe to this heroic scenario.

Which stories get heard depends on which are acceptable to tell. In an area of medical and public hypersensitivity, there is censure because of the fear of any number of negative consequence from copycat suicides to non-medical temptations. Which stories we believe are not being heard depends also on what we want to hear. There are many different ways of being silenced and consumers have different beliefs about which groups are 'in' and which are 'out'. The usual social issues of gender, class, race, ethnicity and education, for example, are powerfully important. Stories about childhood trauma and abuse, family

violence, sexual assault, torture, statelessness, dispossession... often sit in disputed territory. Over the last thirty years, stories of mental distress have changed as the area of mental health has redefined itself as a place for *illness*, *illness recovery* and *illness services* stories. The sigma remains, so complex stories about the relational boundaries and interrelatedness of, for example, family violence and mental health don't get told as people avoid being defined as mentally ill.

Not of high enough standard

In using story for educating clinicians, maintaining standards is a consumer imperative and responsibility. These standards may differ depending on the assumptions of others. When uninitiated clinical educators, for example, use criteria that suit their political agenda there is a problem.

"We do not agree that skill in either form or content is irrelevant. Clearly, all teachers have to be able to communicate or nothing is learned. If content is inaccurate, it can be misleading: if it is extremely negative, students may be left feeling hopeless rather than with increased sensitivity or understanding. The next stage in development of this form of teaching should be training and quality control." (Livingston G. 2014:9)

Crucial standards considered by Fadden include confidentiality (of clinicians), insensitivity towards clinicians, or overgeneralising - for example "...talking about the poor communication skills of psychiatrists" (Fadden G. 2005:274). Reference is made to the fact that..."Universities are now required to ensure that teaching is of an appropriate standard, that there is feedback to students, which is acted upon, as well as peer review" (Livingston G. 2014:3).

The assumption that clinical educators in medicine actually have superior andragogical skills is interesting and needs to be tested.

Often, existing standards are unquestioning and based on absolutist concepts of an evidence-base, in stark contrast to the demands for quality from the more radical end of the survivor movement, (Morrison L.2006; Costa L.2012). Indeed, there is a fundamental disunite in relation to the objectives of sound education specifically referring to consumers who use personal account.

The above comments could be interpreted as pompous, but perhaps both the question of standards and the question or representation and generalisation are more complex than this.

A small pool of active consumers is not ideal. A register of consumer educators, including story using experts (similar to the National Register of Mental Health Consumers and Carers: Mental Health Australia), run by an effective consumer organisation would be useful. Information on areas of specialisation, preferred methods of teaching, type of storytelling techniques used (if using story is a preferred approach), topics covered, experience, references, fees etc. This will assist to convey the message that consumers are expert educators. Three caveats persist:

- enthusiasm and integrity must be applied, the register must be promoted and updated regularly to maintain currency
- it must be accessible and open to all consumers to register, guided when necessary in how to make a case to promote their potential contribution
- anti-hegemonic training in narrative, story and other teaching techniques and capability building opportunities must be provided.

Some consumer commentators suggest however, that user/survivor/consumer groups themselves implicitly (and sometimes explicitly) discriminate against people in certain categories and that that would be reflected in any training and the discrimination would simply be amplified.

For example, Kalikhat (2004) is a service user (consumer) educator in Britain. A black woman with a diagnosis of Borderline Personality Disorder, she observes that the depth of oppression she experiences because she is black, a woman and has a mental illness is significant both in society and in the black community. However she explains that the oppression she experiences in the user (consumer) movement because she has a personality disorder is greater than those mentioned before (2004:27).

Token voices

"It is important that the rationale for consumer involvement is continually highlighted and understood by all mental health professionals ... so as to discourage the practice of including consumers solely for the sake of adhering to political policies" (Gordon S. 2005: 363).

One of the ways to address a lack of representation (Grant A. 2012) is to compile a variety of stories ensuring known minorities are heard. This brings diversity (National Mental Health Consumer and Carer Forum; 2014). However, often diversity is assumed to be only cultural or linguistic. Rarely are consumer storytellers from the mad and queer community (Nguyen B. 2014; Aguinaldo J. 2008), remembering that it is as tokenistic to simply locate someone in the mad community who

just happens to be queer as to find someone in the queer community who just happens to be mad. A body of knowledge is key. Similar concerns exist around fat pride, drug and alcohol, crime and, of course, Aboriginal people. If these diverse groups are considered, it is hard to locate a willing participant, so experienced consumer educators speak pretending to do so on their behalf. Attempts made to make contact with diverse groups often stop with decision makers who claim they have licence to speak rather than consumers. For some, the concept of consumer/user/survivor/person with lived experience makes no sense culturally. They may do their weaving of story in a completely different way and a more holistic context.

It is potentially dangerous to plan a course around one story from **this group** and one of from that category and an Aborigine; thinking this is the way to include. (Wadsworth Y. 2001). It should not be the purpose to ensure inclusion of all groups and categories by individual storytellers. It is fake democracy and diminishes stories, killing off the relational and collective. It can result in putting forward a woman educator who can co-tell stories that are conveniently also about her lesbian experiences, living in rural and regional regions and Muslim... with an expectation that she can tell stories that will cover all the people who usually get left out. This is tokenism. (Epstein M. & Grey F. 2015) Furthermore, if people do not emerge organically from consumer political and social traditions (Wadsworth Y. 2001), it is difficult to ascertain whether they understand the critical consumer perspective, the consumer body of knowledge and important contextual parameters that all disciplines and consumers need to know (Epstein M. and Grey F. (2012).

Speaking from the inside or outside

As part of understanding the role of narrative in the education of mental health clinicians, it's important to know where the narrators' voice is positioned (Grey F. 2011). Most consumers and some commentators (Remen, R. 2006) understand the mental health consumer as central to the story of psychiatry. As Wadsworth's terminology, 'Critical Reference Group' (Wadsworth Y. 2011) acknowledges, consumers are critically important. Without them the enterprise is pointless. Therefore, consumers often describe themselves as insiders and their stories as insider stories. The hesitation is only that implicit to this way of understanding can be an assumption that consumers "in the middle" are seen to lack agency - to be vulnerable to having things done *on* you or *to* you rather than *with* you (Wadsworth Y. 2001; Epstein M. 2011).

In the literature, there is evidence that *some* professional groups understand themselves to be in the middle and consumer/survivor stories are useful only to guide. They see consumers as outside the business of psychiatry (Grey F. 2011).

"One strategy to address an individualist bias in medical education ...involves giving the users of medical services the opportunity to be teachers ...Approaches such as these that focus experiences at the micro-analytical level of being a patient help students to take on outsider's view of medical work." (The Health Foundation, 2010)

This is an important distinction for story. Consumers believe themselves to be the narrators, the protagonists of their own stories. This is central to their message. However, if the audience are taught or simply understand or suppose that the consumer is the 'other' coming in to share with them they will take away from the interaction a very different message than the consumer intended.

Narratives

The dominant bio-medical voice

This is the most powerful narrative that silences consumer voices. The dominant medical narrative is that science and, therefore, medical science, is all knowing, impartial, non-angry nor vengeful, safe, fatherly, benign and beneficent - will work out the most difficult of puzzles given the money and resources to do so. This is a story that is repeated over and over and is sometimes reified into fact.

"People who are physicians have been trained to believe that it is scientific objectivity that makes them most effective in their efforts to understand and resolve the pain that others bring them, and mental distance that protects them from becoming wounded from the difficult work" (Remen R. 2006: 42).

Two sub-plots of this dominant story are the dominant research paradigm in medicine which privileges reductive over experiential evidence, ignoring "...power relations and context..." (Morris P. 2014:1) and a dominant community view that it is the community and stigma that affects a person's recovery from mental ill health or crisis, ignoring the oppression that occurs within services and by dominant medical structures. Stigma is perhaps an inadequate concept for understanding oppression (Grey, F. 2011; Holley L. 2012). It is relatively easy for mental health professionals to dismiss stigma as not concerning them. Radden, a psychiatrist, argues that although consumers using story have a valid role in challenging the dominant narrative, this needs to be a negotiated challenge:

"First person accounts of psychiatric diagnosis and mental health care (shown here to represent 'counter stories' to the powerful master narrative of bio medical psychiatry) offer indications about how experiences of

mental disorder might be framed and redefined as parts of efforts to acknowledge and honour recognition rights and epistemic justice. However the task of cultural semantics is one for the entire culture, not merely consumers. These new meanings must be negotiated, group-wrought definitions risk imposing a revision no less constraining than the mis-recognised one it aims to replace. (Radden H: 2012:6)

Consumers the enemy: the military metaphor

The second most dominant metaphor about illness in contemporary western society is a military metaphor (Penson R. 2014:714). As communities, we are invited to be active players in a 'war on breast cancer', 'war on obesity', 'war on diseases that could be prevented', 'war on mental illness' and so on. Community awareness campaigns (Grey, F., 2012) engaging the war metaphor frequently find themselves caught up in a derisive public story where the carriers of the 'illness' become the enemy.

A corollary of this metaphor is the idea that consumers who tell their story, who speak publicly at all, are war heroes. In the most recent 'mental-as' ABC contribution to Mental Health Week (October 2015), nearly every person who spoke out was described as 'brave'. Many consumers are diminished by such caricatures (Epstein M & Grey F. 2011:45). Bravery is a war metaphor that re-casts the consumer as engaged in a fight against the dominant 'other'. It is reductive and lazy because it protects the passive listener from having to take action. It is people without mental illness who must fight their own and others' fears.

Counter narratives

Dominant narratives are important because it could be argued that it is the role of consumers in all settings, including the education of clinicians, to offer counter-narratives. (Eriksson E. 2013; Costa L. 2012) Therefore it is crucial to provide, through the use of story, a different panorama of possible ways of looking at things. This could be either through sophisticated use of story tools such as metaphor, legend, role play, songs, dance, humour or experiments with different personal stories or it could be through heuristic anti-hegemonic accounts of clinical practice - also through story as a style if it suits.

This counter-narrative work is about drawing attention to contradictions, complacency - non-questioning acceptance, discrimination, creating idea silos, language judgements, and power accepting ways of being within the dominant narrative. By offering counter stories of stark disposition and not filling in the spaces, for example, students are left deprived of ready answers. This is educational and utilising a story-using strategy. (Peavey F. 2012; Costa L 2012) Another strategy is to present, through story, alternatives that students hadn't thought of before and easing them into working out, for themselves, why the difference between: what is and what ought to be (Wadsworth 2011) is so stark? Coulter discusses this as the 'Pedagogy of Discomfort' (Coulter S.2012).

Dominant stories of consumers/ survivors

Beyond the dominant narratives of medicine there are other important stories that to a greater or lesser extent, publicly or privately, paid or unpaid

all consumers tell. None of these narratives and counter-narratives is wholly coherent or wholly complete. All people, groups and cultures can move from narrative to counter narrative and from one counter narrative to another. For example, the strong counter narrative of recovery can, for some people but not all, slip easily into the counter hegemonic narrative of the heroic survivor (known as narrative slip). Some people feel intimidated and judged by those who may appear as zealots for a particular narrative to which they know they can't and won't belong.

Counter narratives are not wholly benevolent or heroic. Consumers may feel that the way they are presented in certain narratives is hurtful, others may perceive they are captured by a narrative that is not theirs. However these narratives, most certainly, are not representative. Consumer stories form part of a larger narrative but these are not epic scripts to which our personal journeys must always adhere.

Service user voice

The service user narrative sometimes described as the consumer narrative and is distinguished by some from the survivor narrative (Duerr M. 1996:83). Eriksson systematically studied the consumer narrative told by 10 local [grassroots] service users. He describes this narrative as holding an "inherent power asymmetry":

"This is a relationship of control that supports the dominant order. Thus, in the context in which narrators tell their stories they have done so from a structurally subordinate position." (Eriksson E. 2013:4)

Eriksson dissects the stories of these service users as they are used to educate staff. He found

little evidence of any emancipatory dimensions i.e. resistance to oppression, challenge of dominant discourses or counter narratives. In these classical stories or feedback narratives, Eriksson found three common sub-narratives: (2013:14)

- the users' narrative, which concentrated on the narrator's ill health - the story of what is wrong with me. Used to create sympathy for the narrator, it focuses on her or him and creates possibilities for empathy
- a focus on services, sometimes called care, with critique of bad practice, asking why the organisation wasn't providing the universal good described in its dominant motif. Eriksson notes that consumers - more radical survivors, would use terms such as: wrong, illegal, violation, and excessive force. However these storytellers weave their story very differently because they aim to be believable (I'm just like you) and fulfil their duty to be a role model - preventing fundamental criticism of the service, " ...rather they curtailed their critique to fit the hidden agenda of their situation."
- a regular life story - ie I'm just like you really, where storytellers beseech others to recognise a shared humanity. Ordinary life is evoked with an emphasis on "...personal responsibility (role model) with stories about strategies I have learnt and stories of really good and/or exceptional practice" (2013:16). This part of the narrative is infused with the hope narrative, to restore faith in services and institutions.

However, when such stories take place outside a concomitant analysis of power arrangements,

social structures and cultural expectations (Poole J.2012) they become "oriented towards the norms of the cultural life script" (Eriksson E. 2013: 17). This allows storytellers to reconceptualise themselves as -human beings and moral subjects, but silences them from theorising their own lives when they haven't been just like everyone else. Eriksson's analysis showed service users then describing their mental condition as the reason for their deviance.

"Service user narrative contains some aspect of a counter narrative of biomedical science. However there were times when user stories actually ran very close to the institutional master narrative which is about a good, genuinely caring... mental health service system." (Eriksson E. 2013:17).

Most story users in Eriksson's study nevertheless held firmly to...

"a belief in professional, clinical authority and knowledge, the canonical diagnostic system as presented by the DSMIV and conventional, clinically proven evidence-based ways of conducting care and therapy more often than not remained unchallenged" (Eriksson E. 2013:17).

This is not a 'test' of story as a pedagogical tool as much as a reminder that personal story is a limited narrative and not the only one. Although Eriksson's detailed analysis offers insight into both the limitations and promise of this method of consumer work it is important to remember Eriksson was also critical of the training received by these local trainers especially where people were asked to be role models for people with mental illness (Eriksson E. 2013:11).

I'm just like you, I'm the best of us (role model) story; and I deserve this service

Given both the local nature of the storytellers in Eriksson's study and their concomitant and assumed role model status and their training by a service from which they receive services one would presume that there would be some pressure on them to protect local services, a role that would impact on the content of their story and how they tell it.

Perhaps this suggests that it may not be ignorance that stops grassroots consumers from talking about the larger social, cultural and political forces but rather much more pragmatic agenda. Many people need to feel that if they are good people they need to belong somewhere, even if it is to a service. They feel the need to demonstrate that they are only utilising resources they deserve and that they are gallant in receipt of what can be seen as a service privilege. In order to do this, the service, with some caveats must be projected in a good light. Without this the need to belong makes no immediately understandable sense (Eriksson E. 2013).

In an early attempt of the Australian Government to run an anti-stigma campaign the jingle was, "Mental Illness is just like diabetes." Bernie McCormick, a consumer who never uses personal life story, does use a pretty good quip declaring his dispair for this campaign. In training session he often postulates: "*Diabetes is just like any other illness. Why, it's just like having Schizophrenia!*" Now, this is a good story, counter-dominant story, albeit a short one.

Coached narratives - hope and recovery

Once I was sick and then I was found (hope) or once I was stuck in an illness and now I have found my life again' (recovery) narratives are popular themes. Although very similar in structure they are found in different places and have different messages. Nonetheless, they remain similar. The latter is more common in clinical education (Gordon S. 2014), the former in community awareness campaigns and community organisation publicity and propaganda (Grey F. 2011). There is some evidence that consumers can be coached or encouraged to construct their story around these typologies with the former being the narrative of hope.

"Initially I wanted to educate people about mental illness but I have developed a great deal of confidence in public speaking and a reassurance of the validity of my life story. In each presentation I hope to change one person's view of mental illness. If I can help one person, I've made a difference and that's all I want."

(Nathan, MIND Newsletter Summer 2012/13)

If the former is the narrative of hope the latter is the narrative of recovery:

"Recovery is a hard journey but every time you say: "no thank you" to all the negatives you are saying: "yes please" to life.

(Writemind, MIND Summer 2012)

There is a question around the authenticity of such stories that are framed, and often coached, to fit a message rather than the other way around.

"Here we seek to explore how resignification of language such as 'resilience' and 'recovery', as told through clients' accounts, as a means by which mental health systems have been able to absorb resistance accounts, sanitise them, and carry them forward in ways that are useful for them, without disrupting their dominant practices." (Costa L. et al 2012: 87)

The success story

There is tension in a narrative about *what works?* Clinical educators believe that stories should all be about what works. Educators are uncomfortable with stories that concentrate on bad things that happen to people in services (Livingston G. 2004). Consumers are advised that their audience will switch off to the negative and only learn from positive stories (Fadden G. 2005). No evidence could be found to suggest that this is the case although the Understanding and Involvement project (U&I, 2001) identified a complex phenomenon that clinicians (even the best ones) are eventually demoralised by consumers who repeat and repeat stories of appalling practice until they felt heard by people they had constructed as 'others' (Wadsworth Y. 2001; Epstein M. & Wadsworth Y. 1994).

Unfortunately, the only clinicians who were eagerly listening were far from others (Grey F. 2011). Indeed, others who had already turned off and released from even attempting to learn. Wadsworth and Epstein provide some evidence that consumers **do** need to repeat and repeat bad stories, not for cathartic reasons as some have perhaps postulated (Grey 2014) but rather because they want this clinical behaviour that so badly affected them to stop: pragmatically and symbolically. They suggest that some people search for a tacit agreement between

the clinicians and themselves that something important **would** change (Epstein M. & Wadsworth Y. 1994; Wadsworth Y. 2001).

However, there is a mismatch. Even good staff members are eventually silenced by the never-ending critique of damaging clinical language and practice (Wadsworth Y. 2001). This is a tragic reflection of clinical education and practice realities. The final report of the U&I project (2001) comments that the project team, predominantly comprised of consumers, could have protected those staff who were genuinely interested in consumer participation. If the staff had had an opportunity to meet separately together as a peer support group they might have been stronger both individually and collectively to hear ongoing stories of poor clinical practise.

Theories and writing on curiosity (Lowenstein, G.1994] seems to suggest that people are as curious about things that go wrong as they are about things that go right.

A lot more work has to be done in this area. Coaching towards the positive maintains an emphasis on what is, rather than widening to the larger social context. Some consumers who use story methods want to open out possibilities from clinical performance to clinician's appreciation of important issues like power, politics for global change - indeed- changing the world in which psychiatry is constructed (Peavey F. 2013; Burch M 2012).

"People with lived experience' has become a catch-phrase to designate those who speak directly to 'living' lives affected by mental illness. But lives are shaped and constructed by social, political, economic, and cultural realities that necessitate an analysis of inequity." (Costa L. 2012:86)

Perhaps some professionals pull away from this because they choose caring professions to "help the poor other" (Wadsworth; 1996 -1999: Mercy Hospital, unpublished) rather than looking beyond the restrictions of their work. Some stories may frighten people who perceive themselves as not having the institutional power to make things right.

And consumers who desperately want things to be lovely and cocooned are not necessarily good educators (Fraser S.2001) even if it is popular education that feeds back to the storyteller that they are brave, clever, wise and so unlike what 'I thought someone with a 'mental illness' to be'. Everyone needs affirmation, particularly many consumers, but stories perceived as feel-good or wonderfully useful, don't necessarily lead to enlightened practice.

The Heroic Survivor

A now very radicalised narrative it is outlined in detail by Morrison (Morrison L. 2006). As with other narratives there is a suggestion that these story tellers are coached, to encourage them to discuss firstly how obnoxious the service system is and then to outline what people have found works (peer support is a good example) and the heroic attempts that have been made both personally and collectively to tear down the asylum. This narrative includes storytelling about the role of Big Pharma, medical corruption, power and iatrogenesis. (Beresford P. 2000; Costa L. 2012, Canning C.2006) Often anecdotes of personal experience are sprinkled through these narratives. Although highly personal, this is no less a narrative script than those previously mentioned, with the same problems. It leaves little room for the storyteller to deviate from

the dominant story of psychosis, force, trauma, anti-medical and anti-pharmaceutical experiences and new (or re-found old) and better ways to define oneself.

This story is dominant in the psychiatric survivor literature. It invokes protagonists who are leaders of resistance marching towards revolution. These people of valour take on the system in this story. It is also the story that sometimes, but not always, criticises the use of personal statement or narrative as a pedagogic tool (Canning, C. 2006). Costa takes this further, arguing that the business of eliciting stories from consumers for the edification of students (amongst others) is porn:

"By pornographic we mean that while some reveal their most intimate personal details, others achieve relief through passive watching, while still others profit from the collaboration of this on the front lines..." (Costa L. 2012: 86).

Although Morrison argues that the words: consumer and survivor (for example) can be seen as simply labels "just like diagnoses" (2006:3), the narrative she describes has a most likely fit in the radicalised survivor story. Indeed she calls it the 'Heroic Survivor Narrative' and she cites writers associated with this story (Chamberlain, 1978; Shimrat 1997, Funk 1998). Books such as Beyond Bedlam (1995), Shrink Resistant (1998) and Cry of the Invisible (1991) are well known to many consumer activists.

Morrison interviewed survivors active in the consumer/narrative movement and identifies a story plot that she argues moves survivors from trust to politics. She introduces Erving Goffman's idea of a 'betrayal funnel' (Goffman E. 1961) - the process of self-told stories of trust in the benevolence of helping institutions morphing into

stories of the recognition of malevolence - the funnel is symbolic of this (MacSuibhne S. 2011). She applies the following typology to in-depth interviews with 12 consumers:

- 1. Entry to the system** the story of moving from trust to distrust - from belief in the expectation of help to recognition that the system was doing harm
- 2. Disregard for the system** or discrediting personal realities.... "Survivor narratives go to describe the experience of harm being compounded by a disregard for their efforts to define experience, to negotiate the terms of treatment, or to leave the situation." (Morrison L. 2006 :....)
- 3. Resistance Response:** or refusing to cooperate Trying to use trust and reason is not useful if no one is listening:
"The 'master status' of mental patient identity and its discrediting consequences are rejected, with an effort to maintain a positive identity of self. The activists resist the internalisation of deviant identity, and the resultant incorporation of (into) the psychiatric narrative" Ibid
- 4. Solidarity of Shared Oppression**
Talking about oppression and rejecting the word of the dominant narrative: 'stigma'. Fighting so that that which happened to us will never happen to anyone else.
- 5. Politicisation:** This is about going from the personal to the general in political solidarity. Building allegiances with other oppressed groups. Fighting for all.

With examples from these grassroots stories, she argues that they all fit within the above schemata.

This is an analysis of story. As a chronology the interviewees from both the activist and grass roots consumer groups would, presumably, tell a different story at each stage of their trajectory through these story categories. It would be interesting to see if such unqualified admiration would be given to a consumer who made a decision that they wanted to be involved but did not want to engage in such radical critique. Perhaps the word 'heroic' in this context may be a bit disingenuous of other stories both of life and in terms of translation into clinical educational settings.

Some of the survivor and more radical consumer literature however suggests that there is a direct relationship between teaching method and the radicalisation of message (Morrison L.2006; Costa L. 2012; Beresford P. 2000). However, a different conclusion may be drawn -that storytellers are coached around this dominant survivor narrative. There is a hint of "false consciousness" in the criticism of less radical interpretative stories in the work from these writers. Although there is a claim that the 'I don't use story' story actually might mean, 'I don't use my story' (Grey 2014).

Writers choosing the 'heroic survivor script' warn consumers using story not to be gullible or be taken in or controlled because of their need for affirmation or 'to be heard'. They write "... our stories are also a commodity" (Costa L. 2012:86) for which they can make a sound argument and tell us that "...consumers/survivors have been harnessed by mental health organisations to further their interests and in so doing have shifted these narratives from 'agents of change' towards one of 'disability tourism' or 'patient porn'"(Costa L. 2012:85). There may be a strong argument that using personal story is exploitative. However some consumers believe

that to remain free from exploitation they must be anti-everything: labelling, pharmaceutical companies, compulsory treatment and ECT for example. Could consumers 'selling' the heroic narrative also exploit others who are fearful of telling a story that deviates from these self-evident 'truths'?

However, everyone does not see using story as the opposite of radical. Mark Cresswell comes from a radical tradition but he concludes:

"This paper has had a more modest ambition: to demonstrate the significance of testimony as a discursive practice of self-harm survivors; to draw the main historical outline of that movement in a restricted spatio-temporal sense; to sketch the rudiments of a theory of testimony as a political practice - as the always highly-charged activity of what Canadian psychiatric survivors Bonnie Burstow and Don Weitz once referred to as 'speaking true words.' (Cresswell M. mark.cresswell@stud.man.ac.uk)

There are many traditions of storytelling. The most skilled consumer story educators call on the knowledge and skills of many of these traditions as well as on a raft of skills and techniques that can be learned (Rossiter, M. 2014; Wright A. 2009; Rofe T. 2009; Sole D. Davidhizar R., 2003). In the various clinical fields the literature that best emphasises the role of story can be found in the studies around students as tellers of their own stories or clinicians-in-practice using story for reflection and professional growth (Hovey R. 2007; Sorrell J. 2001; Hunter L. 2008; Haigh C. 2011; Bradshaw J. 2005; Bekker H. 2012; Carroll, S. 2010). Although there is more in the literature about clinicians and clinical students as storytellers, this does not necessarily exclude

consumers. Consumer educators may well use story drivers to elicit reflective sharing amongst students.

The other area that would seem to legitimately use story is narrative therapy where 'patients'/clients' are guided through rewriting their own scripts by trained therapists (Feedman J. & Combs G. 1996; Epston D. & White, M. 1995; White M. 1990). There is a legitimacy attached to using story in these learning environments.

In mainstream medicine there are two other ways that story is commonly used. These are in creating 'case studies', 'case examples' even 'case notes'. Medicine turns our stories into 'cases' histories and captures and reinterprets them. We have every right to 'talk back to psychiatry about this theft' (Morrison L. 2005, Epstein M & Grey F. 2011). Sometimes story is the best way to retrieve what might have been lost (Epstein M & Grey F., 2011). Medicine is also quite prepared to admit that experiential story **can** be 'proper', valid and reliable, if it is medical empiricism over which doctors have control. This rather large contradiction passes some by.

Empiricism, in philosophy, the view that all concepts originate in experience, that all concepts are about or applicable to things that can be experienced, or that all rationally acceptable beliefs or propositions are justifiable or knowable only through experience. This broad definition accords with the derivation of the term empiricism from the ancient Greek word empeiria, "experience." (Encyclopedia Britannica)

Personal account

In a mental health context it is often assumed that personal account **is** story. This is unfortunate.

Some people will want to use personal 'I' accounts but many won't. Some experienced educators weave narrative with personal account with metaphor with science with politics and with experiential opportunities prepared for students to use their own stories. This is good education if it is done well.

On the other hand, some consumer educators remain disturbingly outside the consumer movement and resist personal account for the purpose of maintaining power in a prejudicial world. This often locates them totally outside their own connection with their consumer experience except in word and title. Positioning themselves amongst the political elite is ethically problematic. Talking from a position of 'them' and not 'us' troubling.

"Sitting in a room full of relatively new consumer consultants a woman in her thirties was obviously uncomfortable. She wriggled in her seat and eventually put up her hand. "Excuse me", she said to the chairperson. "I'm worried about a conflict of interest. When you talk about us all being consumers I don't feel comfortable. I'm actually a teacher, who has had a mental illness of course." After that a strange thing happened. The person next to her came out as a teacher, and the woman next to her and the one next to her. There was a line of teachers. It was an educative moment for all..... She honestly believed the stereotype of someone with **real** mental illness wasn't her. Thus she had effectively removed herself from the oppressed group. She was flabbergasted."(Epstein M. 2014)

Story is a complex. It is not just the opposite of science and it is certainly not just one person's opinion and chronically relativistic.

Applied in the education of clinicians it can lead to accusations of a failure of key consumer educators to be 'representative' (Fadden G.2005). There are several different traditions of using story to educate clinicians in the medical sciences:

- Led by Rachel Remen's celebrated work with cancer patients (Remen R. 1996), clinicians, particularly doctors, use profound and insightful patient stories that speak back to the dominance of science-ways of knowing. Such stories are given a commanding presence with the authority of the clinical educator presenting them in written form (often then translated back into the spoken word by the patient themselves, if they are still alive).
- An accompanying tradition also from cancer patients (Chin N. 2004; Clow, B. 2004) who are offered the opportunity to tell their story to aspiring clinicians. They may be critical but rarely offer a radical critique. (Consumers Health Forum, 2013). These narratives are given the respect of those who have undoubtedly serious medical, socially acceptable illness. Some are stories of malpractice, however these criticise individual practice rather than systemic concerns. Some people from minority cultures are included in this category and asked to tell their stories (Platt J.2012).
- Another cluster of consumer storytellers who hassle to be heard by clinicians partly because they are located on the outside of the acceptable (Hovey R. 2014; 2013; Wolframe, P. 2014). These include consumers fighting for fat justice (Soto L., 2014; Kasardo A. 2009), lesbian, gay, bi-sexual and transgender patients (Aguinaldo J. 2008),

or people with unacceptable diagnoses such as fibromyalgia, self harm and chronic pain (MacDonald J. 2008; Cresswell M. 2005; Epstein M. 2006; Atkins C. 2010; White A. 2011).

This category includes people diagnosed with mental illness demanding to be heard. Significantly, people speaking from the critical perspective of consumers with coexisting drug and alcohol issues, who have experienced the criminal justice system, or with dissociative experiences or diagnosed with personality disorders struggle to be heard. This displays:

"A new kind of stigma has emerged within mental health services. It relates to legitimacy: the mark of infamy is not now that of being 'mad' but rather of not being 'mad.'" (Olsen A. & Epstein M. 2001:17)

Preserving and promoting narratives

"Educators not only tell stories about the subject, they story the subject knowledge itself. In so doing they aim to maintain some interpretative space in which the learner can interact with the subject. To tell too much, to provide answers to all questions spoken and anticipated, is to render the active engagement of the learner unnecessary. To tell too little is to leave the learner with insufficient guidance to support in constructing her or his own meaning and relationship with the content." (Leitch T. 1986 in Rossiter H. 2002)

Whatever the context in which consumers use story it needs to be so much more than 'this is my life'. Although the tradition may have grown from these roots as people diagnosed with 'mental illnesses' came out of the shadows it must now move on.

"When stories are shared together it creates a unique pedagogical interaction between teacher and students" (Sorrell J. 2001:37)

It is troubling that consumers are not well enough prepared as story teller/ educators.

These principles include working from where the students are at, respect for students' adulthood and knowledge and ways of working that are interactive and pursuant to good learning outcomes for adults. Although modelling reversed roles of authority in the classroom and storytelling consumers taking ownership of the podium is a good strategy to promote some important learning about power relationships and gives some consumers confidence, it is not a good strategy if the storyteller is flummoxed or if this is the only way stories are shared.

{ Conclusion

Life is story. People tell stories both deliberately and unconsciously. Life narratives are always laden with the assumptions, aspirations, judgements, status and ways people make sense of their world. Certain traditions and cultures use story, overtly told, for cultural cohesion and historical maintenance. In the reality of post-modernity, some cultures have less direct links to the narratives that play out in their lives. Within this context, the idea of 'storytelling' is often misunderstood, inadequately appreciated and compared with the orthodox of science. And yet, story is a fundamental building block of empirical medicine: case histories (may be co-opting another's story), case studies, case conferences, change-over in the acute unit, medical meetings... Stories are the 'art' of the mental illness enterprise.

As psychiatry is often fragmented, the dominant discourse constantly has to adapt to change. So too do the dominant narratives of the consumer/survivor movement. Voices, both individual and collective, are negotiated. Because consumers are emerging from obscurity as a political force, the problems of silencing are both internal and external. At the level of the collective, certain narratives have influence in certain contexts and particular times. Peoples voices lose traction as others gain it. At an individual level the idea of 'stigmaphobia' (Grey: 2011) is apt. People emerging from the wilderness have political reason to silence others so they, too, can speak.

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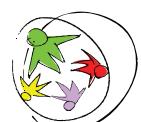


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