Alternative Narratives for Mental 'Distress' / Language Keeps the Score

By Diana Rose

Introduction

This article started life as an attempt to look at emerging narratives that might be candidates for a viable alternative to the dominant psy discourses. These were: trauma; neurodiversity; human rights; mad studies; a social model of distress and the "5 Es" approach. I got as far as trauma (see below) and it struck me, or rather it emerged in a seminar, that something else was going on that needed to be articulated before the initial idea could be addressed. This has to do with language, and other symbolic systems, and in many different ways.

In the seminar just referred to, which was to take new approaches to the 'biopsychosocial' model of mental distress, a user representative said she felt alienated by the language. Hardly a new problem but that was exactly the point. Is there a way of translating the language of academic 'experts' into something other constituencies can run with? Or even understand?

Of course, this happens on social media and elsewhere– 'folk psychology' – and it is not just a 'simplified' version; it alters the narrative. Speed is of the essence here. But when I say it alters the narrative I mean that the signification, the semantics and the syntax change and they are interiorised. In mental health particularly, they impact identity.

I will try to explain. I am hardly the first. Indeed, as I was writing this a piece was re-posted on social media originally published in the Washington Post in 2016 (Haslam, 2016). It argued along the same lines as I will here. Written by a psychologist it suggests that the 'semantic explosion' around trauma leaves people powerless because other people and groups are held responsible for every misfortune. Some of his examples really are laughable but it is ironic that trauma-informed approaches are seen here as disempowering when they are supposed to do the exact opposite.

The first idea

I will proceed by first, writing as if I am writing the first idea for this article including one example – trauma. My conclusion was that it is a pandora's box of a narrative and this hangs on the ways language is used by single people and by different people. After a detour into epistemology, we then get down to the nitty-gritty of linguistic morphology in this domain now, by continuing the analysis of trauma. It is all coloured by my own positionality as an academic and activist in what some people call "survivordom" but most now call "lived experience", itself a telling juxtaposition (D. S. Rose, 2022).

First bash

The original article I had in mind had a double origin. First, it responded to Fricker's analysis of 'hermeneutic injustice' (Fricker, 2007). Fricker was writing about gender divisions at the level of knowledge and proposed the concept of 'epistemic injustice' to analyse this. For Fricker, epistemic injustice had two basic forms: 'testimonial injustice' where someone is positioned as not a credible knower, even their stories about themselves are to be doubted; 'hermeneutic injustice' refers to the

absence of a narrative or set of 'interpretive tools' through which a marginalised group can express their experiences both proximal and institutional. Sometimes she refers to this as a 'hermeneutic lacuna' or 'gap'. In the literature in mental health that deploys the idea of epistemic injustice the focus is squarely on 'testimonial injustice', often in the context of the diagnostic interview (Faissner, Juckel, & Gather, 2022; Hookway, 2010; Kious, Lewis, & Kim, 2023; Kurs & Grinshpoon, 2018; Todd, 2021). Hermeneutical injustice is almost absent in this literature, which is small but growing, with the exceptions of Harper and LeBlanc and Kinsella (Harper, 2020; LeBlanc & Kinsella, 2016). I will argue that this absence is more than unfortunate because the concept has rich potential for illuminating how we might displace the dominance of biomedicine in both clinical and social spaces.

This brings me to the second spur to the first idea for an article. In 2023, Nikolas Rose and I wrote a paper called "Is 'another' psychiatry possible?" (D. Rose & Rose, 2023). Part of the argument was to discuss approaches which styled themselves as 'alternatives' to psychiatry. Our view was that either conceptually or in terms of implementation (or both), none of them effectively represented a distinct 'alternative'. One aspect which we stressed was the lack of attention to any role for users or survivors in these models (post psychiatry is an exception theoretically but this was diluted in practice (Bracken & Thomas, 2005)). It could be said that this analysis was pessimistic although we proposed our own alternative. One explanation for the lack of viable alternatives was that this is an instance of hermeneutic injustice – biomedicine, although not homogenous, is so dominant at the levels of knowledge and meaning that it snuffs out or recuperates new ideas as soon as they begin to appear.

The aim of my article, then, was to discuss approaches that hold the potential to figure what we call 'mental health', and responses to it, differently. They arise from or are heavily influenced by survivor movements although as habitually with such attempts they are often recuperated by the mainstream with time. History, then , is significant. They have tangible implications for practice. They do not pretend to be value-free and are often motivated by a drive for social justice. And, as is to be expected, they position themselves *against* biomedicine but do not rest with critique. The discourses I intended to examine are those delineated in the first paragraph. Although these are presented here as discrete, elements of more than one of them can be intertwined in one body of work.

Epistemological Interlude

I have argued for some years that the days of universal theories are numbered (D. Rose, 2014; Diana Rose, 2017; D Rose, 2017; D. Rose, 2018; D. Rose, 2019, 2021). I am not alone. I am not even original - but let's proceed anyway. The much-derided 'medical model' constitutes one such theory resting on (invisible) assumptions of neutrality, objectivity and *generalisability*. This has become very clear with the development of the Movement for Global Mental Health with its central concept of 'scaling up' which proposes that an 'intervention' shown to be efficacious in one setting will work everywhere, sometimes with 'modifications' (Patel et al., 2018)[1].

Against this are arguments that settings, material factors, structures and 'cultures' vary and this heterogeneity makes for not just different 'contexts' but different subjectivities. Of course, there had been debates like this in 'cross-cultural' psychiatry for a long time but they usually settled on the reasoning that these differences led to variation of *expressions* of the same things, in this case the various mental disorders (Kleinman & Good, 1985). But the importance of these questions was taken much further when marginalised groups started to argue that they were excluded from, or misrepresented in, mainstream theory and research whose ideal subject, to put it bluntly, was white, male and straight. And Western. So feminists, decolonial theorists and queer theorists started to

[1] Patel has had a change of perspective recently but to me, it is not as radical as it seems (Patel et al., 2023)

build their own knowledge where this was rectified and *specific* (Butler, 2011; Gilroy, 2013; Haraway, 1988; Haraway & Goodeve, 2013; S Harding, 2004; Sandra Harding, 2008). There is much to be said here but it is beyond the scope of this paper. The point I am making is that any 'alternative narrative' on madness will not be the replacement of one general model with another. There may be foundational concepts, or ethical imperatives, but they will not constitute a 'general model'. I am of course aware that this is not everybody's perspective. I lay it out briefly here for the sake of transparency.

Trauma-Informed Approaches

The first approach I wrote about was the 'trauma-informed' one. It turned out to be the first and only because of what it threw up but I will reproduce what I wrote here so that what follows makes sense. It is very important to put these approaches in the plural. In particular, there are wide differences in terms of geography.

Prominent writers from North America, for example, give a completely different history to those from the UK. The former concentrate on educational settings, invoke 'zero tolerance' policies as negative for poor people and people of colour and see structural inequalities to be remedied by a social justice approach (Gherardi, Flinn, & Jaure, 2020). By contrast, writers in the UK trace trauma-informed approaches back to Tuke's 'moral treatment', through therapeutic communities and social psychiatry. They understand inequalities *as a form* of trauma and focus on mental health settings (A. Sweeney, Filson, Kennedy, Collinson, & Gillard, 2018). This is so even though both these papers quote the same definition of trauma-informed approaches – that offered by SAMHSA, the chief policy body for mental health and substance use in the USA (SAMHSA, 2014).

As if this was not confusing enough (or interesting enough), a further 'model' of trauma and responses to it is somewhere outside these divisions. That is, the Power / Threat / Meaning framework delineated by Lucy Johnstone and colleagues (Johnstone et al., 2018). This was published by the British Psychological Society and seems part of the effort by some members to drag psychology away from its emblematic individualism but the framing of 'trauma' is squarely interpersonal.

A final crucial contribution was a Report from the American Child Psychiatric Association which introduced the concept of 'toxic stress', again focussing on the effects of childhood adversity across the life course but this time with a complex biological explanation (Shonkoff et al., 2012); It is worth noting that despite the hostility to the 'medical moder' that abounds in some quarters, many of the approaches I would have covered give quite a central role to neurology. It is just not the role proposed by the American Psychiatric Association. This is sometimes known as the 'biological turn'.

I have not defined 'trauma', and given the above, this is bound to be difficult so I will attempt a brief historical sketch. The term appears in both DSM and ICD starting with ICD 10 published in 1980. It appears as 'Post-Traumatic Stress Disorder' a syndrome which results from experiencing or witnessing life-threatening events usually associated with violence, including war. It is characterised by flash-backs, nightmares, chronic anxiety, anger and dissociation and can be very disabling. It is postulated that the 'shell-shock' experienced by some soldiers in the first world war was 'really' PTSD (Barham, 2004). If this seems to be straightforward it had, of course, to be complexified. In the late 1980s there emerged the category of Complex Post Traumatic Stress Disorder. Some survivors who have been diagnosed as having Borderline Personality Disorder are pressing for a re-diagnosis of C-PTSD (Kulkarni, 2017). The addition of the 'complex' is to argue that PTSD as such is defined as a single or a few life-threatening events. What the 'complex' adds is that people may be subject to

persistent, ongoing injuries, particularly in childhood, which are not life-threatening but are seriously harmful.

Although I do not mean it is 'determinant', this opens a door to or aligns with an expanded notion of 'trauma'. This will be important.

In 1998, Kaiser-Parmente, a private health care organisation in the USA, noted that references to early childhood experiences as a precursor to problems in adulthood were increasing. They therefore developed and, predictably, *measured* what came to be known as Adverse Childhood Experiences (ACE's) (Felitti, 1998). The ACE questionnaire was certainly partial and diverse in content and it was validated on a white middle class sample. But the headline finding, at first, had to do with prevalence – more than two thirds of respondents reported at least one ACE and 12% reported four or more. Research gathered pace and ACEs were found to be linked to a range of undesirable outcomes – poor physical and mental health, low educational attainment and even expulsion from school, unstable relationships and incarceration (Boullier & Blair, 2018). In summarising the research, Zarse and colleagues use the words 'childhood trauma' and not ACEs (Zarse et al., 2019). The original ACE questionnaire now seems quite narrow and there are calls to expand what counts as an ACE. In other words, what counts as a trauma has multiplied. If we add memory and subjectivity into the mix then it seems trauma can have any meaning at all. Words or other signs that can mean anything tend to mean nothing. This will be a central argument in what follows.

In discussing this problem, Sweeney & Taggart state*: (trauma) is not seen as the cause of **all** mental distress* (Taggart, 2018). However, in the same year and with some of the same authors, we have: *TIAs are based on the understanding that most people in contact with human services have experienced trauma* (A. Sweeney et al., 2018). These two statements are not quite contradictory but the difference of emphasis is hardly helpful for purposes of clarification. Relatedly, there is the finding that marginalised groups are more likely to experience trauma than those from mainstream society.

In the USA, this is particularly marked for racialised and poor people and it is well known that these groups are vastly overrepresented in prisons and mental hospitals as well as subject to drastic 'remedies 'in education. As I mentioned near the beginning, there is a geographical divide in how this is understood. Briefly put, for many UK writers poverty and racism *are* trauma – they are designated 'social trauma'. They explain this in a way that reduces structural factors to intra and interpersonal ones. Conversely, some writers from the USA see trauma as an *outcome* of structural inequality and plead for a social justice driver to all work. Racism needs anti-racist policies and actions, not therapy.

SAMHSA does include the terms 'social justice' in its Guidance but clearly this is open to many interpretations. Particularly in respect to women, there is a growing feminist literature that argues that the trauma machine has depoliticised male violence (Tseris, 2013). Nearly everyone wishes to end the 'decontextualization' of psychiatry but structural violence and in this case patriarchy are pushed to the margins in some spaces within the trauma-informed approaches

In effect, and despite what I have written above, Trauma-informed approaches are also, even primarily, an organisational challenge. Be it schools or hospitals, workplaces or prisons, trauma-informed organisations must transform the ideas and institutions of contemporary discursive practices such as form psychiatry, education and corrections. The central argument here is that such institutions, if they are trauma-blind, *re-traumatise* trauma survivors – they are a web of *trigger*s that

operate to reactivate the original situation(s) and re-produce the same or similar thoughts and feelings. Power, of course, is central but power has many meanings.

In their writings, Sweeney and her colleagues are focused on control and especially coercion (Angela Sweeney, Clement, Filson, & Kennedy, 2016; A. Sweeney et al., 2018). Sophie Isobel, from Australia, takes a much broader view and even suggests that trauma-informed approaches are traumatic for psychiatrists (Sophie, 2016). For Johnstone et al, power functions as an (interpersonal) threat (Johnstone et al., 2018). That power is multiple has been well-argued by Foucault but these different definitions are not tied theoretically at all (Foucault, 1977). Further the call for ending coercion is hardly specific to so-called trauma-informed approaches, including in the survivor literature (Faulkner, 2005; Olofsson & Norberg, 2001; D. Rose, Evans, Laker, & Wykes, 2015; Spivakovsky, Steele, & Weller, 2020). Even the World Psychiatric Association has a Charter to 'minimise' coercion which includes survivors on its Drafting Committee. Many English writers emphasise the role of survivors here but do not really explain how it should be enacted and this will turn out to be somewhat problematic.

But in terms of both definitions and solutions, there is also what I referred to earlier as the 'biological turn'. Many papers refer to 'epigenetics' or 'neuroplasticity' but without much elaboration. However, this does have consequences in the sense that it points towards 'bodily' interventions. Sometimes the rationale is that the child was pre-verbal at the time of the 'original' event or that it is 'too difficult' to put into words. An example is Hopper and colleagues programme called "STARS" (Hopper, Azar, Bhattacharyya, Malebranche, & Brennan, 2018). They worked with women who had been trafficked into sexual slavery and included body work such as massage, art therapy and drama therapy. Note that these are 'symbolic'; they are just not verbal. The women were gradually able to represent their experiences. This to me is an exemplary approach because it matches, diluted in intensity, the experiential form of the group work, in the moment, with what the women had experienced in the past. It is very specific to which I have no objection but most of these therapies are not.

At the other end of the scale is the much-quoted, chart topper *The Body Keeps the Score* by Besssel van der Kolk (Van der Kolk, 2014). He recommends largely body-based therapy work on the grounds of his conception of the origin of trauma, or rather the location of its memory. He posits that memories of trauma are stored in a different part of the brain to other memories and that part is not accessible to consciousness and hence to most forms of psychotherapy. He suggests this place is the 'limbic system' - an ancient idea about the location of human emotional processes whose existence as a discrete system is doubted by many contemporary neuroscientists (Steffen, Hedges, & Matheson, 2022). It is popularly known as the 'reptilian brain' because it used to be thought of the part of the brain humans share with our ancient evolutionary predecessors that governs human primitive drives and has to be constrained by the 'civilizing process'. The implications of this idea for racism and sexism have been drawn out (Shawl & Ward, 2005). Aside from the proposed neuroscience, there is a problem which follows from what I said before about the multiple referents of the term 'trauma'. If just about anything can be traumatic, the stored memories of trauma in the limbic system must occupy trillions of megabytes, to use a computer analogy.

Conversely, van der Kolk might be arguing that ‘true’ trauma is actually rare which flies in the face of most of the current literature. As might be evident, I would not take exception to that conclusion. But elsewhere van der Kolk does state that trauma is common. The book is immensely popular and also exists in many popularised forms. Why should this be? It raises the possibility, unpalatable to most, that in some sense today many people are attracted to harm – or to interpret their experiences as harm and name them as trauma.

To Semiotics

I changed my objective for this paper whilst writing about ‘trauma-informed organisations’ and attending the seminar on ‘biopsychosocial approaches to mental illness’ mentioned at the start. I really did struggle with what the word ‘trauma’ referred to or what ‘trauma-informed organisations’ were supposed to do. At root, the literature seemed full of slippery language and non-coherent remedies or the use of other symbolic systems and embodiments. So, this reminded me of a field of work – semiotics (Barthes & Fulka, 2004; Barthes & Howard, 1968; Bouzida, 2014; Ricoeur, 1981). This body of work stemmed originally from that of Ferdinand de Saussure (De Saussure, 1916). I can but outline it.

A common view of language is that “words are names for things”. Apart from much of human life being traversed by concepts that are not ‘things’, de Saussure upended this view by splitting the linguistic term ‘sign’ in two – signifier and and signified. ‘Word’ and ‘thing’, right? Wrong. For Saussure the *signifier* was primary, the basis of language and language is a ‘web of signifiers’. They do not represent the world but in some sense constitute it. I will not dwell on this for fear of readers making judgements about ‘structuralism’ but move to how Barthes developed de Saussure’s work.. He too made use of a binary – denotation and connotation. ‘Denotation’ was akin to describing the world; connotation was all the meanings and values associated with any constellation of terms at any given time.

One aspect of this is the narrative in which key terms are placed (O'Toole, 1980). So signifiers take their meaning from other signifiers here and language is not stable – the signifier slides over the signified, is how Barthes put it. We may think that language changes to reflect changed realities but for Barthes language change, in part at least, *generates* new realities. The signifier is principal and connotation trumps denotation when it comes to meaning and representation. There is no such thing as ‘pure description’. However irrelevant, dense and tangential this may seem, I want to use it to address psychiatry and allied subjects, concentrating on ‘trauma-informed approaches’.

A consummate surplus of meaning

I do not know if there can be too many meanings, but if there can the trauma narrative is full of them. It is true that Barthes himself thought denotation was of minor importance, but here we have not just multiple and multiplying referents, each and together are replete with connotations which, I would argue, are not coherent, they clash, disconnect and re-connect anew. If terms like ‘trauma’ and ‘harm’ as well as ‘trigger warnings’ can push the boundaries of language like this they will eventually mean nothing. A multiplication of meanings is like a Black Hole, it sucks everything else into it. It is also opportunistic. Anyone can use it for whatever they like. The momentum is even faster when terms become part of everyday discourse, especially on social media. And ‘implementation’ is simply these narratives in reverse put into action, or rather, they are the reverse narrative inserted into, or trying to overturn, an existing practice which is itself suffused with

meanings but these have been solidified. When a discourse is solidified it takes on the status of the 'obvious'; the obvious way to interpret and do things. The 'normal' way to speak about and do things.

But isn't trauma the result of *acts*, horrible negative acts? Rape, violence, domestic abuse, childhood sexual abuse. I can certainly say "no longer" but aren't these 'core traumas'? And domestic abuse is domestic abuse; childhood sexual abuse is childhood sexual abuse. Well, in the first place these two have been subject to terminological change: wife battery and incest were the original signifiers here. The changes seemed to intensify the horror or reveal the workings of patriarchy or show the origins of dysfunction…… They are reinterpretations effected by locating key terms in a different discourse and practice or web of connotations.

The international literature is instructive too. Rape is sexual intercourse perpetrated by a man without the woman's consent. As if that was easy to establish – she was asking for it versus the patriarchal nature of the criminal justice system or pimps. It is not that I don't know what I think but the alternative interpretations cannot just be denied. And in West Africa, Horn found that 'rape' means not just the act but many associated events and symbols such as loss of status and livelihood – the woman loses her land and cannot feed her children (Horn, 2020). These were not the 'results' of rape, extrinsic to the act, they were intrinsic to the meaning which, to state the obvious, was social. So if these emblematic traumas are not stable what happens when any misfortune can be interpreted as harm?

When shell-shock was said to be 'really PTSD' this too was a reinterpretation but it also shows the 'reality effect' at work. When it was complexified by the World Health Organisation in ICD 10, a new set of meanings was brought into being; in the hands of the trauma writers it was extended to any 'hurt' and in consequence that term too changed in meaning. The only reason this looks like a straightforward process of complexification or a question of 'cultural differences' is that existing discourses and practices have been consolidated into what is obvious or rather, what is 'normal'. To be anecdotal for a moment, incest was not exactly 'normal' when I was growing up in North Scotland but nobody was shocked and some didn't blink an eye when it was revealed that someone's mother and father were, genealogically, their sister and grandfather or that the man who worked in the hotel kitchen was the son of the brother and sister who came to lunch there every Wednesday (personal example). You just have to read Levi-Strauss to see how complicated incest is. In discussing this, Cahill argues that our common troubles ("bane") are: "Incest, Intimacy and the Crisis of Naming" (Cahill, 2000). So maybe what I am arguing is just an extreme but not new.

To expand that last sentence, Barthes' sliding of the signifier over the signified now appears to apply to the domain of scientific fact. Which should lead me to an interrogation of DSM and ICD in these terms but that has already been done (Pickersgill, 2014). So either the trauma narrative is not scientific or science isn't scientific. There is a literature that argues the latter and a bigger one that argues that psychiatry isn't scientific. My argument though, whichever of the above holds, is that the trauma narrative is without meaning because it applies so multiply today that it is meaningless and chaotic as well.

But, the response will be, isn't that 'everything' always negatively valued? Haslam has in his title, for example, the phrase "any misfortune" (op. cit.) and for the person experiencing the hurt it is nearly always framed that way. But others, having listened to the traumatised person, will shrug their

shoulders. We are all individuals, all different? OR being hurt is almost obligatory; it is a trend. People have been given permission to dwell on hurts through knowing the language and how to speak about trauma, they even know how to feel it. I could speculate about why this has happened and I would probably start with Durkheim and anomie. And similar points could be made about neurodiversity although that has pay-offs especially for students and their work. When I get round to writing up the original idea, there will be much more to say about neurodiversity and the other candidates for filling the hermeneutic gap.

There is a final and very important problem about the place of 'survivors' that results from the above analysis. If the meanings of trauma are so multiple and all-encompassing, who exactly counts as a survivor? Who would be the activists? Cliquez ou appuyez ici pour entrer du texte.It would seem there are no criteria or else there is only tautology. This has more general implications which I will explain at the end of the Conclusion.

Conclusion

User-led work is supposed be led by principles of social justice and trauma-informed approaches are supposed to be 'compassionate'. Nothing I have said is directed at individual authors, but I am aware I have said some pretty harsh things. So either this does not count as user-led work or I am making a plea to be realistic about how things are in our world. I have done this through a brief analysis of how language is used in one approach that positions itself as an alternative to 'mainstream' mental health and other institutional discourses. I have concluded that the language is so multiply referential that it is almost meaningless. So I have to further conclude that it is not helpful (unless you think that language doesn't matter anyway). So what are my options? I do not think we are a society of masochists and I do think that life is pretty nasty for most in the modern world. But to universalise 'trauma' pushes us to individualise, at the same time as it universalises, harm, injury etc. It may disempower people as Haslam said. I would argue that terms like 'harm' and 'injury' as well as 'trigger warning' and so on should be 'returned' to everyday narratives and this way the nuances would be easier to speak about. The problem of course is that such terms *are* now part of everyday narratives so we are not talking about a return to the origin. But language evolves, constantly, and this semantic explosion is fairly recent. It could be short-lived. It would help if the 'experts', from whom these ideas emanated, would aid in what amounts to a 'reinterpretation' but anchored in the everyday – in housing difficulties, in relationship problems, at work and at play. For here we seem to have an instance where the 'implementation' of an expert approach has succeeded and succeeded in trivialising terror and horror.

There is also a general point which speaks to who the 'survivor movement' includes. Trauma-informed approaches are an important part of a movement that also installs another boundary – it marks off as unspeakable the truly awful things that happen to some people. As I say this is general and trauma is but an example: "We all have mental 'elf"; "I have a mental health illness" (sic). But let's not talk about hearing voices that tell you to kill yourself or other people, let's not talk about spending the family money and leaving them destitute when you are manic, let's not talk about suicide or rather not when it is completed under the sway of persecuting thoughts or by horrible means. Madness has its gifts and expansive experiences and I do not want to downplay these. But it also has its horrors that no "time to talk" will resolve. Partly because we do not have the language, to return to Fricker's 'hermeneutic injustice'. I do want a new narrative about these experiences which are now paradoxically Othered partly by what narratives like trauma have come to mean. Whether a

new narrative that includes the term ‘trauma’ will be part of this remains to be seen. Other ways of figuring ‘trauma’, such as by indigenous scholars, do give me optimism (Gone, 2013).But, most importantly, I am not the lexical police, I seek only to open debate.

References

:

Barham, P. (2004). *Forgotten lunatics of the Great War*. Yale: Yale University Press.

Barthes, R., & Fulka, J. (2004). *Mytologie*: Dokořán Praha.

Barthes, R., & Howard, R. (1968). The reality effect. *The novel: an anthology of criticism and theory, 1900-2000*, 229-234.

Boullier, M., & Blair, M. (2018). Adverse childhood experiences. *Paediatrics and Child Health, 28*(3), 132-137. doi:https://doi.org/10.1016/j.paed.2017.12.008

Bouzida, F. (2014). *The semiology analysis in media studies: Roland Barthes Approach.* Paper presented at the International conference on social sciences and humanities.

Bracken, P. J., & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford: Oxford University Press.

Butler, J. (2011). *Gender trouble: Feminism and the subversion of identity*: routledge.

Cahill, C. M. (2000). " What Is Our Bane, That Alone We Have in Common": Incest, Intimacy, and the Crisis of Naming. *Stud. L. Pol. & Soc'y, 21*, 3.

De Saussure, F. (1916). Nature of the linguistic sign. *Course in general linguistics, 1*, 65-70.

Faissner, M., Juckel, G., & Gather, J. (2022). Testimonial injustice against people with mental disorders in health care. A conceptual and ethical analysis. *Ethik in der Medizin*, 1-16.

Faulkner, A. (2005). Institutional conflict: the state of play in adult acute psychiatric wards. *The Journal of Adult Protection, 7*(4), 6-12.

Felitti, V. J. (1998). The relationship of adult health status to childhood abuse and household dysfunction. *American journal of preventive medicine, 14*, 245-258.

Foucault, M. (1977). *Discipline and punish: The birth of the prison*: Vintage.

Fricker, M. (2007). *Epistemic injustice: Power and the ethics of knowing*. Oxford: Oxford University Press.

Gherardi, S. A., Flinn, R. E., & Jaure, V. B. (2020). Trauma-Sensitive Schools and Social Justice: A Critical Analysis. *The Urban Review, 52*(3), 482-504. doi:https://doi.org/10.1007/s11256-020-00553-3

Gilroy, P. (2013). *There ain't no black in the Union Jack*. London: Routledge.

Gone, J. P. (2013). Redressing First Nations historical trauma: Theorizing mechanisms for indigenous culture as mental health treatment. *Transcultural psychiatry, 50*(5), 683-706.

Haraway, D. (1988). Situated knowledges: The science question in feminism and the privilege of partial perspective. *Feminist studies, 14*(3), 575-599.

Haraway, D., & Goodeve, T. (2013). *How like a leaf: An interview with Donna Haraway*: Routledge.

Harding, S. (2004). Introduction: Standpoint Theory as a Site of Political, Philosophic, and Scientific Debate. In S. Harding (Ed.), *The Feminist Standpoint Theory Reader: Intellectual and Political Controversies* (pp. 1-16). London and New York: Routledge.

Harding, S. (2008). *Sciences from below: Feminisms, postcolonialities, and modernities*: Duke University Press.

Harper, D. J. (2020). Framing, Filtering and Hermeneutical Injustice in the Public Conversation about Mental Health. *Journal of Constructivist Psychology*, 1-15.

Haslam, N. (2016, 15/08/206). The problem with describing misfortune as 'trauma'. *Washinton Post*.

Hookway, C. (2010). Some varieties of epistemic injustice: Reflections on Fricker. *Episteme, 7*(2), 151-163.

Hopper, E. K., Azar, N., Bhattacharyya, S., Malebranche, D. A., & Brennan, K. E. (2018). STARS experiential group intervention: a complex trauma treatment approach for survivors of human trafficking. *Journal of Evidence-Informed Social Work, 15*(2), 215-241. doi:10.1080/23761407.2018.1455616

Horn, J. (2020). Decolonising emotional well-being and mental health in development: African feminist innovations. *Gender & Development, 28*(1), 85-98. doi:10.1080/13552074.2020.1717177

JOHNSTONE, L. B., Boyle, M., Cromby, J., Dillon, J., Harper, D., Kinderman, P., . . . Read, J. (2018). *The power threat meaning framework: Overview*. Leicester: British Psychological Society

Kious, B. M., Lewis, B. R., & Kim, S. Y. (2023). Epistemic injustice and the psychiatrist. *Psychological Medicine, 53*(1), 1-5.

Kleinman, A., & Good, B. (1985). *Culture and depression: Studies in the anthropology and cross-cultural psychiatry of affect and disorder*: University of California Press.

Kulkarni, J. (2017). Complex PTSD–a better description for borderline personality disorder? *Australasian Psychiatry, 25*(4), 333-335.

Kurs, R., & Grinshpoon, A. (2018). Vulnerability of individuals with mental disorders to epistemic injustice in both clinical and social domains. *Ethics & Behavior, 28*(4), 336-346.

LeBlanc, S., & Kinsella, E. A. (2016). Toward epistemic justice: A critically reflexive examination of 'sanism'and implications for knowledge generation. *Studies in Social Justice, 10*(1), 59-78.

O'Toole, L. M. (1980). Dimensions of semiotic space in narrative. *Poetics Today, 1*(4), 135-149.

Olofsson, B., & Norberg, A. (2001). Experiences of coercion in psychiatric care as narrated by patients, nurses and physicians. *J Adv Nurs, 33*(1), 89-97. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/11155112

Patel, V., Saxena, S., Lund, C., Kohrt, B., Kieling, C., Sunkel, C., . . . O'Neill, K. (2023). Transforming mental health systems globally: principles and policy recommendations. *The Lancet, 402*(10402), 656-666.

Patel, V., Saxena, S., Lund, C., Thornicroft, G., Baingana, F., Bolton, P., . . . Eaton, J. (2018). The Lancet Commission on global mental health and sustainable development. *The Lancet, 392*(10157), 1553-1598.

Pickersgill, M. D. (2014). Debating DSM-5: diagnosis and the sociology of critique. *Journal of medical ethics, 40*(8), 521-525.

Ricoeur, P. (1981). *Hermeneutics and the human sciences: Essays on language, action and interpretation*: Cambridge university press.

Rose, D. (2014). Patient and public involvement in health research: Ethical imperative and/or radical challenge? *Journal of health psychology, 19*(1), 149-158.

Rose, D. (2017). Service user/survivor-led research in mental health: epistemological possibilities. *Disability & Society, 32*(6), 773-789. doi:10.1080/09687599.2017.1320270

Rose, D. (2017). Theoretical perspectives on user involvement in mental health research. In A.-M. Stokken & E. Willumsen (Eds.), *Brukerstemmer, praksisforskning og innovasjon* (pp. 76-88). Norway: Portal.

Rose, D. (2018). Renewing epistemologies: service user knowledge. In P. Beresford & S. Carr (Eds.), *Social policy first hand: An international Introduction to Participatory Social Welfare* (pp. 132-141). Bristol: Policy Press.

Rose, D. (2019). Navigating an insider/outsider identity in exclusive academic spaces: How far can boundaries be pushed? *Journal of Ethics in Mental Health, 10*, 1-18.

Rose, D. (2021). Critical qualitative research on 'madness': knowledge making and activism among those designated 'mad'. *Wellcome Open Research, 6*.

Rose, D. (2022) *Mad Knowledges and User-Led Research*. Springer.

Rose, D., Evans, J., Laker, C., & Wykes, T. (2015). Life in acute mental health settings: experiences and perceptions of service users and nurses. *Epidemiology and psychiatric sciences, 24*(01), 90-96.

Rose, D., & Rose, N. (2023). Is 'another'psychiatry possible? *Psychological Medicine, 53*(1), 46-54.

Rose, D. S. (2022). *Mad Knowledges and User-Led Research*: Springer Nature.

SAHMHS (2014). *AMHSA's Conceptof Trauma and Guidance for a Trauma-Informed Approach.* . Retrieved from Rockville, MD

Shonkoff, J. P., Garner, A. S., Child, C., Wood, D. L. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232-e246.

Sophie, I. (2016). Trauma informed care: a radical shift or basic good practice?*Australasian Psychiatry, 24*(6), epub.

Spivakovsky, C., Steele, L., & Weller, P. (2020). *The Legacies of Institutionalisation: Disability, Law and Policy in the 'Deinstitutionalised'Community*: Bloomsbury Publishing.

Steffen, P. R., Hedges, D., & Matheson, R. (2022). The brain is adaptive not triune: How the brain responds to threat, challenge, and change. *Frontiers in psychiatry, 13*, 802606.

Sweeney, A., Clement, S., Filson, B., & Kennedy, A. (2016). Trauma-informed mental healthcare in the UK: what is it and how can we further its development? *Mental Health Review Journal, 21*(3), 174-192. doi:10.1108/MHRJ-01-2015-0006

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: relationships in trauma-informed mental health services. *BJPsych advances, s, 24*(5), 319-333. doi:https://doi.org/10.1192/bja.2018.29

Taggart, A., Sweeney, A. (2018). Mis)understanding trauma-informed approaches in mental health, . *Journal of Mental Health, 27*(5), 383-387. doi:https://doi.org/10.1080/09638237.2018.1520973

Todd, T. (2021). "Epistemic injustice" in the administration of mental health legislation. *Psychosis, 13*(1), 85-88.

Tseris, E. J. (2013). Trauma theory without feminism? Evaluating contemporary understandings of traumatized women. *Affilia, 28*(2), 153-164.

Van der Kolk, B. (2014). The body keeps the score: Brain, mind, and body in the healing of trauma. *New York, 3*.

Zarse, E. M., Neff, M. R., Yoder, R., Hulvershorn, L., Chambers, J. E., & Chambers, R. A. (2019). The adverse childhood experiences questionnaire: Two decades of research on childhood trauma as a primary cause of adult mental illness, addiction, and medical diseases. *Cogent Medicine, 6*(1), 1581447. doi:10.1080/2331205X.2019.1581447