Dependence and resistance in community psychiatric health care – negotiations of user participation between staff and users

Abstract

Introduction: Implementation of user participation is considered important in today's mental health care. Research shows, however, that user participation lacks clarity and provokes uncertainty regarding shifting roles. Aim: To investigate negotiation of user participation in a micro-study of interplay between users and health professionals in community mental health care. Method: This qualitative study is based on semi-structured in-depth interviews, involving ten service users and ten professionals in community mental health care in Norway. The analysis is inspired by Willig's model for Foucauldian discourse analysis. Results: The study illuminates the dynamic nature of user-participation that arises through negotiation between users' and professionals' positions as change enablers, dependents, resisters, persuaders and knowledge-holders. Discussion: Discourses of user participation allow for different subject positions in mental health care. User participation also involves government and questions of power, as well as ambitions of change and control. Professionals act in different ways to make and keep users active, participating, enterprising and self-governing, and users respond and take part within the same discursive framework. Implications for practice: Awareness of subjects' positions in discourses is important for increase reflection on the dynamic interplay in user-professional collaboration.

Keywords: Community mental health care, discourse analysis, governmentality, negotiations, power, user participation

Relevance statement

User participation is described as a change from a paternalistic health care system to ideals of democratization where users' voices are heard in relational interplays with health professionals. Finding productive ways to cooperate may be challenging for both users and professionals. In this study, we investigate and discuss how user participation is played out and negotiated in user-health professional relationships in community mental health services. Clarifying the discourses at play within user participation can allow for further reflection within existing practices in mental health services and influence how user participation is negotiated in the future.

The accessible summary

What is known on the subject

- Implementation of user participation is described as a change from a paternalistic health care system to ideals of democratization where users' voices are heard in relational interplays with health professionals
- The ideological shift involves a transition from welfare dependency and professional control towards more active service user roles with associated rights and responsibilities
- A collaborative relationship between users and professionals in mental health services is seen as important by both parties. Nevertheless, the health professionals find it challenging in practice to reorient their roles and to find productive ways to cooperate

What this paper adds to the existing knowledge

- This study illuminates how user participation is negotiated and involves multiple and shifting subject positions in the collaboration between users and professionals in community mental health care
- By taking different positions, the relationship between users and professionals develops through dynamic interaction
- This study challenges understandings of equality and implicit "truths" in user participation by illuminating subtle forms of power and dilemmas that arise in user-professional negotiations

What are the implications for practice

- Instead of denying the appearance of power, it is important to question the execution of power in the interplay between users and professionals
- Focusing on the negotiation processes between users and professionals is important for increasing reflection on and improving understanding of the dynamic in collaboration and speech
- By focusing on negotiations, power can be used in productive ways in user-professional relationships

Introduction

There have been major changes in mental health care over recent decades, in terms not only of deinstitutionalization but also of policy. New ideals of user participation, person-centred care, equality and resource orientation have been demonstrated internationally (Ministry of Health 1993, WHO 2005). Implementation of user participation is described as a change from a paternalistic health care system to ideals of democratization, where patients' voices are heard, with an aim of improving circumstances for patients with chronic conditions (Directorate of Health and Care Services 2005). It is argued that more engaged and informed service users[1] mean better outcomes and cost-effectiveness (Lawn 2015). WHO describes how user involvement represents ideals in mental health care:

> "The core service requirements include: listening and responding to individuals' understanding of their condition and what helps them to recover; working with people as equal partners in their care; offering choice of treatment and therapies, and in terms of who provides care; and the use of peer workers and supports, who provide each other with encouragement and a sense of belonging, in addition to their expertise" (WHO 2013, p. 14).

The focus on user involvement can be connected to "recovery", that has become a central feature of mental health policies in many countries (Slade, Amering and Oades 2008; WHO 2013). The "recovery movement" is claimed to be an important reason why the voice of people with lived experience of mental health problems has been better heard (Bonney and Stickley 2008). The intention is to make a shift away from a dominance of institutional

[1] Various terms are used to describe receivers of health services (Christmas & Sweeney, 2016). In order to talk about these individuals as a group, separated from the professionals, we use the term "user" in this article.

responses, diagnosis, drug treatments and coercive interventions to encourage people's hope and beliefs, support self-determination and community services, and promote social inclusion and human rights (Slade et al. 2014).

Such a shift from a paternalistic, institutional-medical approach to empowerment-community integration in community mental health care indicates that users should be active participants and encouraged to improve their health condition (Mancini 2011, Nelson *et al.* 2001). Furthermore, the traditional psychiatric focus on diagnosis should be replaced with ideals of person-centred care and user participation (WHO 2013). This ideological shift involves a transition from welfare dependency and professional control towards more active service-user roles with associated rights and responsibilities (Juhila *et al.* 2014). Consequently, people who are in need of services from community mental health care services are expected to participate in decisions about their health and life in close cooperation with the professionals. In addition, professionals are expected to transform their traditional roles as practitioners (i.e. expert, therapist, and care provider) into new collaborative roles (Mancini 2011).

WHO (2013) and the Norwegian health authorities (Directorate of Health and Care Services 2005, 2006) assert that independency and the ability to cope are important goals in mental health care. Ideals of user participation might, however, also be understood within a liberal economic rationality involving a transfer of responsibility from health care professionals to chronically ill patients (Ayo 2012, Beresford and Russo 2016). In a situation with chronic conditions and consequent cost increases, individualized discourses imply that patients are given increased responsibility for their situation (Ayo 2012, Brown and Baker 2012).

According to the Norwegian Directorate of Health and Care Services (2006), user participation implies that users participate in shaping mental health services in partnership with professionals, to enhance the services. There are nevertheless concerns that user participation is limited, because professionals still control the participation process and outcome (Broer *et al.* 2014, Milewa *et al.* 2002).

Power in user participation

In mental health care, power often has negative connotations, and is associated with restricting others' freedom of action, as well as with domination, control and coercion, in a hierarchical system where health professionals are in power (Ørstavik 2008). Foucault's (1980) perspective on power is different from the conventional way of understanding power, claiming that it is not a substance or a property somebody can possess. Power is exercised rather than possessed, as a mobile and unstable force, determined by an internal logic. Within such a perspective, power should not be understood as repressive, but rather as a productive force that promotes actions (Gaventa 2003). Power can be seen as a process and not as an end product (Foucault and Gordon 1980), because power and resistance are involved in all human relationships and embedded in everyday practices and interactions in relationships between users and professionals, constantly performed and negotiated (Foucault 1980). Individuals are always in a position of being subject to and exercising power simultaneously (Foucault 1980). Davies and Harré (1990, p. 62) state: "A subject position is a possibility in known forms of talk; position is what is created in and through the talk as the speakers and hearers take themselves up as persons". By using the notion of position, the multiple and shifting subject positions the participants take within this discourse can be illustrated.

In liberal societies, power is exercised as productive power where free individuals are influenced by encouraging actions in directions that are in compliance with existing norms (Foucault 1991). By completing actions, individuals govern themselves, for example by examining and optimizing their capacities and resources through what are described as technologies of the self, underlining how people are engaged in self-constituting practices (Lupton 2013). The term "governmentality" coined by Foucault relates to "conduct of conduct", or a decentred governance, where individuals play an active part in their own self-government (Rose 1999). Governmentality represents a new understanding of power, as it includes forms of social control as well as the forms of knowledge and actions that enable individuals to govern themselves.

Power relations involve shifting attempts to control each other, and a process of negotiation as well as resistance between "players and partners" in specific fields (Gordon 1991, p. 36). In the field of health care, Carr (2007) argues that after an initial step of introducing user participation comes a second step of exploring how user participation is actually played out and changes practice. Although the term user participation or involvement is frequently used and discussed, the literature is inconsistent and lacks clarity in relation to mental health care (Borg, Karlsson and Kim 2009). Aspects of involvement are described as underexposed (Tambuyzer, Pieters and Van Audenhove 2014). Studies show that users in mental health care emphasize the importance of their relationship to health professionals (Ljungberg, Denhov and Topor 2016, Ådnøy Eriksen, Arman, Davidson, Sundfør and Karlsson 2014). The importance of a collaborative relationship between users and professionals is seldom disputed. Studies show however that health care practitioners find it challenging to reorient their role in practice (Ness, Borg, Semb and Karlsson 2014; Rugkåsa, Canvin, Sinclair, Sulman and Burns 2014). Rugkåsa et al. (2014) find that professional authority might threaten the relationships

between professionals and users. To enhance understanding of user-centredness in care and the interplay between users and professionals, they argue for micro-level analysis of implementation of user-centred care in clinical practice.

Rational and aim

We have taken up Rugkåsa et al.'s (2014) recommendation and question how user participation is played out in community mental health care. Our specific contribution is a micro-focus on the negotiations of user participation taking place between health care professionals and users. By taking advantage of understandings of productive power, shaped by subject positions, norms and resistance, we intend to explore such negotiations to increase insight into how user participation is played out in practice.

Methods

Research team and reflexivity

The two authors of this study have different backgrounds as clinicians and researchers. The first author is a mental health nurse and PhD candidate, and this article is part of her PhD study focusing on user participation in mental health care. The second author is an associate professor and nurse with a background in research on discourse and empowerment in chronic conditions. The first author performed the interviews and made contact with the clinical field. Both researchers cooperated on the analysis of data and on writing this article.

Study design

To gain insight into experiences of user participation from the perspectives of both service users and health professionals in psychiatric health care, we decided to undertake a qualitative

study with individual interviews. Service leaders in five municipalities were informed about the project and invited to recruit participants. Participants, both users and professionals, were purposely selected for interviews by the service leaders to provide rich, relevant and diverse data pertinent to the research question (Tong, Sainsbury and Craig 2007). Professionals with a bachelor's degree in a health or social profession who had worked in half- to full-time positions for at least six months were informed by their service leader about the study orally and received written information and asked to participate. Inclusion criteria for service users in community mental health care were adults (>18 years) who were assisted by health services at least once every other week for at least two months, and who would give informed consent. Users were informed orally and received written information about the study by professionals, who were not themselves involved as participants. The first author received telephone numbers from users who accepted to be contacted for more information and to give informed consent. We ended up recruiting ten users and ten health professionals. The themes in the interview guide focused on experiences of user-professional interaction and cooperation to promote reflections on roles, expectations, opportunities and experiences. The interviews were guided by the interview guide, lasted for 45-60 minutes, were audiotaped and subsequently transcribed verbatim by the first author. Foucault's notions of discourse and power represent the main theoretical framework in the study. The analysis used Willig's model for Foucauldian discourse analysis to explore how power was negotiated in user-professional relationships (Willig 2013).

Data analysis and findings

Willig's six stages were considered as a guideline rather than a set of "rules" in order to analyze the texts systematically.

A basic point for the analysis was to understand user participation as our discursive object. We looked for different ways in which the participants talked about and reflected on cooperation and user participation in mental health services (Stage 1). Then we identified various discourses lying behind users' and health professionals' statements (Stage 2). Stage 3 involved an action orientation and we questioned the texts about "what is gained from constructing user participation this way in this situation?" and "what is the function of this construction and how does it relate to other constructions?" We also looked for the subjects' positions (Stage 4) and asked why they positioned themselves in different ways in the different situations to understand how negotiations and actions opened up or closed down opportunities for action (Stage 5). Finally, we considered available subject positions to understand the interplay and negotiations taking place between users and health professionals (Stage 6) (Willig 2013). Following these steps, five main positions the participants talked from arose from the analysis. Table 1 illustrates the analytical process, which was not linear, but went back and forth between the different stages. Acknowledging that power relations are created within an interview situation, the first author was aware that her background as a mental health nurse might affect the interview, as well as the analytical process. The transcripts were analysed and discussed in close cooperation by the two authors and extracts of the analysis were discussed with users and professionals.

Ethics

The Regional Committee for Medical Research Ethics in Norway approved this study (REK-midt 2011/2057). Service users in mental health care may be understood as vulnerable according to ethical guidelines (WHO 2005), even though vulnerability is a contested term, broadly defined as an immanent characteristic of being human (Hurst 2008). Mental illness is connected to stigmatisation and dependency (Marcussen and Ritter 2016), underlining the

importance of taking care not to cause unnecessary harm. This implies a need to act with sensitivity in interview situations to avoid participation becoming a burden. Reflexivity and consciousness in the interview situation were therefore important. All participants were informed in writing and orally prior to signing their consent and were informed about the opportunity to withdraw from the study at any time without consequences. The participants and authors did not know each other. Participants' names in this paper are fictional.

Findings

The interview texts illuminate how the negotiations between users and professionals concerning reciprocal roles and responsibilities were multiple and taking place at different levels within the framework of community mental health care. An obvious concern for both users and professionals was their mutual relationship, and how to play their role in the collaboration.

An ability to negotiate in processes of participation appeared to be crucial for users as well as professionals. Both groups expressed frustration when participation was complicated and difficult, as one user explained: "It feels like I am parked in a corner, and have to accept what they offer". This reflects a position of resignation and hopelessness, with few opportunities to negotiate. Even though participation was seen as important, the interviews show that participation and cooperation have certain limits. The participants were not solely predetermined by their role as users or professionals; they talked about themselves and took various positions.

Position as activator and promoter of change

The position as activator and promoter of change was taken by professionals aiming to activate the users towards change. Health professionals construed activity as important even in periods when users described themselves as struggling. If professionals understood users as passive because they stopped performing activities such as getting up in the morning or attending appointments, professionals sought to activate them. “It is important that the employee offers and shows different solutions when she (the user) cannot see the options herself”, a professional claimed, implying that professionals ought to find ways to motivate users towards activity.

When a person is offered mental health services, professionals and users discuss what services are available and what services the user needs. Some professionals sought the users’ suggestions in order to stimulate them to participation, and some expected users to undertake everyday activities themselves, like calling the dentist or making an appointment with their general practitioner.

> “What does it take for you to do it yourself?” (…) They would rather have me do it for them, but they do not learn anything from that. I tell them why they should do it themselves and ask what they can do on their own. “Well, maybe I could do it with some time pressure.” (Emma, nurse).

This quote not only shows how the professional strives to get the user involved and take responsibility, but how she puts herself in a position of deciding whether the user’s solution is acceptable or not. Furthermore, professionals acted as a driving force, expecting users to set

goals, and pursue them as partners. One way of doing this was to give users "homework", ~~t~~o reach goals.

The texts show that the professionals positioned themselves as leaders of change to push users towards responsibility and activity. Users responded in different ways, but Hannah (user) explained how some felt: "I know patients who don't dare to say stop. They keep it to themselves".

Position as dependent

We have seen how health professionals pushed users into an active role, contrary to a more traditional role as dependent, patient and grateful. Slipping into a passive role was accordingly construed as problematic, and to meet expectations users described how they tried to act in compliance with what they believed the professionals wanted. The users understood themselves as dependent, which made opposition difficult. This was the case of a user who did not cook dinner after years of struggling with an eating disorder:

> I remember a professional who came to make dinner. He said I had to practise. I had to practise making dinner! I did not want to, but I did not dare to say no when they offered me help. Maybe I wanted to be a good client. I was afraid of the consequences if I said no ... (...) I was afraid of many things ... That Richard [*professional*] would be mad at me and keep on talking about it a lot. In addition, even worse: that they would not talk to me anymore. ... (pause). Maybe he was testing me, to see if I dared to say no. (Liz, user).

Liz cast light on her feelings of dependency. Some users position themselves as teammates, but adjust their conduct to what they believe is expected in order to avoid conflicts. Tanja (user) claimed that she needs lowered expectations from the professional when depressing symptoms bother her the most. To be a "good user" is described as stressful, due to uncertainty about the professionals' expressed or unexpressed expectations.

Users' construction of themselves as dependent on health care thus puts them in a subordinate position, especially when the community health care system wishes to restrict the number of users. The professionals are expected to discharge patients and limit the number of users, as here where they describe trying to convince users to discharge themselves.

> We have waiting lists. We have to discharge somebody. I believe I have discharged a lot more users than they ever did. I was aware of it when I started working here. I knew that is how they work here. (Emma, nurse).

Accordingly, in some situations, health professionals view themselves as loyal to the health care system at the expense of the users. They did however identify this as a matter of balancing. An open and positive relationship with users was necessary to perform their duties and services, being able to negotiate and cooperate with users. Accordingly, dependency was not unilateral.

Position as resistant

Even though users' positioned themselves as dependent, they did not necessarily act subserviently. The interviews show that users sometimes resisted professionals in different

ways, but took a role as active and responsible. Discussions between users and professionals were sometimes explicit, and at other times tacit.

> "I was supposed to receive help from a newly graduated woman once. What she said was straight from the textbook. Does she really know what she is talking about? I did not have any respect for her as a professional. (...) I resigned. I would not let her get to know me. … I was not motivated to get to know her either." (Liz, user).

In some situations, users positioned themselves as resistant and resigned from, or declined, the service offered. The user's right to oppose and speak up for him-/herself was highlighted in some interviews. The user took action instead of accepting the professional she was assigned, showing that proposals for alternative actions are negotiable.

Position as persuader

Several users asserted that the professionals were astute at defending their views, and thus they found negotiations related to the services challenging. Nevertheless, some had trust in the professionals' persuasion at times, perceiving it as reasonable. "Somehow, I guess they have tried almost everything before they say: 'enough is enough - this is not working.' They make you change your mind by talking you onto the right path again" (Tanja, user).

First, the use of persuasion was described as gentle, often appealing to their sensibilities. Tanja explained how she told the professional at the community mental health care and the general practitioner that she wanted to quit drugs. In response, they appealed to her previous experience with the medicines, trying to convince her to continue to take the medication. But when the professionals failed in their efforts, they changed strategies: "If I do not take them

by myself, they say nurses from the homecare will come and watch me take them" (Tanja, user). In this example, persuasion amounted to coercion applied in an effort to restrict the user from making autonomous choices that professionals view as bad and contradictory to participatory and person-centred services.

Lack of persuasion could be challenging too, as when professionals were concerned about the consequences of a decision, but nonetheless refrained from preventing it or easing the user's burden. A user became ill and needed hospitalization when she decided to come off her medication.

> I told the general practitioner and professional I used to see in community mental health care: "I quit". Therefore, I quit. They did not say anything. They knew me well, that I would do it anyway. I had to go through it myself, to see what happened. It was a huge letdown. Hospitalized! I felt terrible. When I felt better, they told me they could not have stopped me anyway. "You had to find out for yourself. That is how we saw the situation, but we hoped it would work out in a good way. We knew you would do it anyway" (Greta, user).

This quote illuminates difficult negotiations between a user and health professionals, leading to hospitalization. By presenting the professionals as passive and unenterprising, the user's position as persuader is illustrated.

The opposite situation arose when professionals made decisions against the user's request or waited until it was too late before telling them, as when a professional arranged a meeting

with the Child Welfare Service against the mother's request, because the professional considered the user incapable of caring for her child.

> I told the mother what I intended to do. When I informed the participants at the meeting, she already knew I was going to tell them. I did not do it in writing. I just told them about my concern for the child (Mona, nurse).

With the professional taking the position as an authority, the user's opportunity to participate was very limited. Preparing the mother may be seen an attempt at user participation, hoping that the mother will agree with the decision.

Position as knowledgeable

The interviews illuminate how expert discourses were often present when topics of knowledge were discussed. In mental health services, 'true knowledge' is typically associated with having specialist professional knowledge, thus allowing professionals to take sole power and control. Expert knowledge often appeared through expressions like "it is for the patient's own good". Involving users by appealing to them about their experiences did however also frustrate users sometimes.

> He does not give me the answer right away when I ask him something. He says I have to figure it out myself. He helps me to figure out how I actually feel about it myself. At the same time, it is quite frustrating. Why can he not just give me the answer right away? (Liz, user)

Users' knowledge does however also challenge health professionals.

> I am convinced that medication is important for his kind of illness, when I think about it as a professional (…). He [referring to a user] has a lot of power as well: "I have read about it, I read it in… he is a member of Mental health [a nationwide user organization in Norway]. It is this book written by a man diagnosed with schizophrenia who manages without any medication, just by changing his diet. Eat less sugar, and that kind of thing. He has a lot of power through his knowledge, and he uses it against me.

The user's construction of himself as the expert made the nurse insecure regarding what knowledge to trust and if her own knowledge was outdated.

Discussion

User participation is widely supported in policy and in mental health services, and it reflects and is reflected in current discourses of democratization and equality in contemporary society. The findings in this study illustrate how ideals of user participation, equality and empowerment are played out at a micro-level in the close relationships between users and professionals in primary mental health care. As language is understood as constitutive and meaning situated and created in interaction in discourse analysis, the analysis of position opened a theoretical space and a way to grasp how the participants understood their situation, how they believed the other part positioned them and how they believed they positioned themselves towards the other party in collaboration. When approaching everyday practices in a discursive perspective, the practices are understood in the light of greater societal structures of discourse.

The concept of service user participation sounds dynamic and emancipatory (Stickley 2006), compared to old-fashioned health care systems dominated by paternalism. Nevertheless, perspectives of user participation and government also include notions of power, change and control (Hui and Stickley 2007). This study shows how professionals try to activate users and govern them to participate in services offered and furthermore towards independence from services. It is a common finding that contemporary discourses in mental health services involve users with rights and responsibilities, where health professionals expect users to be active participants encouraged to improve their own health conditions (Mancini 2011, Nelson *et al.* 2001, Solbjør *et al.* 2013). This might be understood as an aspect of liberal societies where liberty and freedom are transferred to the citizens in an effort to empower them to become self-governing, enterprising individuals (Vander Schee 2008), thereby leading to new collaborative roles between users and professionals (Mancini 2011), which is illuminated by findings in this study. Transfer of responsibility can be a complex process. The study illustrates that professionals refrain from intervening even when they know users have made decisions that might worsen their condition. When professionals avoid intervening, thereby risking challenges and decreased health, this might be understood as a fear of power and as negligent (Dean 2010).

Today the perception of the "active self" appears with a new, different kind of freedom to make choices (Rose 2008). Concepts such as personal choice and the freedom to choose are key tenets of neoliberal rationality (Ayo 2012), and exemplify an individualistic stance within neoliberal health care policy. Personal engagement in one's own health might be understood as an expected duty in contemporary discourses. Accordingly, we can say that user participation draws on discourses of responsibilization. The findings in this study illuminate

negotiations of responsibility. Health professionals sought user participation and self-government and aimed to discharge patients from services because of high workload. The participants, however, did not aim for responsibility and independence, at least not all of them. Some were scared of being discharged and losing contact with the health services. Others compromised themselves in order to avoid unpleasant situations or losing services.

Juhila *et al.* (2014) claim that professionals construct service users as consumers by offering service options in choice-making sequences. However, professionals in this study aimed to make users conduct themselves in ways the professionals considered to be the "right" way, in line with ideas of governmentality. The ambiguity in the notion of governmental power is that governors aim to govern so effectively through self-government that external coercion can be reduced to a minimum (Foucault 1977). Within contemporary liberal government, there is however a paradox, as Karlsen and Villadsen (2008, p. 360) point out, i.e. that self-governed individuals are to be "managed". Broer *et al.* (2014) describe how users and professionals frequently feel powerless as they struggle with the contributions users could make to the improvement processes and functions they should fulfil.

User participation and empowerment in mental health care draw on discursive ideals of freedom and independence, realizing the individual's willpower, authority and capacity to act (Hui and Stickley 2007). This study shows that, despite the efforts to engage users' participation, staff-administered and powerful actions are played out to achieve these ideals. The professionals' will to empower users and play a role as negotiators and to provide cooperation was present. The study sheds light on how users and professionals talk from different positions when they talk about their user-professional relationships. By seeing power relations as dynamic, different subject positions appear and illuminate how power in user-

professional relationships can be understood as constantly performed and negotiated (Foucault 1980). The study illustrates how both power and practice change within contemporary discourses, and underlines the importance of studying practices to "grasp the conditions that make these acceptable at a given moment" (Foucault 2002, p. 225).

What the study adds to the international evidence

This study illuminates the micro-focus power at play in negotiations of user participation in mental health care from the positions of users and professionals. The study adds knowledge about the dynamic nature of user participation appearing through negotiations of positions through activation, dependency, resistance, persuasion and knowledge. The perspective of productive and ambiguous power revealed an interplay of tensions and instability. The study illuminates fragile situations in clinical practice with a relational and interleaved play of power. We argue for investigating power where it is played out and have not found other studies illuminating such play of power between actors in this field.

Strengths and limitations of the study

A strength of the current study lies in its focus on how users and professionals position themselves when power is negotiated in user-professional relationships in community mental health care. An equal number of users and professionals were interviewed. When 20 participants were interviewed, saturation appeared to be attained. However, within a Foucauldian discourse analysis, there is no goal to find an "overall truth" about user participation in mental health care. Discourse analysis does not aim give a neutral approach in a study. This implies that other perspectives will raise other interesting findings. As there are

other studies supporting the findings we describe, we find that our approach is relevant and informs the field.

Despite the fact that generalization is not a focus in discourse analysis, one may assume that the knowledge attained regarding the subject positions may be transferable to similar contexts. This may allow for and lead to further reflections within existing practices in mental health care and influence understandings of user participation and its limits.

Implications for practice

User participation is understood to displace paternalistic power in mental health care. This study shows that power plays have changed in the clinic through the implementation of user participation as an ideal, and the power appears in more subtle ways. This tells us that concepts of redistribution of power are idealistic and easily overshadow questions of power. Instead of denying the appearance of power, it is important to question its execution in the interplay between users and health professionals.

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Table 1: Example of analyzing process: Position as activator and promoter of change

Stages	**Descriptions of the stages**	**Examples from the material**
Stage 1 Discursive constructions	Identification of different ways in which the discursive object is constructed	Discursive object: Positions in negotiations **1. Activating others and promote changes** **2.** Dependency **3.** Resistance **4.** Persuasion **5.** Knowledge

1. Activating others and promote changes

Quotation: "They do not quite know what they want, and we have to find out where to begin. Will they be able to do a certain task before coming next time? Will they manage to make a phone call, take the bus or such things?" (Emma, nurse)

Stages	**Descriptions of the stages**	**Examples from the material**
Stage 2 Discourses	Differences between constructions Locate the various discursive constructions of the object	Expert discourse where the professional: - acts as a driving force, expecting goal-setting - takes charge, demands change - decide whether the user's choices are acceptable User participation discourse - seek for users' suggestions to stimulate towards participation
Stage 3 Action orientation	A closer examination of the discursive contexts within the different constructions of the object	Economical rationality, need of discharging patients - promoting and expecting users to act in specific ways to improve independency - pushes users towards responsibility and activation
Stage 4 Positioning	The subject positions made available within the networks of meaning that speakers can take up	Nurses take role as activator and promoter of change through role as helper and expert. Users constructed as active users, participating in their health promotion. Users negotiate knowledge
Stage 5 Practice	The relationship between discourse and practice. The possibilities for action	Nurses judge users' behavior as acceptable or not Users scared of losing services if not playing their part in the right way Example of nurses' omission leading towards undesirable outcomes

Stage 6 Subjectivity	Relationship between discourse and subjectivity	New roles negotiated. Illuminate dependency, resistance, persuasion and knowledge