SOCIAL REPRESENTATIONS OF MENTAL ILLNESS:

A STUDY OF BRITISH AND FRENCH

MENTAL HEALTH PROFESSIONALS

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ABSTRACT

Based on the theory of social representations, the thesis explores how mental health professionals understand mental illness. The principle data source for this investigation is semi-structured interviews conducted with sixty mental health professionals in Britain and France, two countries currently moving towards community-based care for the mentally ill. Systematic qualitative analysis of these interviews (using QSR-NUDIST) is both grounded in the data and guided by previous research findings, theoretical considerations, and other data sources (policy documents and observations). Research explores how the nature, causes and treatment of mental ill health are represented by professionals, and provides an empirical test of the concept of 'professional social representations'. These are conceived as professional practitioners' representations of the object of their work, which consist of five inter-related elements: practice, theory, professional identities, organisational factors and lay representations. Analysis highlights how, despite their 'expert' status, mental health professionals adopt an agnostic stance and their representations are fraught with uncertainty, questioning and debate. Mental illness is understood as a polymorphous category, broadly divided into 'neuroses' and 'psychoses' and understood in essentially social terms. Thus, various forms of difference, distress and disruption are central themes. Professional practice is conceptualised as a social rather than medical endeavour, which involves eclectic interventions in many aspects of clients' daily lives. The dominant role in France of psychodynamic theories and practices is the only major difference between professionals in France and Britain. With contemporary shifts towards community-based care, practitioners experience added uncertainties and difficulties in renegotiating professional working relationships. The findings suggest that professional social representations serve important compromise functions, helping the practitioner community to reconcile the tensions and conflicting agendas of mental health work, and reflecting the unique role of professionals in the development and circulation of social knowledge. This research extends the scope of application and the conceptualisation of the theory of social representations.

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INTRODUCTION

'Mentally ill', 'mad', 'psychologically disturbed', 'insane', 'crazy', 'nut-case', 'cuckoo'. Whatever terms we use, in modern western society forms of mental distress rank amongst the most feared and misunderstood aspects of human existence, shrouded in mystery, intrigue, taboo, and enormous social stigma, and continuously attracting the attention of writers, artists, media producers, academics and politicians. The Office of Population, Census and Surveys (1994) estimates that one in seven people in Britain experience some kind of mental distress during their lifetime, alerting us to the fact that this is no marginal issue, but one of vast psycho-social relevance, with implications in our daily lives, in politics, in education and in the law.

This, then, is the starting point of this research. It is a vast arena within which any serious study must be selective. As a piece of social psychological research, this thesis is concerned to investigate the social meaning of 'mental illness'. This is not a new issue - volumes of literature already exist on how mental illness is construed socially, as the chapters which follow will attest. But this thesis offers a novel approach and focus in concentrating on how professionals who provide services for the mentally ill in two European countries - France and Britain - understand and react to mental illness.

1 Initial Comments on the Focus of the Thesis

Studying Mental Health Professionals

> 'there is a need to develop a truly sociological perspective on (mental) diseases and (mental) illness which takes into account the fact that such phenomena belong as much to social and cultural contexts as they do to persons. And that is why it is only through the study of the ways in which such things as psychiatric services are organised and the ways in which psychiatric issues are presented and re-presented through diverse forms of professional practice that we can arrive at a sound understanding of what psychiatric disorders are.' (Prior, 1993, p 197)

There are many possible routes of access into societal understandings of mental distress. Analyses of the media, the daily lives of people with mental illness diagnoses, policy decisions and documentation, and numerous other social artifacts would all allow the social scientist to mine rich hermeneutic seams in this area. Motivated by a desire to

capture the very tangible social practices and daily interactions which constitute much of the reality of mental illness in contemporary society, this thesis focuses on the practice-based understandings of mental health professionals. It aims to avoid a solely abstract and generalised level of analysis, which risks reducing to a dry intellectual argument, and to remain very much grounded in daily social reality. The 'real world' of mental illness is socially constructed in the psychiatric out-patients clinic, the hospital ward, the day centre, the case conference. It is here that the fate of thousands of distressed people is decided by professionals whose work is to care for and treat the mentally ill in the ways they deem most appropriate, whether this is medication, psychotherapy or group activities. A study of the social representations of mental illness held by these professionals, of which these daily practices are a part, relates directly to the real experiences of people whose contact with mental health services defines them socially as mentally ill.

Mental health professionals play a uniquely powerful role in the changing construction of societal belief systems about mental distress. They occupy a distinctive position at the interface between expert and lay knowledge, belief systems whose basic assumptions and agendas may not necessarily correspond. It is through professionals' daily practice that clinical research and government policies are implemented, and become integrated into social reality and societal belief systems. This thesis starts from the assumption that the ways we organize care and treatment for those suffering from mental health problems both reflects and constitutes how these problems are socially represented. Thus by studying what mental health professionals believe and practice in relation to 'mental illness', we may gain insights into broader societal understandings of mental distress, as well as into social knowledge in a particular social group which warrants study in its own right.

During the early 1990s, as community care policies were debated and implemented in Britain, mental illness became an increasingly controversial social and political topic. In the space of only a few years policies have been introduced which attempt to reverse the historically established western European practice of marginalisation and segregation of those deemed mentally ill, and which constitute radical challenges to mental health professionals' established working practices. Change stirs collective memories and highlights the arbitrary status of collectively constructed representations whose existence

as a part of social reality has previously gone unchallenged[1]. In its desire to make sense of these new integrative policies and their implications, society is now engaged in vigorous discussion about the nature of mental illness and our reactions to it. This debate is played out in the media, in daily conversations, in medico-legal decision making, in mental health case conferences and so on. Following a prolonged history of being silenced and negated, mental illness has moved to the forefront of contemporary social debate. This makes the current time an opportune moment to capture a snap-shot of these renegotiation processes as they emerge and develop through the rapidly changing practices of mental health professionals. Through the active translation of policy guidelines into specific practices with particular individuals, new professional representations are currently being negotiated and developed.

'Positioning' of the Thesis

The thesis takes an explicitly constructionist perspective, the nature of which is elaborated in the following section. However, the adoption of a constructionist stance carries with it more than simply theoretical implications. If one recognises the socially constructed nature of collective belief systems and practices, then one must equally recognise the constructed nature of one's own work, indeed of the whole endeavour of academic psychology, as a culturally and historically situated practice (Rose, 1990). Accordingly, it is necessary to articulate the frames of reference which guide the thesis and form its point of departure, informing the reader of the prior knowledge, basic assumptions and choices about what to include and what not to include which contribute to the 'story'[2] told in the following chapters. In accounting for the 'positioning' of this thesis, I find it useful to make a somewhat arbitrary division between the related areas of 'theoretical', 'methodological' and 'personal' positionings. Each of these is discussed in turn below.

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[1] Moscovici (1984, p 54) notes that 'the character of social representations is revealed especially in times of crisis and upheaval'.

[2] I use the term 'story' to emphasis the constructed nature of any empirical research and the way it is re-worked into a linear format for the purposes of a thesis. It should not be taken to imply that what is presented is simply 'anecdotal' or lacks the theoretical grounding and methodological rigour required for social psychological research.

Theoretically, the thesis is positioned within the framework of social representations theory. Whilst the form of constructionism that this implies is an issue of much current debate (Wagner, 1996), it is safe to say that the theory falls beneath the broad umbrella of social constructionist positions within the social sciences. It is therefore compatible with a range of other perspectives on mental illness (those considering gender or ethnicity, for example) which, although they do not form part the explicit theoretical and methodological framework of the thesis, are nevertheless taken-for-granted as the background to a theoretically focused piece of research. The specific theoretical concerns of this thesis are to extend and develop the theory of social representations in its application to professional (rather than lay) collective knowledge structures. It aims to investigate various structural and functional features of these 'professional representations', and to use the application of this theoretical model to the world of mental health practitioners as an initial empirical test of its validity.

In choosing to work within a social representational framework, other theoretical perspectives and foci have been given lower priority. For example, whilst literatures on gender and ethnicity are part of the core background reading for a social psychological study of mental illness, given the constraints of space and time, these are not included in the body of the thesis. Omission of this material does not imply that these contributions are judged uninteresting. The impact of gender, for example, on collective constructions of the mental health status of individuals (through differential manifestations of distress, help-seeking strategies, professional reactions, treatment decisions, the semantics of masculinity and femininity and so on) has been one of the most thoroughly researched areas of recent years in this field (Busfield 1996, Miles 1988, Ussher 1991). Similarly, the role of ethnicity and social class are not addressed explicitly, although these are both controversial areas in which inequalities have been identified (Dohrenwend & Dohrenwend 1969, Hollingshead & Redlich 1958, King et al 1994). In particular, ethnic inequalities in the diagnosis of certain mental illnesses and prevalence in specific mental health service settings are currently of great concern in the world of mental health practitioners[3].

[3] For example, in the British context, the over-representation of young Afro-Caribbean men in secure settings and given a diagnosis of schizophrenia is a finding noted by several studies (Harrison et al 1984, McGovern & Cope 1987). This example highlights the need to consider factors such as gender and ethnicity <u>in combination</u>,

Essentially, choices had to be made, and for my theoretical and empirical interests these bodies of literature were judged to be of less centrality. Having said this, the empirical strategies adopted in the thesis are nevertheless designed to avoid theoretical blinkering. Whilst choice of data sources and styles of analysis are necessarily theoretically driven, the analytic approach allows possibilities for the data to 'speak' outside of this theoretical framework. There would be space, for example, for variations in the gender or race of the clinician or of the mentally ill person to emerge as a contributing factor in how mental ill health is differentially understood[4].

This brings us to a second area of 'positioning', namely the methodological stance adopted. The thesis presents a comparative study of collective professional knowledge in two countries - Britain and France. This focus was motivated originally by both theoretical and circumstantial factors (illustrating the inter-connections of the types of 'positionings' I discuss here): A year of post-graduate study in Paris provided the ideal opportunity to embark on a cross-cultural piece of research. As my understanding of the theory of social representations increased during this time, I realised that comparative research could be an extremely valuable tool in bringing into sharp focus the social constructive processes associated with what is taken as 'natural' or 'normal' in any given society. From a substantive view-point, Britain and France offer an interesting comparison of two countries currently moving, each in their own particular way, towards 'community care' for the mentally ill, united by many common western European values but simultaneously differentiated by others.

Whilst the theoretical assumptions of this thesis necessitate a full recognition of the impact of cultural, historical and local socio-economic and political factors in shaping the uniqueness of any single mental health service, investigations across a range of 'typical' adult mental health services in London and Paris have been conducted with the intention

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and in relation to specific <u>forms</u> of mental distress, and to avoid assuming homogeneity within social groups which may lead to simplistic or over-deterministic arguments.

[4] The fact the race and gender of both clinicians and clients do <u>not</u> emerge from analysis as significant variables could be interpreted as an important finding in its own right, given the importance of these demographic factors which has been so robustly demonstrated in other research.

of making more generalisable observations about the forms of 'professional common sense' which proliferate in France and Britain in the 1990s. The style of empirical analysis conducted in this thesis reflects this concern. Its primary goal is to chart variations across interview respondents who are differentially located within worlds of mental health care in Britain and France. Again, the constraints of a thesis mean that adopting this strategy necessarily precludes others. For example, I have chosen not to explore narrative structures within each interview, a strategy which could well highlight some interesting findings regarding how individuals construct accounts of mental ill health within a (public) interview setting.

The actual process of conducting cross-cultural research is, of course, extremely difficult, not least in the personal challenge it poses to the researcher in adapting to and understanding the complexities and nuances of cultural mores. It also forces the researcher to consider the thorny issue of the 'cultural equivalence' of data collected and analysed by a researcher native to one country and foreign to another. Whilst some of these questions are addressed in the chapter on methodology, this limited account cannot do justice to the depth, complexity and personal struggles associated with these issues.

We are moving now into the realm of 'personal positioning'. There is always a personal or political agenda behind why anybody decides to study one phenomenon and not another (even if this had traditionally remained unacknowledged by mainstream psychology operating within the positivist paradigm and its ideal of objectivity). As a social constructionist researcher, one has an obligations to give at least some account of one's preconceptions and motivations from the start: My initial interest in studying mental illness from a social psychological perspective was sparked by the experience of working as a research assistant within a team of psychiatrists and clinical psychologists at the Institute of Psychiatry in London.. Fresh from the intellectual stimulation of masters study at the LSE, my first encounter with the inner world of the British mental health system was with the eyes of a social psychologist. But my reaction to this world was personal as well as academic. Doubtless I was not the first to have the impression of entering a whole new social arena, cut off from the world outside. What struck me initially was the 'taken-for-granted-ness' of the social dynamics which structure this

world, and the way that certain implicit rules and assumptions about the nature of mental distress and the role of those employed in the mental health system seem to have developed an unquestioned life of their own. Despite the dramatically different context, I was struck by parallels with the exclusionary practices reported by Denise Jodelet (1991a) in a rural community in France. This seemed to me a perfect world in which to study the construction of collective understandings in daily practice, talk and organisational structures.

The prior knowledge that I bring to this study of the world of public mental health care is that of an interested outsider. Having worked in mental health, the social worlds in which I have moved whilst conducting this thesis have been populated with the very people I set out to study, namely clinical psychologists, psychiatric nurses, psychiatrists and others working in mental health services across London. This informal contact has proved a valuable resource in making contacts, checking the 'grass-roots' validity of somewhat esoteric ideas and concepts, and ensuring the social relevance of my work. Simultaneously, I have not become a true 'insider' - I have not pursued a training in clinical psychology that would enable me to become a mental health practitioner myself. Whilst those within these professions may argue that I can never really know what it is like to work in mental health, I would argue that this has also kept my mind fresh in a way which is necessarily overwritten by the socialisation process of any vocational training and the daily concerns of mental health practice. My lack of personal investment in professional ways of thinking and acting means that I can analyse and evaluate these on a different level. My position could be described perhaps as an 'outsider on the inside'. If I had been a clinician myself, the thesis I produced would undoubtedly have been different.

A note on constructionism

The theoretical basis of this study is the theory of social representations. This is an explicitly social approach to social psychology, which takes a constructionist position, and aims to provide a multi-level framework for understanding social phenomena, integrating psychological understandings with approaches from other social sciences. The reader will find this stance reflected in the thesis, which draws on research and writing from a range of social scientific sources, and in which consideration of social and political contexts is considered to be a vital component.

The epistemological issues associated with social constructionism are complex. Given that several different versions of social constructionism can be identified (Sarbin & Kitsuse, 1994; Gergen, 1985; Wetherell & Still 1996), I will outline the stance taken in this research. The version of social constructionism adopted in this thesis corresponds to Sarbin & Kitsuse's (1994) 'contextual constructionism', or to what Wetherell & Still (1996) term 'new realism'. It assumes that social meanings are constructed in response to phenomena which exist in some sense 'as a reality', and that to explore how societal understandings are constructed is not to refute the authenticity of certain ontological processes and entities. I take the view that what is termed 'mental illness' cannot be completely reduced to a social construction, and that this term corresponds in some way to a set of experiences and processes (even if these are heterogenous and vary across time and culture). The palpable signs of distress, disturbance and suffering experienced by the majority of people designated mentally ill cannot be simply dismissed as a social construction, even though this experience may be understood by that person and others in a socially determined way. As Mary Boyle puts it '(i)t is obviously the case that

people claim to hear voices, speak incomprehensively and show other disturbing behaviours. What is contested is the interpretation of these observations' (Boyle, 1990, p 166). To explore the socially constructed nature of concepts like mental illness is not to deny the existence of certain behaviours and experiences[2].

The analytic focus of social representational research, and of this thesis, is on epistemological rather than ontological questions. Social representations theory is a theory of social knowledge concerned with psycho-social processes in the formation and maintenance of social beliefs systems, rather than with relationships between these knowledge structures and ontological reality (Markova, 1992). The very term 'representation' implies some sort of 'reality' exterior to the representation. Although they may take on a social reality of their own, social representations are always symbolic of something. Having said this, pursuance of an analytic split between the experience of mental illness and the way it is socially represented should be avoided. After all, what defines mental illness in a very real sense is its attention by mental health services and the social processes which flow from this.

Terminology

Language use and choice of terms is never a neutral process. In this thesis I use the terms 'mental illness', 'mental distress' and 'mental health problems' interchangeably. Use of the term 'mental illness' should not be taken to imply a medical model - I recognise the users-movement argument that 'mental distress' may be a more appropriate term which conveys experience rather than objective medical labelling. However, 'mental illness' is used as it is the term which holds the most social currency at the present time, especially within the community of mental health professionals with whom this research was conducted.

The thesis deliberately avoids the term 'madness'. Evidence from various studies

[2] A common criticism levelled at social constructionist perspectives on mental illness has been their negation of the 'reality' of mental illness (for example, Gove (1982) on labelling theories; Sedgewick (1982a) on the anti-psychiatry movement). These critiques are based, often incorrectly, on the assumption that what Sarbin & Kitsuse (1994) define as a 'strict' constructionist perspective is being adopted. (A position of radical relativism in which the ontological status of social phenomena is questioned.) Such misunderstandings have often led to social constructionist perspectives on mental illness being dismissed by empiricists or by those who work with the mentally ill who adopt a strict realist approach to mental illness (Boyle, 1990).

(Ayesteran & Paez 1986; Petrillo 1987; Serino 1987) suggests differences in the social connotations of the terms 'mental illness' and 'madness'. 'Madness' is seen much more in the realm of the bizarre, associated with dangerous and florid behaviour, and is a more specific term than the generic term 'mental illness'. 'Madness' is also associated with pre-medical belief structures, and as such is less appropriate for a thesis written in the English language which focuses on contemporary mental health professionals[3].

2 Overview of the Thesis

Writing a thesis is like telling a story. The writer constructs a structure which guides the reader through a body of research findings, analysis and theoretical ideas. In order for its focus to make sense beyond the world of the author, and its analytic and theoretical contribution to be evaluated, the construction of this story must necessarily be reader-centred. It does not, therefore, include all the various strands explored during the research, whose selective omission defines what is present in the final version of the thesis. Nor can a linear structure capture the circular nature of qualitative research. As such, the structure of this thesis bears witness more to this process of constructive story-telling than to the chronological sequence of events and development of ideas from which it is constituted.

The thesis begins with a short preamble. Chapter 1 serves to set the scene, and to provide the reader with information about the field of study, namely mental health care systems in France and Britain. It reviews the history of mental health care in these two countries, illustrating a common historical legacy of marginalisation of the mentally ill, followed, in recent decades, by similar moves towards integrative, community-based policies and practices. Simultaneous with these broad similarities, France and Britain are also somewhat different in their current strategies of care for the mentally ill. Theoretical approaches to mental ill health have also differed, the most significant difference being the greater impact of psychoanalytic ideas in France.

[3] The use of the term 'madness' (la folie) in Denise Jodelet's (1991a) study of social representations in a rural French community seems more appropriate than in this case for two reasons. First, it reveals the weight of pre-medical belief systems in contemporary lay understandings. Secondly, the term 'folie' has more social currency in France than its equivalent in the English language. This is evidenced by French mental health professionals' use of the term 'folie' in the current research (see Chapter 5, section 1).

Following this prologue, the main body of the thesis begins with Chapter 2. The literature review and exposition of the theoretical framework of the thesis are split between this and the following chapter. This division is intended to guide the reader from the general to the specific, focusing in Chapter 2 on lay and societal understandings of mental illness, and in Chapter 3 on mental health professionals and their practice-based beliefs about the nature and treatment of mental illness.

Chapter 2 introduces the central tenets of the theory of social representations which forms the theoretical foundations for this research. It presents the theory of social representations as a powerful tool which allows social psychologists to conceptualise processes of social knowledge production and circulation. Social representations are common sense theories or branches of knowledge which help individuals and collectivities make sense of phenomena in their social world. The strength of social representations theory lies in its ability to conceptualise both the agency of the individual and the power of society in this process. The second part of Chapter 2 provides a selective review of research and writing on mental illness as a social phenomenon conducted from the perspectives of social representations theory, social history, sociology and psychology. Uniting this work is the pervasive finding that mental illness is understood in western societies as a strange, threatening and dangerous 'other', which has been marginalised throughout history by exclusionary practices at macro-social, group and inter-personal levels. It is suggested that as the manifestation of unreason and irrationality, mental illness is feared in modern western society because it represents loss of control over the self and an undermining of the very essence of person-hood. Representing mental illness as a distant and different 'other' allows individuals and collectivities to make sense of a phenomenon which is socially and individually challenging. Within this context, contemporary policies of reintegrating the mentally ill into society constitute a dramatic challenge to society's historically rooted understandings and reactions to mental distress.

Chapter 3 begins by returning to the theory of social representations, this time with the aim of developing a theoretical tool to study professionals. When the world of professionals is the focus of study, several problematic aspects of the original theory are identified. To overcome these problems, a model of 'professional social representations' is proposed. Five 'building blocks' of professional social representations are proposed: theory, practice, professional roles and identities, lay representations, and organisational

factors. This model conceptualises professional practitioners as fulfilling a unique role in the circulation of social knowledge, acting as translators, vectors and integrators of diverse knowledge sources between various social worlds. Following this theoretical elaboration, Chapter 3 returns to research on mental illness, this time, with the specific focus on understandings amongst mental health professionals. It elaborates the theories, roles and daily practices which characterise the world and work of mental health professionals, and highlights the multiplicity and diversity of understandings of mental distress available to mental health practitioners.

In Chapter 4 the methodology of the current empirical investigations is set out. This chapter constitutes a deliberate attempt to sketch a clear and transparent path through the practical processes of qualitative data collection and analysis, allowing the reader to evaluate the study's findings with full knowledge of the procedures from which they are derived. Although the theory of social representations does not privilege any particular method of research, the use of semi-structured interviews complemented by secondary data sources (documentary evidence, observations and interviews with key informants) is compatible with the epistemological assumptions of the theory in accessing social life *in situ*, integrating individual and collective perspectives, and providing tools for in-depth exploration of content. After describing data collection procedures, the chapter considers recent developments in the use of computer technology for analysing qualitative data. A detailed account of how the process of analysis is both aided and shaped by the use of a specific computer package, 'QSR-NUDIST' is provided. Analysis is both grounded in the data and motivated by certain theoretical preconceptions, aiming to inform understandings on both substantive and theoretical levels. It is essentially qualitative and thematic, but makes some use of quantitative measures. The final section of Chapter 4 considers the thorny issue of the 'credibility' of qualitative analysis. It argues that a dynamic concept of credibility is needed, and that this can be best assessed through multiple criteria. In aiming to ensure its own credibility, the current research adopts strategies of 'triangulation', 'researcher reflexivity' and 'transparency'.

The following three chapters, Chapters 5, 6 and 7 present the empirical findings of the thesis. This begins in Chapter 5 with an analysis of mental health professionals' most basic understandings of the concept of mental illness and its causes. Two key features which characterise these representations are uncertainty and multiplicity. No single

uncontested representation of mental illness emerges, and there is constant debate and questioning. For mental health practitioners, mental illness is a polymorphic category whose boundaries are not clearly defined, and within which an important binary opposition between 'neuroses' and 'psychoses' is made. Mental illness is defined in essentially social terms, as experiences and social behaviour which are in some way different from the norm, distressing (either to the person or to other people), and disruptive of social life and personal relationships. For professionals, mental illness is not definitively 'other' - themes of mental illness as a fragile but powerful 'other' compete with themes of similarity. This is one important way in which 'psychosis' and 'neurosis' are differentiated. Professionals' understandings of the causes of mental illness highlight the agnosticism which permeates these representations. Complex but provisional causal models draw upon ideas derived from several theoretical perspectives, whilst remaining consistent with common sense. Within these causal understandings, psychodynamic ideas are given more weight in France, whereas medical and social perspectives carry more weight in British.

Chapter 6 focuses on professional practice, illustrating how professionals' social perspective on mental illness and the multiplicity and agnosticism which pervade their representations are lived out in eclectic treatment strategies. The chapter focuses on three investigative areas. Firstly, it explores what professionals aim to achieve in their daily work. This highlights how professionals conceptualise their work as a social rather than medical endeavour, which targets both intra-psychic problems and life-style issues. Their ultimate aim is to enhance the quality of their clients' lives within the parameters of social acceptability and the enduring existence of mental illness. The second part of Chapter 6 investigates the practical strategies that professionals use to achieve these aims. In their dual concerns with long-term care and crisis intervention, professionals make use of an eclectic package of measures including medication, group activities and various 'talking therapies'. All of these practical strategies are underpinned for professionals by the quality of the relationships they establish with clients. In enabling a connection with mental illness, relationships form the bedrock of professional practice. The third area of investigation centres on the role of theory in professional representations. Links between theoretical understandings and daily practice are typically weak, but theories serve several important functions acting as anchors, *post hoc* justifications for practice, components of professional identity construction, and tools to manage relationships with

mental illness.

The third analytic chapter, Chapter 7, explores professionals' experiences and evaluations of recent moves towards community-based care. The historical significance of this relatively rapid shift after several centuries of marginalisation is reflected in its disorienting effect within worlds of mental health care. Whilst there is general consensus that moves towards community-based care are a desirable ideal, professionals perceive significant discrepancies between this and the reality of its implementation. Especially in Britain, concern over the limitations imposed by financial constraints is considerable, and there is a pervading sense of powerlessness. Implementing new styles of care raises particular issues in the domain of professional inter-relationships: Multi-disciplinary team working is often experienced as a double-edged sword which overcomes old hierarchies but poses new problems of role blurring and ambiguities. Within this, the difficulties experienced by social workers and clinical psychologists reflect, respectively, on-going debates regarding the remit of mental health services and their relationships with other social agencies, and shifts in the traditional dominance of the medical profession.
Section 3 of this chapter conceptualises current community care policies as effecting professional representations of mental illness in three inter-related ways. Firstly, novelty, ambiguities and lack of knowledge add uncertainty to representations already characterised by much agnosticism and confusion. Second, community care constitutes a significant challenge to both lay and professional representations of mental illness. And finally, new policies highlight conflicting agendas, bringing into sharp focus the unique and difficult 'cross-road' position of mental health professionals.

The final chapter of the thesis, Chapter 8, draws together its principle empirical findings and uses these as the basis for reflection on both theoretical and substantive issues. A common theme which emerges across all areas of empirical analysis is that professionals understand mental ill health not as an isolated medical event, but in relation to the norms of the social world. Despite their expert status, professionals' representations of mental illness are characterised by unusually high levels of agnosticism and uncertainty. Professionals of all disciplines are united by broadly similar representations, and commonalities between Britain and France generally outweigh differences. The chapter argues that a key function of professional social representations is the construction of compromise solutions in response to the ethical dilemmas and tensions which are raised

in many people-based professions, but are particularly rife in the work of mental health practitioners. A number of theoretical issues are discussed. These include how otherness themes, multiplicity and ambiguity can be accounted for within the framework of social representations theory, and a call for a more complex conceptualisation of 'unfamiliarity' than is currently provided. The thesis ends by considering potential avenues of future research, and evaluating its contributions in furthering understanding of contemporary mental health work, and suggesting practical strategies which may ultimately improve the lot of the mentally ill. For example, training to challenge professional representations of psychosis as an un-understandable 'other', and greater participation of practitioners in organisational and policy changes may contribute to the successful implementation of community-based care as it develops in years to come.

CHAPTER 1

SETTING THE SCENE: MENTAL HEALTH CARE PAST AND PRESENT

This short chapter serves as a prologue to the thesis. It provides the reader with information about the field of study which is a necessary prerequisite to understanding the analyses and arguments which this study presents. Specifically, it reviews the contextual background to this research project, namely historical and contemporary societal reactions to mental illness. A discussion of the history of mental health care in France and Britain begins the chapter (section 1). Following this, section 2 moves into the present day, reviewing the principle features of contemporary mental health care policies in both countries.

1 A Brief History of Mental Health Care in Britain and France

The history of societal reactions to mental illness in Europe has been elaborately investigated by many authors (for example, Barham 1992, Busfield 1986, Foucault 1967, Mangen 1985, Miller 1993, Pichot 1983, Porter 1987, Prior 1993, Scull 1979, 1981). These reviews suggest broad similarities in the historical development of reactions to mental distress in France and Britain. Although the confinement of paupers, mad people and other social deviants began in Europe in the seventeenth century, mental illness first became the specific target of State involvement in the early nineteenth century. Acts of parliament were passed in most European countries requiring the establishment of asylums to care for those designated mentally ill. The construction of asylums in remote areas deliberately distanced from centres of population served to marginalise mental illness, for the supposed good of both society and the inmates themselves. Foucault (1967) argues that this move initiated the medicalisation of madness and its transformation into mental illness which has shaped our understandings of mental distress ever since. A view of madness caused by imbalances in humours, spirits and vapours and tensions within the bodily system was gradually replaced by a more 'scientific' view in which problems were localised in the brain. Mental illness fell under the medical gaze of 'mad doctors' and 'alienists', whose ideas and practices developed in tandem on both sides of The Channel. (Early British psychiatrists were strongly influenced by prominent

French psychiatrists such as Esquirol and Pinel.) The development of nineteenth century asylums set the stage for societal reactions to mental distress centred around the twin themes of medicalisation and marginalisation. Long term incarceration, squalid conditions, overcrowding and inhumane practices became the norm in French and British asylums, and this approach to mental illness remained relatively unchallenged well into the twentieth century[1].

During the first half of the twentieth century, medical interest in mental illness continued to develop and asylums became places not only of containment, but also of 'treatment'. The remit of psychiatric institutions widened from custody and control to include the possibility of cure (Prior, 1993). Developments of medical treatments such as electro-convulsive therapy and psychosurgery in the 1930s served to enhance the medicalisation of mental illness which had begun in the early nineteenth century, although at this stage, there was little challenge to the view that the mentally ill should be segregated from society.

It was not until the 1950s that the role of the asylum began to be seriously questioned. Following World War II there was a growing trend towards State involvement in public health and welfare in most European countries. Together with the development of phenothiazines in the 1950s, and increased recognition of the role of social factors in mental illness[2], this marked the beginning of changes in State reactions to mental illness. Essentially, this constituted a widening in the attentions of mental health practitioners into areas of prevention, social relations, behaviour and the mind which, in the custodial model of asylums, had previously been left unexplored. While the influence of

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[1] Some notable exceptions were the attempts to develop more humane ways of dealing with the mentally ill by a small number of psychiatrists. Under the influence of the Gheel Lunatic Colony in Belgium, a handful of 'colonies' or 'community schemes' were established during the nineteenth century:- a village scheme in Bicknill, England; the farm-hospital of Sainte-Anne, then on the outskirts of Paris; the two 'family colonies' of Ainay-le-Chateau (1897) and Dun-sûr-Aron (1891) in central France described by Jodelet (1991a), as well as other experimental schemes in Scotland and Germany (Parry-Jones, 1981). Although these schemes influenced only a tiny minority of the mentally ill, they were an important influence in the more recent development of community-based strategies of mental health care.

[2] Epidemiological studies such as those conducted by Faris & Dunham (1939) and Hollingshead & Redlich (1958) began to demonstrate a link between social positioning and the prevalence of mental illness. During the 1940s the Tavistock Clinic developed group therapies for war neuroses, while Maxwell Jones was developing the principles of 'therapeutic communities'.

psychiatry remained strong (the American Psychiatric Association first published its Diagnostic and Statistical Manual of Mental Disorders (DSM) in 1952 and its forth edition is now used internationally by psychiatrists), this began to supplemented by other approaches to mental ill health. A wave of therapeutic optimism developed among mental health experts leading, by the end of the 1950s, to a growing belief in the possibility of more community based care. For the first time, institutionalisation was not the only option for those with long-term mental disturbances. Pharmacological control of symptoms suggested the possibility that patients could be engaged in more genuine human relationships, the development of a variety of psychotherapeutic techniques and the possibility of rehabilitation into the community. These ideas formed the building blocks of moves towards care of the mentally ill in the community in most European countries. However the translation from ideas to practice has taken several decades and has been achieved in different ways in France and Britain.

2 Contemporary Mental Health Care Strategies

2.1 France

The development of mental health care in France in the last three decades is characterised by the proliferation of many new and radical ideas at an early stage, followed by a much slower and less dramatic translation of these ideas into practice. Moves towards community based care have been under way since 1985 and this gradual change process is still on-going.

The 1950s, 1960s and 1970s saw a huge proliferation of psychodynamic ideas, both within mental health and in French society more generally (Castel & Le Cerf, 1980; Turkle, 1979). This centred around the ideas of Jacques Lacan, leader of a new school of French psychoanalysis, whose ideas represented a radical reworking of the early writings of Freud (see Appendix 3). His anti-biological, anti-establishment, poetic, linguistic and political version of psychoanalysis captured the zeitgeist of French intellectual society. Moscovici's (1976) study of the infiltration of psychoanalysis into French society in the late 1950s showed moderate diffusion of psychoanalytic concepts into many sections of society. However, following the left-wing movement of the late

1960s, centred around 'Les Evénement' of May 1968 psychoanalysis was elevated to 'the rank of a major ideology' in contemporary French society (Moscovici, 1984, p58)[3].

In the post World War II decades French mental health services had been dominated by medical approaches, with psychoanalytic ideas making a marginal impact. The developments of the 1950s described above began to be detected beyond the world of mental health as early as 1960, when a Ministerial Circular stated that '(t)he essential principle in the struggle against mental illness is to separate the patient from his family and social environment as little as possible. ... It must not be forgotten that the majority of the mentally ill present important medico-social problems which cannot be resolved by hospitalisation, and that hospitalisation may even be detrimental' (from Jaeger, 1989, p17, my translation.) However, this was not accompanied by legislative changes and psychiatric in-patient numbers in France continued to rise over the next two decades. In this context, the political events of 1968 fuelled a desire for real changes amongst many mental health practitioners. Drawing on both Lacanian theory, and the anti-psychiatry movement which was developing in Britain and the United States, there were calls for a radical overhaul of the French mental health system. Some attempts were made to develop a new approach based on analytic psychotherapy (for example the mental health services of the 13th arrondissement of Paris, developed by La Borde and colleagues). However, for the most part, the principle effect of these radical ideas in mainstream mental health care was the infiltration of psychoanalytic approaches into a system which remained structurally unchanged. French mental health became dominated by a combination of medical and psychoanalytic ideas and practices (Castel, 1981), although the last decade has seen a gradual waning of interest in psychoanalytic approaches.

It was not until 1985 when legislation on 'sectorisation' was passed, that any significant changes to styles of mental health care in France were implemented. 'Sectorisation' or 'la psychiatrie de secteur', based on approaches to public mental health developed by Daumézon in Paris in the 1950s, represents the French approach to community based

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[3] In a study similar to Moscovici's research, Turkle (1979) found that the extent of diffusion and penetration of psychoanalytic ideas into French society was much greater in the early 1970s compared to the 1950s. She found interest and understanding across people of all ages and classes, and a six fold increase in the percentage of middle class people who claimed that psychoanalysis was a frequent subject for conversation.

care for the mentally ill (Gittleman et al, 1973). (It also applies to services for the elderly, people with learning disabilities and children.) 'La psychiatrie de secteur' is based on the principles of a decentralised system in which highly localised networks of hospital and community based services are provided by autonomous multidisciplinary mental health teams. The 1985 legislation divided France into 789 geographical 'secteurs', containing an average population of 70,000. It required a reduction in the number of hospital beds and recommended the development of services focusing on prevention, rehabilitation and community based support. 'Centres medico-psychologique' would form the basis of community based services, complemented by day centres, hospital out-patient departments, 24 hour crisis centres and sheltered accommodation.

At the time of this research project the new 'psychiatrie de secteur' is still being negotiated. The shift in France towards care of the mentally ill in the community is gradual. It is neither as rapid nor as radical as the changes in Britain. In-patient facilities still form an important part of the mental health system and are mainly provided in the large psychiatric institutions constructed in the nineteenth century. This means that for many secteurs, hospital facilities are located a long way from the secteur itself, leading to lack of integration between hospital and community services and personnel. This has also enabled the peaceful coexistence of medical and psychoanalytic approaches. Professionals of a psychoanalytic orientation, and those most influenced by the social movements of the late 1960s have appropriated community based services, while hospitals have remained bastions of medical power.

As an indication of the recent changes, average lengths of hospital admissions have gradually reduced over the last three decades (from eleven months in 1965 to three months in 1989), although this period has also seen a three fold increase in readmissions (Jaegar, 1989). However, average figures such as these mask the considerable variations which characterise contemporary mental health services in France. The decentralised system places decisions regarding the development of services and use of financial resources in the hands of 'chefs de secteur' (invariably a consultant psychiatrist). As a result the development of community based services varies enormously across secteurs (Mangen & Castel, 1985). In some, hospital admissions are kept to a minimum and a wide range of community services has been developed. In others, mental health services remain essentially hospital based with only minimal development of community services.

The descriptions of the mental health services in which research was conducted in Appendix 1 provide examples of contemporary mental health services in three secteurs in the Paris region.

2.2 Britain

In comparison to the gradual and variable shift in styles of mental health care in France, contemporary mental health services in Britain have been shaped principally by recently introduced policy changes. Since the late 1980s sweeping policy changes have been imposed across all areas of health and welfare provision. Not only have changes in mental health care been extremely rapid in recent years, but they have also been more politicized than in France. As a consequence, these changes have been the focus of a large body of literature in the social sciences (see, for example, Barham, 1992; Bornat et al, 1993; Braden-Johnson, 1990; Busfield, 1986; Murphy, 1991; Ramon, 1992; Sayce, 1990; Sharkey & Barna, 1990). The purpose of this review is not to get involved in these evaluative debates[4], but to highlight the recent policy changes which most authors would agree have shaped mental health care in Britain in the 1990s.

Contemporary policy changes can be traced back to the post World War II period when the idea of community based care for the mentally ill as a viable alternative to large scale institutionalisation began to gain ground[5]. This was fuelled by the diversification of perspectives on mental ill health which occurred in the 1950s and 1960s. The rise of social theories of mental illness (translated into social psychiatry), and developments in psychology, (translated into cognitive and behavioural therapies) were especially prominent during this period[6]. While psychodynamic ideas prevailed in France, their impact remained marginal and indirect in Britain, entering mainstream mental health care

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[4] Common themes in this literature include concerns about lack of adequate financial resources, the ideologies underpinning recent policy changes, the gap between policy rhetoric and practice, and the difficulties of introducing community based care in the face of public scepticism or opposition.

[5] The term 'community care' first appears in a report by the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency in 1957 (Bulmer, 1987), and the principle of reorienting mental health care away from the asylum was expressed in the Mental Health Act of 1959 (Mangen & Rao, 1985).

[6] See Appendix 3 for a review of these theoretical approaches to mental illness.

primarily through group therapy, with individual psychoanalysis remaining within private practice. The anti-psychiatry movement of the 1960s constituted a vehement attack on institutional care and added further strength to calls for changes in mental health policies. In response, a series of government White Papers in the 1970s and 1980s began to provide legislation for the gradual dismantling of institutional care and development of community services. However, most commentators regard the publication of the Griffiths Report in 1988 as the key initiator of a series of policies which have reshaped contemporary mental health services in Britain.

The government commissioned report by Sir Roy Griffiths in 1988 set the tone for the development of community care for the mentally ill in Britain. It recommended that the responsibility for community care should be taken primarily by local authorities, and that provision of community services by the private and voluntary sectors should be encouraged. A series of government White Papers followed, culminating in the massive reorganisation of health and social service resources set out in the 1990 NHS and Community Care Act. Legislation in this Act, in which financial control of all non-hospital based care for the mentally ill, the elderly and people with learning difficulties was transferred to local authorities, was implemented in stages during the beginning of the 1990s. Changes in mental health care were only one aspect of a range of policies transforming health and social services to reflect the right wing ethos of the ruling Conservative government. This included a general reduction of the welfare state, major cuts in public spending, and the introduction a market structure and ideology into health service provision.

Within this context, the introduction of community care for the mentally ill in Britain has become a major political and social issue in recent years, commanding much media attention and debate amongst the public, mental health professionals and academics alike. What began as a principle often associated with left-wing ideologies and social criticism has been appropriated in Britain by the political right and firmly relocated at the heart of their individualistic and consumerist policies. 'Community care' has become something of a 'buzz word', an emerging term associated with value-laden rhetoric, whose definition remains fluid and unclear. The general aims of recent policy changes have been to encourage provision of care for the mentally ill based on a consumerist model of care and the twin themes of independence and normalization. Policy rhetoric seeks to reconstruct

the previously disempowered and institutionalised patient as an independent consumer in a free market society. This is implemented in strategies attempting to achieve the following aims: reductions in the number of people hospitalised for mental health problems and lengths of hospital admissions; provision of care principally in small, locally based, non-residential units in the community; flexible and individualised service provision targeted towards those with the greatest needs; an integrated network of services targeting treatment, prevention and rehabilitation; the provision of these services jointly by health and social service agencies; and an increasing role for private and voluntary sector agencies in the provision of services, together with increasing reliance on networks of family and friends in caring for the mentally ill. The achievement of these aims depends on multi-disciplinary mental health teams in which community based and non-medical professions (social workers, case managers, community psychiatric nurses) play an increasingly important role.

The speed with which these changes have been implemented in recent years is one of the defining features of mental health care provision in recent years in Britain. There has been widespread reduction of hospital capacities, with the closure of many large psychiatric hospitals dating back to the nineteenth century, and little time to develop a network of community services. The development of community services has also been hampered by financial constraints. The changes charted in this section represent a huge shake up of mental health services in a very short period of time. Unlike in France, these are the result of politically motivated changes imposed on mental health services 'from above'. Appendix 1 presents descriptions of the mental health services in London where research was conducted. This provides examples how these policies have been put into practice in specific mental health services.

The first section of this chapter highlights how France and Britain share a common historical heritage in the ways they have reacted to mental illness. The large scale segregation of the mentally ill from main stream society reigned unchallenged up until the middle of the twentieth century. Mental distress became not only medicalised, but also regarded as something dangerous and beneath humanity. Within this historical context, the shift towards integration of the mentally ill into the community which has

occurred in recent decades in France and Britain represents a dramatic change in societal reactions to mental illness. It also represents an expansion beyond medical interventions. The relocation of mental health care within the community has been associated with a diversification in the types of interventions, treatment strategies and professional groups associated with the mentally ill.

During the late twentieth century there has been a general trend throughout Europe and north America towards care of the mentally ill in the community. (Similarities across the European community have been noted by Mangen 1985, Rivière 1991, and Rowland et al 1992.) France and Britain have participated in this movement, although they have implemented strategies in somewhat different ways. Community based care for the mentally ill in France is characterised by variations and gradual change, and is still in the process of becoming. In Britain, more rapid and dramatic changes have been imposed in recent years. The association of these changes with political agendas has meant that community care in Britain is currently an important social issue. Recent decades have also seen both similarities and divergences in the development of theoretical understanding of mental illness. While the influence of anti-psychiatry and social models of mental illness was felt on both sides of The Channel, psychoanalytic ideas have dominated in France, whilst psychological and social understandings have held more sway in Britain.

This brief review of the history of mental health care and the development of contemporary strategies of mental health care in two countries serves as a springboard to the main body of this thesis. Having set the scene in this preamble, we can now turn to address the theoretical framework which orients this analysis of how mental illness is understood by contemporary mental health professionals in Britain and France.

CHAPTER 2

SOCIAL REPRESENTATIONS OF MENTAL ILLNESS

This chapter begins the main body of the thesis. It serves to orient and position the thesis both theoretically and substantively. The theory of social representations, which provides the theoretical framework for this research study is introduced, followed in section 2 by an overview of a large and heterogenous body of theory and research on lay and societal understandings and reactions to mental illness. This selective literature review provides a necessary backdrop to a study focused on mental health professionals, whose practices form part of this broader representational tapestry. The chapter ends with a brief consideration of the implications of these common sense understandings for professionals working to treat and care for the mentally ill.

Section 1 documents the basic tenets of social representations theory[1] and is based on a reading of the works of some of its principle proponents (Farr 1987, 1989; Jodelet 1991a, 1991b; Moscovici 1981, 1982, 1984, 1987, 1988). While the theory has inspired much lively and critical debate (see, for example, Harré 1984, Jahoda 1988, Potter 1996, Potter & Litton 1985, Raty & Snellman 1992), we will not enter into these debates at this point. Critical evaluation of aspects of the theory relating to the empirical and substantive focus of this research will be tackled in Chapter 3, and in Chapter 8 aspects of the empirical findings will be used to support suggestions for some modifications to the theory.

1 The Theory of Social Representations: An Initial Overview

For social psychologists wishing to break out of the individualistic and cognitive approaches which have dominated social psychology in the English speaking world from the 1960s to the mid 1980s, the theory of social representations is an exciting development. Although its reception has generally been most positive in European and

[1] While I will adopt the convention of referring to *the theory* of social representations, this should not be taken to imply a consistent and well defined theory in the strict sense. There is currently much diversity of opinion about even the most basic epistemological tenets amongst researchers working under the umbrella of social representations. I would agree with Wagner (1996) that it may be preferable to refer to the social representations *approach*.

Latin American countries, it is clear that together with discourse analysis and social identity theory, the theory of social representations is now part of a significant shift towards more social approaches within English language social psychology. This is evidenced by its inclusion in recently produced undergraduate texts on social psychology (eg Augoustinos & Walker 1995; Wetherell 1996), as well as by a growing body of empirical research using the theory (see for example Farr & Moscovici 1984; Breakwell & Canter 1993).

Social representations theory is essentially a theory of social knowledge. It was developed originally by Serge Moscovici as a tool to guide research on understandings of psychoanalysis in 1950s French society (Moscovici 1976). While drawing on the Durkheimian notion of collective representations - socially shared beliefs about broad topics such as religion or science - Moscovici regarded Durkheim's notion as too static for social psychologists studying contemporary society. If they wish to understand the dynamic processes through which understandings develop and circulate in late modern societies characterised by diversity, reflexivity, an explosion of mass media and communication channels, and disintegration of central institutions and their doctrines (Giddens, 1991), social psychologists need a theory which can capture the fluidity of these individual and social processes. The theory of social representations sets out to provide this framework. Its strength lies in its ability to conceptualise both the agency of individuals and the power of society, and to capture the dialectical nature of their inter-relationship.

The theory of social representations takes an essentially social approach to social psychology. Moscovici sees social representations as part of a 'thinking society' in which the thinking is done out loud. Social reality is constructed and negotiated through the talk, activities and interactions of individuals and groups, which are part and parcel of wider collective practices and belief systems lived out through the structure of society and its institutions. From this point of view, society becomes the focus of study rather than simply the backdrop, and can no longer be reduced to the sum of a collection of individuals. What constitutes a thinking society is greater than the sum of its parts. Not only does the theory aim to integrate intra-psychic, inter-individual and societal processes, but it also recognises the value of drawing upon social psychology's sister disciplines in the social sciences. As Jodelet (1991b) notes, it is this brave position at

the crossroads between psychology, sociology, anthropology and social history that lends the theory of social representations its richness. There is the possibility for integration of a range of perspectives and accompanying methodologies, and for theoretical advances through the combination of different approaches from disciplines which have traditionally followed rather separate paths in their understanding of social phenomena.

Social representations theory also takes an explicitly social constructionist stance[2]. Moscovici stresses that social representations are involved in a complex interaction between the re-presentation and the creation of social reality. They are involved jointly in the creation of images and in the creation of meaning. Moscovici offers the following definition of social representations:

> 'a set of concepts, statements and explanations originating in daily life in the course of inter-individual communications. They are the equivalent, in our society, of the myths and belief systems in traditional societies; they might even be said to be the contemporary version of common sense.' ... 'They have a curious position somewhere between concepts whose purpose it is to distil the meaning of the world, to make it more orderly, and perceptions that reproduce the world in a reasonable manner.' (Moscovici 1981, p 181 and p 184).

This constructionist position sees content as equally as important as process, and the split between subject and object as meaningless. Social representations cannot be separated from the individuals, social groups and collectivities that create and use them. Their content reflects something of the experiences and positionings of those who hold them. 'The representor is thus present in the thing represented' (Moscovici, 1988, p 232). The theory also looks beyond the cognitive and the rational, considering the symbolic, the unconscious and the emotional as valid aspects of social psychological investigation.

Common sense theories or shared branches of knowledge - in other words, social representations - serve to familiarise what is unfamiliar. These may be concepts or

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[1] Social constructionism is defined by Gergen (1985) as based on one or more of the following four assumptions: Radical doubt in the taken-for-granted world, inviting challenges to the objective basis of conventional knowledge; a view of terms in which the world is understood as social artifacts and products of historically situated interactions; an assumption that 'the degree to which a given form of understanding prevails or is sustained across time is not fundamentally dependent on the empirical validity of the perspective in question, but on the vicissitudes of social processes' (p 268); and finally a view of forms of negotiated understandings as critical to social life in their connection to many other social activities. There is currently much debate within the international community of social representations researchers as to what form of constructionism is most compatible with the theory. The author's own position in the social constructionism debate has been elaborated in the Introduction.

phenomena which are new to a society, such as AIDS or scientific and technological developments, or those which inspire feelings of unfamiliarity through disjunction with conventional sets of ideas, images and beliefs. 'It is in this way that the mentally handicapped, or people belonging to other cultures, are disturbing, because they are like us, and yet not like us' (Moscovici, 1984, p 25). Unfamiliarity inspires both attraction and intrigue as well as fear, threat and a sense of disturbance. It is society's and individuals' deep-rooted fear of the strange and the abnormal, and desire to live in a safe, comforting and secure world which motivates the creation of familiarising social representations. The theory suggests that familiarity always wins over unfamiliarity[2] - what is new or strange is incorporated into familiar established belief systems in such a way as to create minimal disturbance to the established order. So the images, ideas and language which are historically shared by a given group dictate the way the group tries to come to terms with the unfamiliar. For example, Moscovici (1976) found that in certain sectors of 1950s French society the new practice of psychoanalysis was made familiar by comparing it to the act of a religious confession.

In familiarising the unfamiliar, social representations function to allow individuals and collectivities to achieve several things: to order their social world; to position and define themselves relative to each other; to explain aspects of the world and in so doing gain a sense of mastery and understanding; to guide and justify interactions and social practices; and to communicate, by shaping both what is taken-for-granted, and the spaces in which debate and negotiation is possible. The circulation of social representations in the media, in day-to-day conversations and practices, in politics, in social organisation, and in the cultural *zeitgeist*, is part of the continual negotiation and reconstruction of social reality.

At a meta-theoretical level, social representations theory is based on the assumption of a qualitative split between lay knowledge and understandings (which circulate in the 'consensual universe' - the world of common sense), and 'scientific' knowledge produced

[2] Much of the empirical research on mental illness reviewed in section 2 of this chapter and in Chapter 3 does not support this assumption. It suggests that social representations of mental illness retain unfamiliarity as one of their central themes. The notion of unfamiliarity is a particular aspect of social representations theory which is challenged by the current research. Consideration of this issue, together with some suggestions for theoretical elaboration occurs in Chapter 8.

within the world of science (the 'reified universe'). Although concepts and ideas produced in the reified universe may be translated (through the mass media or eduction) into the consensual universe, it is assumed that the processes of knowledge development in these two worlds are fundamentally different[3]. The consensual universe is where social representations develop and circulate. Their genesis may involve integration of ideas and concepts originating in the world of science with society's stock of knowledge, ideas and beliefs which have developed throughout its changing history. This familiarising and sense making process is achieved through two basic processes - anchoring and objectification.

Anchoring is defined as 'a process which draws something foreign and disturbing that intrigues us into our particular system of categories, and compares it to the paradigm of a category which we think to be suitable' (Moscovici, 1984, p 29). This is achieved through the two processes of categorisation and naming, which serve jointly to establish a link between what is known and what is not known. The unfamiliar object or idea acquires some of the basic characteristics of the category to which it is anchored and is readjusted to fit within it. Anchoring processes occur within the context of a web of other social meanings and belief systems and are never neutral. More than merely a process which allows us to deal cognitively with the complexities of the social world in which we live, anchoring involves affective processes and allocation of value judgements. It makes description, explanation and evaluation possible. To the extent that the same anchors are accepted and shared by members of a society or a social group, communication about a new concept is made possible. Through conversations and media debates a new representation circulates in society and its nature and social position can be modified. So for example, as psychoanalytic vocabulary became anchored in the vocabulary of everyday life and thus socialised, terms such as 'neurosis' could be used to refer to previously unnamed states of tension, maladjustment or alienation understood previously as half way between madness and sanity (Moscovici, 1976).

Billig (1988, 1993) draws attention to some other aspects of anchoring which he claims

[3] This aspect of the theory has important implications for the current research on mental health professionals. Chapter 3 discusses problems with this reified - consensual universe split, and suggests some theoretical modifications which would allow the theory to deal more successfully with processes of knowledge generation and circulation amongst professional practitioners who are socially positioned midway between the world of science / experts and the public sphere.

social representations theory has overlooked. As a rhetorician, he suggests that the essence of a thinking society is the capacity of its members to debate and argue the meaning of the categories it creates. The basic process of categorisation on which anchoring relies is complemented by its opposite, the ability to particularise. By representing individual cases either as members of a category or as unique instances, the social thinker has the possibility for negation. This means that the choice of anchors is always an active argumentative social process involving justification, criticism and rejection of the chosen anchor. Billig suggests that anchoring is usually not as smooth a process as Moscovici implies. New or unfamiliar concepts are not passively and unproblematically assigned to pre-existing categories. Instead 'the unfamiliar is likely to be a focus of controversy.... (it) is not painlessly anchored, but the dilemma of how to anchor the unfamiliar can lead to a debate about the meanings of the categories into which the unfamiliar will be inserted' (Billig 1993, p 50). These aspects of anchoring processes in the development of professional knowledge are addressed by the empirical analysis presented in this thesis.

The second process involved in the genesis of social representations is objectification. This transforms what are at first purely intellectual concepts in a remote universe into things we can see, discuss and imagine in our physical, mediated and interactive world. Objectification involves the creation of a tangible social object, the translation of an abstract concept into a concrete image. It encourages beliefs in both the physicality and the ontological realism of a scientific or abstract concept (Jost, 1993). Concept becomes interchangeable with percept, and a visual image is created representing intangible ideas or concepts such as health, AIDS, the unconscious or mental illness which can never be 'seen' in their natural form.

Objectification is assumed by the theory to involve three stages (Jodelet, 1991b): In the first stage of selective construction, elements of the idea or concept are selected, decontextualised and sorted. The choice of elements is determined according to the pre-existing stock of images and meanings which are available and acceptable to a given society. This initial process allows scientific concepts to be detached from the world of experts and appropriated by lay people. Rather than having to rely on the mediation of experts, lay people are able to feel they have a direct relationship with previously distant concepts such as AIDS or biotechnology, even if their contact with these phenomena in

fact remains minimal. This leads to a second stage of objectification - the creation of a figurative nucleus, 'a complex of images that visibly reproduces a complex of ideas' (Moscovici, 1984, p 38). The figurative nucleus of phenomena associated with people often involves personification. So abstract concepts such as AIDS and mental illness become objectified as images of the AIDS patient and the mentally ill person. Once a society has adopted a figurative nucleus it finds it easier to talk about whatever this image stands for. Finally, the figurative nucleus is naturalised - it develops a reality and existence in its own right. The fact that this image is a re-presentation or a metaphor for a concept is forgotten, as is the fact that it is merely a conventional and arbitrary reality. A representation develops its own authority allowing it to be exploited in various social situations to understand, explain and justify the social world and the actions and positions of individuals within this.

As an example, Moscovici's (1976) study illustrates the objectification of psychoanalytic concepts in French society. The psyche is visualised by lay people as two areas, the conscious and the unconscious, located in space one above the other and linked by various conflicts and tensions. In contemporary society, there is a tendency to treat terms borrowed from psychoanalysis such as 'complex' or 'repression' as if they actually existed, rather than as hypothetical constructs. Attributes or relationships are turned into things - what was originally conceived as a process develops a quasi-object status - a repression, for example. The social reality of these images permits their use as explanatory and interpretative devices, so that the odd behaviour of a friend can be attributed to their 'complex' or their 'neurosis'.

This section has provided a relatively uncritical review of the theory of social representations. Although this is the theoretical starting point for this research, it is not accepted as an unproblematic theoretical tool. We will return to aspects of the theory at various points in the thesis, often from a more critical stance. Chapter 3 uses problematic aspects of the 'consensual' and 'reified' universes as the starting point for a theoretical elaboration which provides the framework for empirical work on social representations amongst professional practitioners. In Chapter 4, methodological issues relating to the empirical application of social representations theory will be discussed.

Finally, Chapter 8 presents some theoretical implications of the findings of this research, returning in particular to the notion of unfamiliarity and the 'compromise' function of some social representations.

The second section of this chapter turns to the substantive topic of mental illness. A review of a vast body of research on lay and societal understandings of mental illness is undertaken from the point of view of social representations theory. This serves two important functions. Firstly, it highlights the ways in which mental illness has been understood both historically and in contemporary society, showing the themes which dominate how mental illness is socially represented. Secondly, it illustrates the strengths of a social representational approach which can draw together concepts and findings from several analytic levels, and in so doing provide a truly social psychological understanding of how the power of social forces interacts with interpersonal and intra-psychic processes in shaping our societal understandings of mental illness.

2 Research on Mental Illness: Social Psychological, Societal and Psychological Perspectives

The topic of societal and individual understandings of mental illness and reactions to those defined as mentally ill has attracted considerable interest across the range of social sciences. Between them, sociologists, psychologists, historians, anthropologists, politicians and philosophers have generated a body of theory and research which is as large as it is diverse. The purpose of this section is not to present an exhaustive review of this work, but rather to focus on theory and research which is compatible with a social psychological approach based within the framework of social representations theory[4]. I begin with a discussion of work on mental illness conducted by social representations researchers (section 2.1). The integrated, multi-level nature of a social representational perspective requires the researcher to consider work conducted in many of social psychology's sister disciplines. Accordingly, the focus of the following two sections is on work on mental illness conducted by sociologists and historians (section 2.2), and by

[4] This review does not include work focused specifically on mental health services, treatment strategies for mental illness, and mental health professionals, which is considered in the literature review in Chapter 3 (section 3).

psychologists (section 2.3). Section 2.4 reviews a rather different area of study, suggesting how mental illness might be understood in terms of 'folk theories of mind'. From a social psychological perspective, much of the work in sections 2.2, 2.3 and 2.4 is problematic both epistemologically and methodologically. This is especially true of much of the psychological, individual-based research. Whilst acknowledging these problems, this critical review ends by demonstrating how research from several perspectives can nevertheless be integrated into an initial understanding of how mental illness is socially represented (section 2.5). This serves as the primary framework for the current empirical research focused on the world of mental health and the professionals who work in this world.

2.1 Social Representational Perspectives

One of the most well known pieces of research using the theory of social representations, which has done much to promote the theory across the international academic community is Denise Jodelet's Madness and Social Representations (1991a, first published in French in 1989). This is a detailed case study of a 'family colony' based at Ainay-le-Chateau in central France. Established in 1900 the 'colony' aims to provide an alternative to hospital based care for over 1,000 mentally ill men who live as lodgers with local families paid a minimal sum to act as 'foster parents'. This is therefore a unique opportunity to study how an established community lives in close proximity with mental illness, and to investigate what type of representations and related daily practices have built up through the colony's history.

The methods used were primarily ethnographic, involving a range of techniques. Participant observation throughout the four year study allowed the author to investigate various types of contact with mental illness in people's homes, in public places and at social occasions. In-depth interviews were conducted with community nurses and local people who housed lodgers. These were complemented by surveys of the present day and historical functioning of the colony through questionnaires and analysis of historical documents.

Jodelet reports a picture of massive social exclusion of the mentally ill in a community

whose routines of life reflect various ways in which its members establish and maintain a psychic and social distance from their mentally ill lodgers. Compared to other lay people, these villagers may be publicly more accepting and tolerant of mental illness - a phenomenon whose constant presence over several decades has made it familiar - but their anxieties surrounding their proximity to mental illness are expressed in a range of normative practices in interactions with lodgers. These anxieties are denied in speech, and may not even operate on a fully conscious level, but they are manifested in concrete actions which serve to differentiate lodgers and separate them from family members.

Jodelet suggests that the penetration of insanity into the private realm of the family home inspires a sense of fear and fragility in the face of such unknown and unpredictable aspects of human life. 'Normal' family life is threatened and there is an underlying fear of aggression or lack of control. Consequently, rituals and practices serve to give a sense of mastery and control to foster parents in their interactions with lodgers. Lodgers live 'as if' they were family members, but through the organisation of daily life and the delimitation of living spaces, they are constantly kept separate. This separation goes way beyond social conventions on public-private boundaries in other circumstances. For example it is the exception rather than the rule for lodgers to eat with the rest of the family. Practices such as washing the cutlery and clothes of lodgers separately from those of the family are the norm, and there are strong social taboos against emotional and sexual contact with lodgers. The position of villagers is summarised as follows:-

> 'In instituting the rule of distance and in raising its prescriptions to the level of a practical moral code, is the group of foster parents not trying to overcome the contradiction of its life of openness towards those who are normally hidden behind the walls of the asylum? And whilst participating in their social integration, are its efforts to prevent their intrusion into the private domain not an attempt to avert contact with insanity?' (Jodelet, 1991a, p 137).

Jodelet finds foster parents reluctant to talk about mental illness directly, suggesting a certain shame associated with being mentally unwell. Their understanding appears to be influenced very little by established psychiatric knowledge. The lodgers' problems are never described using psychiatric nomenclature, nor are they analysed as a medical condition. Mental illness is represented as a permanent state which people 'are' rather than 'have'. It affects the whole being of the person making them incurably abnormal. Representations of mental illness in this rural community appear to be based on an underlying three fold model of the human organism which consists of the brain, the body

and the nerves. This suggests a pre-medical belief system which allows no place for affective aspects of existence. Modern medical knowledge circulates, but remains secondary to these older beliefs. For example, although families know that mental illness is not contagious, they act as if it were. Medical contagion is denied but magical contagion is feared. This involves contagion through visual contact and through bodily fluids, reflecting traces of medieval beliefs about humours. Perhaps this is also a reactivation of the historical myth that asylums and their inmates were containers and transmitters of unspecified physical illnesses (Foucault, 1967).

As a case study investigating the maintenance of social representations in everyday practices and patterns of interactions, the principal weakness of this study is its neglect of the perspective of the lodgers themselves. In excluding the lodgers and effectively silencing their voice, Jodelet risks perpetuating their marginalisation and devaluation as a group whose views would not add anything to this detailed in-depth study. Furthermore, she misses a vital perspective on social exclusion practices - we cannot judge how these practices are experienced by those to whom they are directed. Despite this, Jodelet's findings are an impressive demonstration of how a detailed and in-depth approach can reveal implicit deep-seated systems of belief regarding mental illness embedded subtly but powerfully within daily practices. The representations of mental illness found in this study may have developed historically within a very specific environment, but echoes of the themes it reveals are found across a range of other empirical investigations.

A study by De Rosa (1987) reveals similar historically grounded, pre-medical and emotionally loaded social representations of mental illness amongst lay people. This study aims to investigate the figurative nucleus of representations of mental illness using a drawing task[5]. Italian adults and children (aged 5 to 16) were asked to draw a picture of a human figure, a picture of a madman, and to draw as a mad person would. The author argues that, by bypassing rationalisation and self presentation which may be present in verbal techniques, such projective, unstructured and non-linguistic

[5] The 'figurative nucleus' is defined as the core of a social representation containing its most basic semantic elements, which may exist in a pre-linguistic or figurative form. The theory postulates that the core of a representation exists in a more permanent and consensual form than variable periphery aspects which are more sensitive to personal experience.

methodologies provide powerful access to the latent semantic universe which structures a range of manifested social representations (De Rosa, 1988, 1991).

Thematic analysis of the drawings produced shows a heterogenous range of images linked together by themes of otherness, danger and strangeness, and by a strong historical grounding. Traces of archaic images which are accorded little expression in currently dominant views of mental illness are detected, reflecting a general sense of something beyond normality and reason. Madness is anchored into ancient belief systems and objectified in images of people who are magical-fantastical, monstrous, demonic, and socially deviant[6]. De Rosa points out parallels between some of the drawings and images of madness going back as far as medieval times. This illustrates the historical constancy of core themes in social representations of mental distress which draw not only on current stocks of ideas and images, but also on archaic beliefs about otherness and difference which have permeated western societies throughout history. In the drawing produced by both adults and children, mental distress is frequently objectified in monstrous and bestial forms. Similarities between these drawings and those produced by children in France and Italy when asked to draw a monster are noted. Other images include misshapen and polymorphous figures, devils and people possessed by evil forces. Social deviance is a common theme - the mad person is represented as sexually deviant, a drunk, a tramp, a criminal and a person showing odd behaviour. However many of the drawings suggest ambivalence towards mental illness. The mentally ill are also represented as 'other' in more positive images including the clown, the jester and the artist, suggesting an association with creativity and the lighter side of life.

Despite the innovative methodology used in this study, there is also a considerable methodological flaw. By asking respondents to draw both a mad person and a human figure, the implication is that the former is somehow different to other human beings. The dominant themes in the drawings reflecting various states of deviance could be interpreted in terms of the demand characteristics of the situation. However, this methodological tautology does not detract from the archaic nature of the images produced.

[6] Cohn (1993) shows how these themes have always been part of western societies' fantasies about marginal groups, tracing links from Roman and Greek persecution of Christians in the second century to the witch hunts of sixteenth and seventeenth century Europe.

A number of other studies based on the theory of social representations provide further evidence of lay representations of mental illness which are multiple and heterogenous, but united by themes of abnormality and 'otherness'. A large scale project conducted in Italy in the 1980s explored social representations of mental illness amongst children, adolescents, students, parents of psychiatric patients, teachers and mental health professionals in Rome, Bologna and Naples (Bellelli, 1987). A range of methods including word association tasks, semi-structured questionnaires and in-depth interviews were employed.

The word association task (Serino, 1987) asked respondents to generate descriptive terms associated with five stimuli:- yourself, a normal person, a mentally ill person, a mad person, and a physically ill person. Correspondence analysis of the data showed high levels of consensus regarding relationships between representational themes. A dimension of normality - abnormality contrasted the self and a normal person with a mentally ill and a mad person. Normality was associated with generally positive terms implying personal integrity (eg intelligence, altruism, generosity) and social acceptance (eg polite, sociable, a hard worker). Mental illness and madness were seen as abnormal, defined in generally negative terms implying social stigma and danger. A second dimension of physical versus mental ill health contrasted mental illness and madness with physical illness. The mental distress terms were defined in terms of social deviance (eg dangerous, unstable, isolated, strange, aggressive) and contrasted with terms describing physical illness in terms of suffering (eg weak, pale, sad, preoccupied). A significant split between illnesses of the body and those of the mind was perceived, with descriptions of a physically ill person showing more similarities to descriptions of 'yourself' and 'a normal person' than either of the mental distress terms. To be ill is to be different, but mental ill health is a more threatening and marginalised type of difference than physical illness.

Pre-medical knowledge structures associating mental distress with deviance are again detected in this research, but are evoked more strongly by the term 'madness', than by 'mental illness', which often produces the use of psychiatric labels (Petrillo, 1987). A similar word association task in Spain (Ayesteran & Paez, 1986) confirms that madness and mental illness are construed differently by lay people. Madness is seen much more in the realm of the bizarre (abnormal, irrational, dangerous, aggressive) than mental

illness which generates terms such as 'different', 'unadapted', 'incapable', and 'distressed'.

Finally, two other studies demonstrate multiplicity and the coexistence of medical and pre-medical understandings in social representations of mental illness. Zani (1995) reports that Italian respondents asked in a structured format about the causes, consequences and treatment of mental illness appear to draw on a range of models. These include those currently dominant among mental health professionals and experts (medical, psychological and social models), as well as older conceptions, particularly a criminalised model of mental illness. A study of university students in Finland (Räty, 1990) finds several coexisting orientations to mental illness. The mentally ill are represented as qualitatively different and inferior to normal people. This coexists with a view of a 'fuzzy' border between normality and pathology, and an orientation based on social criticism (the mentally ill as victims of society or the object of unjust labelling).

To conclude this section, social psychological research based on the theory of social representations demonstrates the socially shared, deep-seated, emotionally loaded and historically rooted nature of common sense understandings of mental ill health. While the most in-depth analysis is undoubtedly provided by Jodelet (1991a), the other studies reviewed in this section demonstrate how similar representational themes can be detected across a range of European countries. They also demonstrate the diverse methodological strategies that have been applied in social representational research, a theme we will return to in Chapter 4. (Other social representational studies focused on understandings amongst mental health professionals will be reviewed in Chapter 3.)

Taken together, these studies suggest that lay representations of mental distress are multiple and heterogenous, but united by themes of difference, 'otherness', and abnormality. The exclusionary practices enacted by the villagers in Jodelet's study are a reaction to feelings of fear, anxiety and suspicion inspired by mental ill health. These emotionally charged themes are central to the lay representations found in all these studies. Furthermore, while modern medical knowledge appears to shape lay representations to varying extents, common themes derived from pre-medical, archaic

beliefs are an important component of contemporary common sense theories of mental illness (for example, moral and religious views, deviance and inhumanity).

The research in this section indicates the power of history and broadly shared belief systems in shaping individuals' understandings of mental illness. It is to these more macro-social concerns that we now turn. Research on societal understandings of mental illness, drawn from across a range of social sciences offers the social psychologist working from a social constructionist perspective an important way of understanding the nature and origins of contemporary social representations of mental illness. The review in section 2.2 serves to highlight the web of historically grounded belief systems and social practices within which the contemporary understandings and practical strategies of both lay people and mental health professionals are embedded.

2.2 Historical and sociological accounts

One of the most influential writers on the history of societal reactions to and understandings of mental illness is Michel Foucault. In his book Madness and Civilization: A history of insanity in the age of reason (1967, first published in French in 1961) Foucault analyses the treatment and social position of the mentally ill from the Middle Ages to the nineteenth century, and argues that these social practices both reflected and perpetuated historically dominant representations of mental illness associated with unreason, death, animality, sexuality and imbalance[7]. Foucault's thesis is that during the seventeenth and eighteenth centuries, European societies developed a structure and value system based on reason. Reason was equated with civilization and new moral values of work and rationality prevailed. Mental distress conflicted with this value system and was defined as its antithesis - unreason. The social definition of mental illness as difference and 'otherness' both justified and was perpetuated by the exclusion, marginalisation and inhumane treatment of the mentally ill. Mental illness became a threat and a scandal to society, associated with shame, guilt and stigma. At the same

[7] Foucault's work is complex, both in style and content and this brief review is both a simplification and one of several possible readings. Although the power of Foucault's ideas is undeniable, his work has been criticised by Sedgewick (1982) for its poor use of historical evidence, its glorification of mania, and its overemphasis of the rationality - unreason divide.

time it retained a certain fascination in allowing expression of the passionate and non rational side of humanity[8]. Society coped with this dangerous combination of threat and fascination by excluding, distancing and silencing the mentally ill:

> 'Confinement is the practice which corresponds most exactly to madness experienced as unreason, that is, as the empty negativity of reason; by confinement, madness is acknowledged to be *nothing*. That is, on one hand madness is immediately perceived as difference....; and on the other hand, confinement cannot have any other goal than a correction (that is, the suppression of the difference, or the fulfilment of this nothingness in death)'. (Foucault, 1967, p 116)

As an illustration of how Foucault's ideas continue to be relevant in the modern day, the legal plea of diminished responsibility on the grounds of mental ill health is one of the most dramatic illustrations of the assumed link between mental illness and unreason.

Similar ideas are developed by Gilman (1985, 1988) who traces the history of visualising madness in art and medical texts as a way of illuminating the myths, beliefs and ideologies of the society in which they are created. Historically, representations of mental distress have emphasised aggressive and bizarre behaviour and down-played more passive, depressive states. The image of the mad found in the art of western cultures tends to be imbued with a sense of loss of control, disintegration and danger. Modern day equivalents of these themes are detected in the drawings analysed by De Rosa (1987) described in section 2.1. Similarly, recent studies of media representations of mental illness (Glasgow University Media Group, 1994a; Rose, 1996) involving analysis of British television output, newspapers and popular magazines, find that although mental illness is multiply represented in the media, violence and danger to others are the most common themes.

Gilman (1988) argues that 'root metaphors' such as sexuality as a corruptor of rationality have linked the mentally ill historically with other social groups (he cites Jews, homosexuals and blacks) which in western cultures have been consistently feared, stigmatised, socially marginalised and represented as dangerous forms of 'otherness'. He

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[8] For example, Becker (1978) notes how the Romantic poets of the nineteenth century fostered associations between madness and genius in order to define themselves as different, unique and endowed with special creative talents. (Unfortunately, many of these self-professed leanings towards madness back-fired and were used as justification for silencing or institutionalising creative thinkers who were perceived as a threat to the social *status quo*.) Society's fascination with mental illness is also evidenced in the fact that viewing the insane for a small price became a popular nineteenth century leisure activity at asylums such as the Bethlem Hospital.

proposes that representations of mental illness (and illness in general) have served historically to localise fears of collapse, disintegration and loss of control, both on collective and individual levels. (Similar arguments are put forward by Sontag (1979, 1990) in relation to syphilis and tuberculosis in the nineteenth century, and cancer and AIDS in contemporary society.) This fits with the anthropological analysis provided by Gaines (1992) who suggests that modern psychiatric classifications, based on a northern European cultural concept of the person as autonomous and self controlled, serve to 'otherise' mental illness as the manifestation of various forms of imbalance associated with loss of control. 'The mad, especially in the incarnation of the aggressive mad, are one of the most common focuses for the general anxiety felt by all members of society, an anxiety tied to a perceived tenuousness of life' (Gilman, 1988, p 11).

Although Gilman conceptualises these representations as constructed and functioning on a social level, he integrates an intra-psychic level of analysis into his argument. The various 'others' that societies construct function to reflect both fantasies and fears associated with central aspects of human existence (for example, fragility, death, sexuality)[9]. Drawing on the ideas of psychodynamic theorists such as Melanie Klein and Otto Kernberg, Gilman suggests that these representations are reflective of psychodynamic process of splitting good from bad and projecting anxiety-provoking experiences onto others defined as distant and separate from ourselves. In projecting individual and collective anxieties onto the mentally ill, he argues, their threat to ourselves is reduced. This serves to reassure us as it both displaces internally generated fears into the outside world, and localises them within a specific sub-group of our social world[10].

Sociologists studying the social position of the mentally ill in contemporary society have also picked up on themes of marginalisation and difference, but have tended to

[9] 'Others' may be represented variously as dangerous, exotic, benign or idealised. Their emotionally charged construction may inspire high levels of ambivalence - for example, simultaneous fear and fascination, attraction and repulsion. The fact that madness and deviant sexuality have historically been such favoured subjects for artists, novelists and playwrights, despite the taboos surrounding their open public discussion reflects the tensions and ambivalences in societal relationships and definitions of 'Otherness'.

10 This stance is consistent with arguments put forward by several social representations theorists (for example Jovchelovitch 1995, Kaes 1984, Moscovici 1993a), who stress that non-rational and unconscious intra-psychic process should be included in a social representational approach, and that this does not necessarily risk de-socialising the theory.

conceptualise this as social deviance. Labelling theories developed by sociologists in the 1960s and 1970s are most radically applied to mental illness by Scheff (1966) who argues that the label of 'mentally ill' is a response by individuals and society to rule breaking behaviour which violates social norms and is deemed deviant and unacceptable. Social institutions such as the legal system and mental health services act as agents of social control by imposing socially sanctioned labels on various types of rule breaking behaviour. Once a person receives the label of 'mentally ill' certain types of behaviour are expected of them and any signs of bizarre behaviour are immediately attributed to their illness. The label of mental illness takes on a 'master status' which overrides all other social roles.

The writings of Scheff are just one example of what has become known as the 'anti-psychiatry movement', an umbrella term used to refer to sociological conceptualisations of mental illness developed in the 1960s (for example, Cooper 1967, Goffman 1961, Laing 1960, Szasz 1962). Although there is considerable diversity in the arguments of each of these writers, they are united by common assumptions which question the ontological status of mental illness, and advance the claim that the concept of mental illness is a moral and social one rather than simply a medical category. These theorists recognise the role of social constructive processes in defining what is taken as mental ill health, and perhaps most importantly, stress the centrality of power in these processes (Sedgewick, 1982b). The coercive nature of the treatment of mental illness, and the status of psychiatry as an institution which maintains dominant ideologies are primary concerns of this approach.

These macro-social arguments are translated into a micro-social analysis by Goffman (1963) in his work on stigma[11]. Goffman conceptualises mental illness as an example of a 'spoiled identity' which is deeply discrediting in the way it influences personal and social identity and interpersonal relationships, and which marks a person out as different, undesirable, and in extreme cases, dangerous, bad or weak. A stigmatized person is 'reduced in our minds from a whole and usual person to a tainted, discounted one' (p 12), and seen implicitly as not quite human. A wide range of imperfections are imputed

[11] Consideration of Goffman's earlier work on 'asylums' is left for Chapter 3 (section 3.2), which focuses specifically on how mental illness is understood and treated by mental health practitioners.

on the basis of the original one, which serve in part, to justify the way the stigmatised person is treated. The person may be defined in terms of her stigmatising attribute which may override other characteristics, and may find herself discriminated against in ways that significantly reduce her life chances. These processes have a profound impact on the person's sense of self and personal identity. Goffman's descriptions of 'phantom acceptance' based on 'phantom normalcy', in which social interactions are limited while a superficial appearance of acceptance is simultaneously maintained show similarities with the findings of Jodelet (1991a) described in section 2.1. His insightful writing stresses the subtle, implicit but powerful ways that macro-social phenomena enter into everyday inter-personal interactions, and as such this approach is compatible with a social representational perspective.

However, more generally, the anti-psychiatry perspective is problematic from a social psychological point of view in that its conceptualisation of micro-social, interpersonal and intra-personal processes is limited and simplistic. Critical evaluations of the anti-psychiatry movement (for example, Gove 1982, Miles 1987, Sedgewick 1982b) make similar points. Anti-psychiatry is criticised for failing to take account of the distressing experiences of those suffering from mental illnesses, presenting the increase of public tolerance as an overly simplistic solution to mental ill health, and being unresponsive to recent changes in mental health care. Nevertheless, as Miles notes, the important achievement of this body of thought was that it 'revealed the existence of social processes in diagnosis and treatment, and acquainted a wide readership with the arguments of social scientists - that mental illness is a social construction and psychiatry a social institution that incorporates the values and demands of its surrounding society.' (Miles, 1987, p 21). (The role of anti-psychiatry in shifts towards community based care in both Britain and France was noted in Chapter 1, and illustrates the impact of this perspective beyond the confines of academia.)

The sociological and historical perspectives on mental illness reviewed in this section offer some powerful conceptualisations of mental illness as a socially marginalised, feared and discredited social phenomena. These are important considerations for a social psychological analysis in which the weight and power of history, culture and macro-social

structures in shaping everyday practices, interactions and understandings is acknowledged. Historical analyses provide a rich account of how and why mental illness has come to be feared and marginalised in contemporary society. In its equation with unreason and loss of control, mental distress represents the antithesis of the fundamental values of modern western cultures which rest on rational individualism. Sociological accounts of mental illness in contemporary society serve to contextualise the working of mental health services within the dominant power structures of society. In so doing they remind us that neat separations between public and societal understandings of mental illness and those of 'experts' and professionals cannot be made. This point will be taken up in the theoretical elaborations provided in Chapter 3.

The principal weakness of these perspective from a social psychological point of view is their inability to adequately conceptualise psycho-social processes in the construction of social knowledge. Although retrospective analyses can access process on a broad societal level, through the analysis of historical artifacts and changes, they are necessarily limited to speculation regarding more micro-social and individual processes. Similar problems beset sociological and anti-psychiatric accounts of mental illness in contemporary society. Radical macro-social arguments take precedent, and the subtleties of meaning construction which involve the self and the group on both interactive and affective levels are lost.

2.3 Public attitudes research

A review of research into lay and societal understandings of mental ill health would be incomplete if it did not acknowledge the body of research on public attitudes towards mental illness conducted within psychology and individual-based social psychology. One of the earliest and largest surveys was conducted in the USA by Nunnally (1961). This found that the mentally ill were regarded with fear, distrust and dislike by all social groups. They were highly stigmatised and 'considered unselectively as being all things bad' (p 233). Another important early study conducted by Cummings & Cummings (1957) investigated public attitudes towards mental illness in a small Canadian community. The strength of fear and threat inspired by mental illness was indicated not only by the failure of their public education program aiming to improve public understanding and tolerance of mental illness, but also by the hostile community reactions

they experienced towards this intervention. The community appeared to have a deep-seated investment in its established rejecting views of mental illness to which it held tenaciously.

Following this early research, studies have been conducted into lay attitudes towards mental illness in many Western and non-Western countries. (For reviews see Bhugra 1989, Miles 1987, Rabkin 1972, and Sarbin & Muncuso 1970.) Typically using quantitative individual-based methodologies such as Likert type attitude scales or written vignettes, these studies have consistently found that lay evaluations of mental illness are negative and reflective of rejection and discrimination against the mentally ill. This negativity far exceeds the generally negative attitudes that western societies hold towards illness in general, eliciting special responses of fear and rejection. Reviewing a range of studies, Miles (1987) suggests that three characteristics are commonly attributed to the mentally ill:- they are assumed to be easily recognisable, potentially dangerous and very unpredictable. The outcomes of mental illness are usually viewed pessimistically.

As a typical example, Phillips (1966) used 'social distance scales' as a measure of American respondents' willingness to associate with mentally ill individuals described in written vignettes. Compared to complete acceptance of all types of social interaction with a 'normal person', there was considerable reported unwillingness to associate with all types of mentally ill people. A continuum of rejection of different types of mental illness was found, with the person described as suffering from paranoid schizophrenia suffering the worst rejection consistently. Less than 2% of respondents said they would let their children marry a paranoid schizophrenic. This rose to 10% for the depressed person, 31% for the person suffering from schizophrenia and 60% for the phobic-compulsive sufferer. The majority of respondents claimed they would be willing to work with and be neighbours of all the people described except the person suffering from paranoid schizophrenia, with whom only 11% would work and 70% would be willing to have as a neighbour. Acceptance levels dropped consistently if respondents were also told that the person described had spent time in a psychiatric hospital. These results demonstrate the desire by lay people to keep themselves and their family distant from the mentally ill. Parallels with the work of Jodelet (1991a) and Goffman (1963) described above are clear. The social marginalisation of the mentally ill is lived out through limitations imposed on the scope and possibilities of day-to-day interactions.

A common area of investigation in recent public attitude research has been into the public diffusion and understanding of 'scientific' or 'expert' theories and aetiological models of mental illness. Several studies detect echoes of expert theories such as medical, psychodynamic and social models in lay populations (for example Furnham & Bower 1992, Kuyken et al 1992), and show how causal beliefs are related to views of treatment strategies, possibilities for change and locus of control (for example, Fisher & Farina 1979, Norman & Malla 1983.) For example, the second of these studies found that adolescents' beliefs in organic causes are associated with beliefs in a poorer prognosis compared to psychosocial causal models which are associated with greater social acceptance and more optimistic views of prognosis. Other research describes the public as 'woefully ignorant' (Furnham & Rees 1988, p 214) in expert knowledge terms, finding, in this case, that public understandings of schizophrenia centre instead around dangerousness, unpredictability, amorality and vagrancy.

While the results of these investigations are useful indicators of the strength of negative and rejecting attitudes towards mental illness in the lay population, from a social constructionist / social psychological perspective, they are also problematic on epistemological and methodological grounds. These problems can be categorised into four areas: Firstly, their individual focus means that social processes in the genesis and circulation of beliefs and opinions are ignored. Secondly, they fail to acknowledge the weight of culture and history in shaping contemporary understandings. This has been adequately demonstrated in the research described in sections 2.1 and 2.2. Third, in using quantitative methodologies, the complexity of the social meanings associated with mental illness is lost. Public understandings are often measured using single scores on rating scales, thus reducing the hermeneutic to the numerical. The findings of any research can only be as complex as their methodology will allow. Thus, a recent study by the Glasgow University Media Group (1994b) using a more complex multi-method approach (group discussions of media output, interviews and questionnaires) was able to detect ambivalences and coexistent oppositional themes among lay people (for example both fearful and sympathetic reactions to mental illness), which in more simplistic methodologies may have been reduced to single scores and dominant themes. Finally, these studies often take scientific or expert knowledge as a bench-mark, and in so doing, fail to take seriously common sense or lay belief systems which social representations theory postulates as a qualitatively different universe of knowledge from that generated

by science, and one which is worthy of study in its own right.

Given these short-comings, perhaps the best approach to this body of individual-based findings is to consider them as 'indicators' of social representations of mental illness, or as snap-shots of the consequences of social meaning construction in the realm of individual cognitions[12]. On its own, research within this paradigm cannot undercover the nuances and complexities of social representations of mental illness. Nor can it account for why such public attitudes to mental illness exist. However, the pervasive negativity, fear, rejection and social distancing which these studies detect shows parallels with the more in-depth qualitative research described in sections 2.1 and 2.2 above, and suggests that it would be unwise to reject this body of work out of hand.

2.4 Folk Theories of Mind: Social representations of person-hood?

A final area of theoretical activity which is relevant to the current argument concerns the work of philosophers of mind. Although these ideas have not previously been applied empirically or theoretically to the topic of mental illness (as far as the author is aware), and generally lack a social dimension, they offer an interesting slant on issues of psychological threat and loss of control, themes which the research reviewed in previous sections consistently uncovers as central to how mental illness is socially represented.

'Theories of mind' refers to conceptualisations of the cognitive workings of the human mind. The 1980s saw an explosion of interest in theories of mind by philosophers, developmental and evolutionary psychologists, cognitive scientists, and artificial intelligence researchers (Whiten, 1991). For example, developmental psychologists have investigated how children develop understandings of others by developing theories of mind (Astington, Harris & Olson, 1988), and have conceptualised autism as a failure to develop theories of mind (Baron-Cohen, Tager-Flusbery & Cohen, 1993). By extension, the notion of 'folk theories of mind' refers to how lay people conceptualise the minds of others, as a way of understanding other people's behaviour. By attributing beliefs,

[12] Similar suggestion for conceptualising the relationship between attitudes and social representations are made by Fraser & Gaskell (1990) and Jaspers & Fraser (1984).

desires and other mental states to others, we achieve a powerful ability to predict their behaviour and gain a sense of mastery, understanding and control over our social world. Whiten (1991) suggests that successful use of theories of mind in the social world rests upon the following: An awareness of our own inner experiences; an assumption that other people experience similar mental states to our own; and a systematic linkage to behaviour and observable events. In other words, we assume that other people's experiences, motivations and mental states are similar to our own, and use this to make sense of, explain and predict the behaviour of people in our social sphere.

Although theory of mind literature falls within information-processing and cognitive paradigm, presenting essentially asocial arguments, which fail to take account of the socially constructed aspects of experience, cognition and notions of person-hood (eg Heelas & Lock 1981, Rosaldo 1984), a perspective on social reactions to mental illness can be developed by extrapolating from these notions of 'folk theories of mind'. Conceptualised as beliefs which are collectively and historically created within a specific socio-cultural context, folk theories of mind can feasibly be considered as social representations of person-hood. The assumption that folk theories of mind operate on the basis of an 'intentional stance' (the belief that other people act according to rational intentionality (Dennett, 1987)) can be redefined as a culturally specific way of representing the person, constructed within the bounds of western individualism and its values of reason and rationality. Parallels can also be drawn with the ideas of Mead (1934): Folk theories of mind are essentially shared constructions of the 'generalised other' which are prerequisites of social interaction, and the development of mind and identity.

If mental illness is defined socially as irrationality and unreason, this suggests that conventional folk theories of mind or social representations of person-hood based on reason and rationality cannot be relied upon. Defined as a radically different 'other', the behaviour, motivations and internal state of the mentally ill person become unknowable in terms of our own experiences. They can no longer be anchored into our conventional theories of mind or social representations of the 'normal person', and fall outside our concepts of the 'generalised other'. Social representations of mental illness constitute attempts to develop alternative theories of mind which allow us to make sense of the acts of a mentally ill person, but removal of assumed parallels with our own experiences

renders these models tentative and uncertain. A sense of loss of control based on a perceived inability to predict the behaviour of a mentally ill person or to make sense of their experiences on our own terms may ensue. This shared representation of mental illness as an irrational and unpredictable 'other' becomes self-perpetuating: Faced with behaviour which cannot be accounted for by conventional model of mind we are likely to interpret this as signs of mental illness.

These ideas offer another perspective on the relationship between mental illness and loss of control. The work of Gilman (1988) (reviewed in section 2.2) highlights how mental illness symbolises intra-psychic and societal fears of loss of control. From the perspective of philosophy of mind, mental illness can also inspire a sense of loss of control, associated with a perceived breakdown of conventional sense-making models and one's inability to predict aspects of one's social world. If we accept the social cognition argument that we have a fundamental need for a sense of control and understanding in our interactions with the social world, a person defined as mentally ill is threatening because we fear that our conventional models of mind may not be appropriate tools in our interaction with this person, and that we may not be able to predict their behaviour or make sense of them on our own terms. From this perspective, 'otherness' equates with a failure of conventional folk theories of mind. To be 'other' in this sense is to fall outside the bounds of the 'generalised other' which forms the basis of our collective understandings of self-hood and moral action. Representations of mental illness as other can be seen as attempts to postulate alternative theories of mind, or shared concepts of a 'non-generalised other', in which the internal experiences and mental processes of the mentally ill person are assumed to be somehow fundamentally different from our own.

2.5 An Initial Model of the Social Representation of Mental Illness

Drawing on the conceptualisations and empirical findings reviewed in sections 2.1 to 2.4 is it possible to develop some kind of integrated understanding of how mental illness is socially represented in contemporary western society? Despite the very different foci and epistemological approaches of the research reviewed, points of comparison can be found across this heterogenous body of social scientific work on lay and societal understandings and reactions to mental illness. The most obvious theme uniting this research is the

representation of mental illness as a strange, threatening and dangerous 'other'. From a social representational perspective, the theme of 'otherness' can be understood as both constituted in and perpetuated by exclusionary practices. Such practices can be detected equally on a macro-social level (eg Foucault 1967, the anti-psychiatry writers), in the micro-social domain (eg Jodelet 1991a, Goffman 1963), and at the level of individual cognition (eg Phillips 1966). Much of this research highlights the historically rooted nature of these social representations (eg De Rosa 1987), which can be linked to the development of western cultural values based on reason (Foucault 1967). The power, rigidity and emotionally charged nature of these representations is also highlighted (eg Cummings & Cummings 1957, Gilman 1988, Jodelet 1991a). Beyond these common themes, social representations of mental illness have been found to be multiple and heterogenous. Echoes of modern scientific understandings of mental ill health can be detected in the public sphere, but these coexist with, and are often eclipsed by archaic common sense understandings of mental distress.

Extrapolating from these ideas, an initial model of the historical and contemporary social representation of mental illness is proposed: In modern western societies whose basic values are based on rational individualism, the mind is held to be the core of the person (Lukes 1973, Rorty 1987, Turner 1986). Within this cultural context, mental illness has become a vessel for intra-psychic and societal fears of collapse and disintegration. As the manifestation of unreason and irrationality, mental illness is psycho-socially challenging and fear-provoking both because rationally-based folk theories of mind are assumed to be inappropriate tools for predicting and understanding the behaviour of the mentally ill, and because mental illness represents loss of control over the self. Mental illness becomes associated with unpredictability, incomprehension and an undermining of the very essence of person-hood. 'Otherising' mental illness - representing it as something different and distant from the rational, controlled self - is a way of coping with the threat of this possibility. Representing the mentally ill as 'other' is safe because it creates a clear, unambiguous binary opposition between self / sanity and other / madness. It negates views of the mentally ill as 'just like us', of mental illness as a possibility for each and every one of us, perspectives which suggest no clear dividing lines between reason and unreason, and between sanity and madness. From this perspective, the tendency for individuals to see the mentally as different from themselves can be understood as involving similar social psychological processes as the pervasive

marginalisation and disempowerment of the mentally ill which occurs on a societal level. Both are safe ways of representing potential danger. Social representations of mental illness as a different and distant 'other' function as coping strategies which allow individuals and collectivities to make sense of a phenomenon which is socially and individually challenging, serving to localise a phenomena which threatens both personhood and society. Through its projection and localisation within a specific person or group, the threat of mental illness is contained, and its perceived impact is reduced through its positioning as reassuringly distant.

This initial model of how mental illness is socially represented aims to integrate concepts and findings at several analytic levels, from the broad macro-social level to the intra-psychic level. In so doing, it allows a truly social psychological understanding to be developed, in which reductionism to any single level of analysis is avoided. This conceptualisation provides an initial broad framework which will be used as a spring-board for the current research focusing on one specific social sphere, namely the world of mental health care and the professionals who work in this world.

Given the model of mental illness representation which has been developed in this chapter, what implications for the contemporary world of mental health can be extrapolated? How can the daily work of caring for and treating those with mental health problems, and the functioning and social role of mental health organisations be understood within this social representational field? As a prelude to the next chapter, in which the world of mental health and the people who work in this environment is the focus, some brief suggestions can be made. The power and pervasiveness of social representations of mental illness as something strange and different suggests that these themes are likely to permeate the world of mental health. Indeed, if mental health organisations are seen as social institutions which function to up-hold and put into practice societal values, then the daily routines and structure of these organisations can be seen as reflective and constitutive of societal understandings of mental illness. Similarly, the individuals who populate this world - the professionals and the mentally ill themselves - are unlikely to be immune from the representations which permeate wider society.

Viewed in this light, the contemporary policies of community based care described in Chapter 1 take on enormous social significance. They represent a radical departure from a historical legacy of marginalisation of the mentally ill. But more than this, they challenge how mental illness is social represented, a challenge which is likely to be felt not only at the broad macro-social level, but at the level of daily routines and inter-individual interactions. Community care policies create a paradoxical situation in which society is expected to integrate those it has defined as threatening, different and 'other'. Yet the conventions of families living in close proximity with the mentally ill studied by Jodelet (1991a) suggest that physical contact cannot necessarily guarantee social and psychological integration. The threat of mental illness is enhanced by its proximity, and subtle but powerful practices can be brought into play to create a sense of separation and distance.

Faced with the task of integrating the mentally ill into society, the work of mental health services and the people who work in them must be radically redefined. Community care represents a significant challenge to historically established working practices and professional roles. This contemporary situation in the world of mental health is the focus of empirical investigation in the current study (community care is addressed specifically in Chapter 7). Before turning to this empirical analysis, it is necessary to consider the world of mental health professionals in more detail. This is the focus of the following chapter which proposes a theoretical framework for the study of professional practitioners, and reviews research into the world of mental health and the professionals who work in this world.

CHAPTER THREE

THE PROFESSIONAL PERSPECTIVE: 'PROFESSIONAL SOCIAL REPRESENTATIONS' OF MENTAL ILLNESS

This chapter has two broad aims: Firstly, it offers theoretical progression, extending some aspects of the theory of social representations so as to provide a theoretical spring-board from which to embark on an empirical study of mental health professionals. Secondly, building on the general discussion in Chapter 2 of the ways mental illness is socially represented, it provides a selective literature review of research on mental health professionals which is compatible with the theoretical positioning of this thesis.

The chapter begins with an investigation of how social representations theory has conceptualised the circulation and development of social knowledge (section 1). It is argued that the dichotomised model of science and common sense is problematic for research addressing social representations which develop in other social spheres. A more complex model of the social circulation of knowledge is proposed, involving interactions between professional practitioners, policy makers, 'experts', the media and ordinary people. Based on this, section 2 presents a model of 'professional social representations' as an important component in this social circulation of knowledge. 'Professional social representations' are the representations which circulate in professional worlds regarding the object of their work - for example, the representations of mental illness held by mental health professionals. Five 'building blocks' of professional social representations are proposed: theory, practice, professionals roles, lay representations and organisational factors. It is suggested that professional practitioners fulfil a unique role in the circulation of social knowledge, acting as translators, vectors and integrators of diverse sources of understanding between various social worlds.

Having developed this general theoretical framework, section 3 turns specifically to the world of mental health professionals. This constitutes a shift in emphasis from the theoretical and the general to the substantive and the specific. As such, it serves to familiarise the reader with the contemporary world of mental health care and to locate the current study in relation to previous research on mental health professionals.

1 The Theory of Social Representations: Problems and Prospects

1.1 The Consensual and the Reified Universes

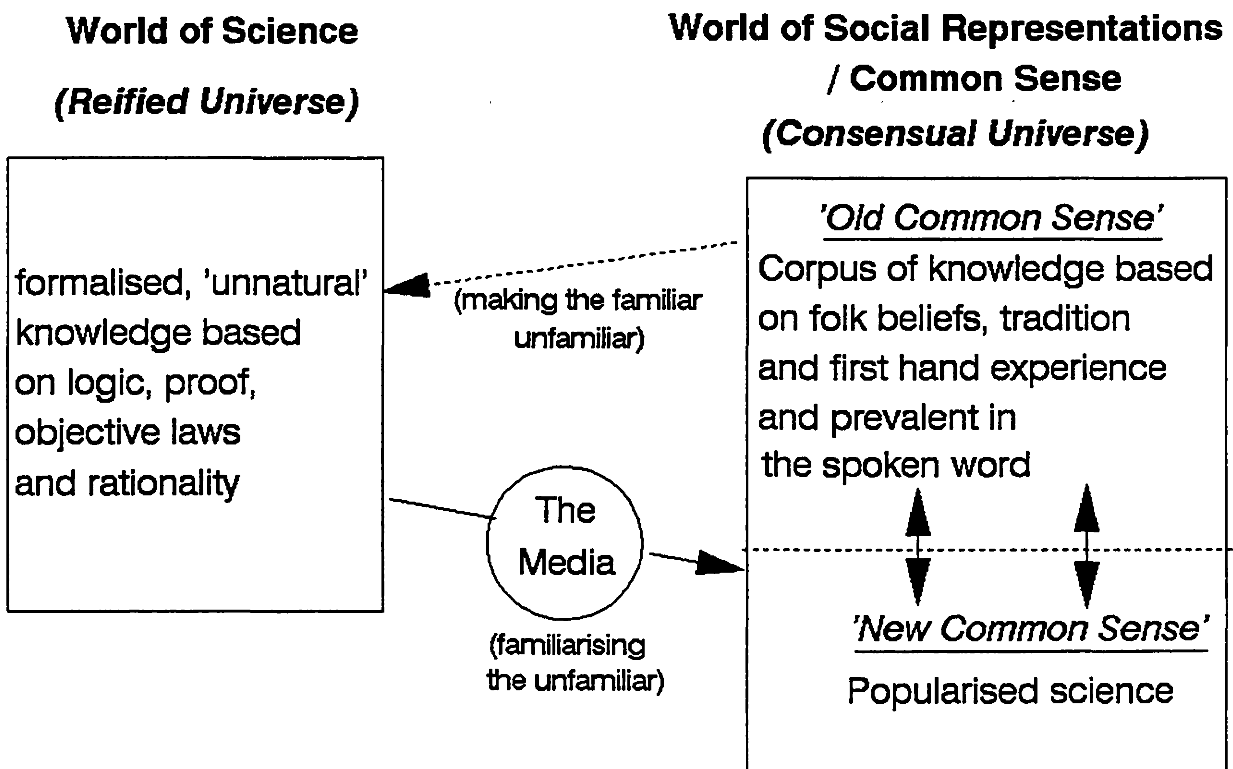
The overview of social representations theory in Chapter 2 presents the original theory's assumptions regarding the nature of lay and scientific knowledge. To reiterate briefly, a sharp distinction between the 'reified' and the 'consensual' universes is made, and it is assumed that knowledge generation in these two worlds is based on fundamentally different and contrasting epistemologies. In the 'consensual universe' (the world of common sense, lay people and social representations) there is a drive towards creating familiarity, a bias towards confirming hypotheses, and a predomination of memory over logic. The consensual universe operates on human (as opposed to logical) principles. Everyone has the right to express an opinion, and what is essential is the maintenance of social relations and the fulfilment of human and societal needs (such as a sense of order, mastery and understanding, location of threat etc) through communication and expression within the confines of a shared meaning system. In contrast, in the 'reified universe' (the world of scientific knowledge generation) the principles of logic determine the rules of the game. Moscovici describes the epistemology of the reified universe as unnatural, as a procedure which 'goes so much against the grain of what human beings do spontaneously, that a solid apparatus of logic and proof must be marshalled' (1981, p 191). Scientific modes of knowledge attempt to establish objective laws and 'truths', based on rationality and logic. Knowledge, and the rules of its generation, is highly formalised and assumed to be independent of its creators.

In inter-relating these two distinct universes of knowledge, the focus of social representations theory is principally on the flow of ideas and knowledge from the world of science into common sense. 'Common sense is science made common' (Moscovici, 1984, p 29). As science evolves and produces ever increasing amounts of knowledge, there is a need to transfer this into the lay or consensual universe in ways which make sense to the lay person. Through processes of anchoring and objectification, social representations are involved in transforming, familiarising and integrating unfamiliar scientific concepts into pre-existing lay belief systems. The media and education are the principle carriers and transformers of scientific knowledge which serve to re-present and popularise science such that its products become part of modern collective life (Farr,

1993b). Thus, the everyday talk of individuals is replete with references to viruses, unconscious processes, the ozone layer, inertia, radiation and myriad other concepts which derive from the world of science, but which have become socially meaningful and part of social reality. This 'new common sense' makes sense to lay people because it is integrated into and re-presented in a form consistent with 'old common sense', the corpus of knowledge based on tradition, implicit folk beliefs and first hand experience which is prevalent in conversations, the spoken word and everyday thinking (Moscovici & Hewstone, 1983). This link between the scientific and the consensual universe in not entirely uni-directional: There is also a flow of ideas in the opposite direction from common sense to science. Science takes elements from ordinary knowledge and transforms them into scientific knowledge. In doing so, it works to make what was familiar to the lay person unfamiliar and difficult to understand. This conceptualisation of the relationship between scientific and common sense knowledge as presented in Moscovici's early writings on the theory of social representations (eg Moscovici 1981; 1984; Moscovici & Hewstone 1983) is summarised graphically in Figure 3.1 below.

In presenting this meta-model of the relationship between science and common sense, Moscovici certainly succeeded in his aim of proposing that common sense is much more than a dilution of scientific knowledge, that it is based on complex principles which are different, but not inferior to scientific epistemologies, and is therefore worthy of serious consideration by the social psychologist. However, while such a sharply dichotomised model may have been useful in the infancy of social representations theory, its continued value is becoming increasingly limited as the theory matures. The concepts of the reified and the consensual universes have been some of the most criticised aspects of the theory of social representations in recent years, many of most important critiques coming from proponents of the theory (eg Bangerter 1995; De Rosa 1994; Purkhardt 1993; Raty & Snellman 1992; Wells 1987). From the perspective of the current research, this original conceptualisation of science and common sense becomes both over-simplified and unworkable as a framework for the study of professional practitioners. The problems with this meta-theoretical model are summarised in the following five points, which lead to suggestions for theoretical reformulation. The first two points take issue with the assumption that the theory of social representations is applicable only to lay knowledge. This arises from two flawed assumptions:-

Figure 3.1: Moscovici's original model of Science and Common Sense



1) Firstly, the world of science is assumed to be exclusively a reified universe, down-playing its properties as a social system in its own right. This conceptualisation is an oversimplification, even a caricature of science, and fails to offer an adequate description of the workings of the modern scientific community. Moscovici's description of the principles which guide scientific knowledge in the reified universe appear to describe the principles of classic positivist epistemology, based on refutation of hypotheses through empirical tests. But this is not the only way that knowledge is accumulated by scientists. This is confirmed by the body of work on the sociology of scientific knowledge begun by Fleck (1935) in relation to scientific understandings of syphilis, and continued by Kuhn (1963, 1970) and many others. Broadly speaking, this work conceptualises science as a social institution (eg Merton, 1973), and highlights the ways discourses and knowledge are constructed in science (eg Knorr-Cetina & Mulkay 1983, Gilbert & Mulkay 1984). It shows how scientific knowledge is culturally situated and socially constructed and how its progression and change cannot be explained by logic and rational argument alone. Like lay people, scientists may follow 'hunches' and search for consensual validation of their ideas through debate and conversation with contemporaries over lunch and in coffee bars. Various sub-groups within science interact and clash, and ideological and power struggles are enacted as part of everyday life. In short, while scientists may claim to use certain formalised methods, theoretical concepts and lines of reasoning, they are nevertheless not immune to more 'natural' or informal types of knowledge generation. These social processes are essentially those which are characteristic of social representation development and circulation. It seems reasonable to suppose therefore, that social representations theory could be fruitfully applied to our understanding of the development of scientific knowledge

2) Secondly, the distinction between science and common sense is overaccentuated: Science is conceptualised as entirely separate from the consensual universe and from common sense. From this point of view, science falls outside the world of social representations, and would therefore be an inappropriate subject for research based on the theory. However, I would argue that there are considerable overlaps between the consensual and the reified universes (a point also made by De Rosa 1994), and that the world of science operates within the world of social representations, rather than separate from and immune to the social knowledge which circulates in lay belief systems. Much scientific or 'expert' knowledge, especially in the social sciences, technology and

medicine develops in response to social problems and in close relationship with social developments.

The implication of these two points is that social representations theory could be applied equally to the world of science as to lay thinking. This idea has also been pursued by Bangerter (1995), Jost (1993) and Moscovici (1993b) who, despite his original conceptualisation of science and common sense, has suggested more recently that a social psychology of science based on social representations theory and theories of groups processes, conformity and persuasion, would allow us to understand better the inner workings of the scientific community and its construction of knowledge. By extension, social representations theory could also be used to understand knowledge generation in other social spheres such as the world of professionals, of politics or the law, all of which form part of the modern social world replete with social and collective representations. It is this belief that social representations theory can be applied to spheres of knowledge other than lay common sense that prompts use of the theory (albeit with some modifications) as a tool to study mental health professionals.

3) It is unclear what the theory of social representations takes to be 'science'. As the theory derives originally from Moscovici's empirical research on the diffusion of psychoanalytic theories into lay consciousness (Moscovici 1976), one can only assume that a broad definition of the term 'science' is being used. Yet as many commentators have pointed out (for example, Stevens, 1983) it is debateable whether psychoanalysis qualifies as a science. It is unclear whether the term 'science' encompasses the social sciences or even the humanities. Yet those within these communities would certainly argue that they inhabit very different worlds based on different epistemological assumptions. In many fields the epistemology of the reified universe competes with other styles of knowledge construction, for example constructionist and hermeneutic epistemologies in the social sciences. Not only can multiple different 'sub-worlds' of specialist knowledge be identified, but within each of these there are variations in the degree of linkage with the 'real world' inhabited by lay people. For example, while pure researchers spend most of their time in laboratories, libraries and offices in universities and research institutes, aiming to elaborate specialised and abstract theoretical knowledge of an esoteric form, applied researchers, working in factories, hospitals and government institutions, who share much of the theoretical knowledge of their pure research

counterparts, may be more concerned with the generation of exoteric knowledge and the application of theoretical knowledge to practical problem solving.

4) This conceptualisation of the development of social knowledge fails to adequately address issues of power and the very real inequalities which exist in society, permeating everyday interactions, conversations and practices and shaping the forms of knowledge which develop and come to dominate. The influence of social power relations receives little attention in social representations theory (Joffe 1995, Rose et al 1995), and is only acknowledged implicitly in the distinction between hegemonic, emancipated and polemic representations (Moscovici, 1988). It is assumed that in the consensual universe 'society views itself as a group made up of individuals who are of equal worth and irreducible' (Moscovici 1981, p 186). Clearly this is not so. The rules of hierarchy and legitimacy according to which scientists in the reified universe offer opinions according to their level of qualification (eg 'as an expert in the field', 'as a medical practitioner' etc) apply equally to all social spheres from politics to the world of common sense. Thus the opinion of the black teenager on racial harassment by the police carries a very different status from the opinion of the Oxford don on the same subject. Communication and expression of opinion is far from equal and fair. It is shaped by the social positioning of speakers and by the unequal power relations which structure society. And these power relations are also part and parcel of the circulation and development of social representations. I will return to this issue in Chapter 8, where I will argue that the theory of social representations should take more account of issues of power and social inequalities.

5) The suggestion that social representations and the consensual universe deal principally with familiarising the unfamiliar fails to deal adequately with the concept of unfamiliarity. As the literature review in Chapter 2 adequately demonstrates, unfamiliarity in the form of themes of strangeness and 'otherness' remains at the heart of social representations of mental illness. Again, this issue will be taken up in more detail in Chapter 8 where, in the light of empirical findings, it is argued that the nature and sources of unfamiliarity should be given more attention within the theory of social representations.

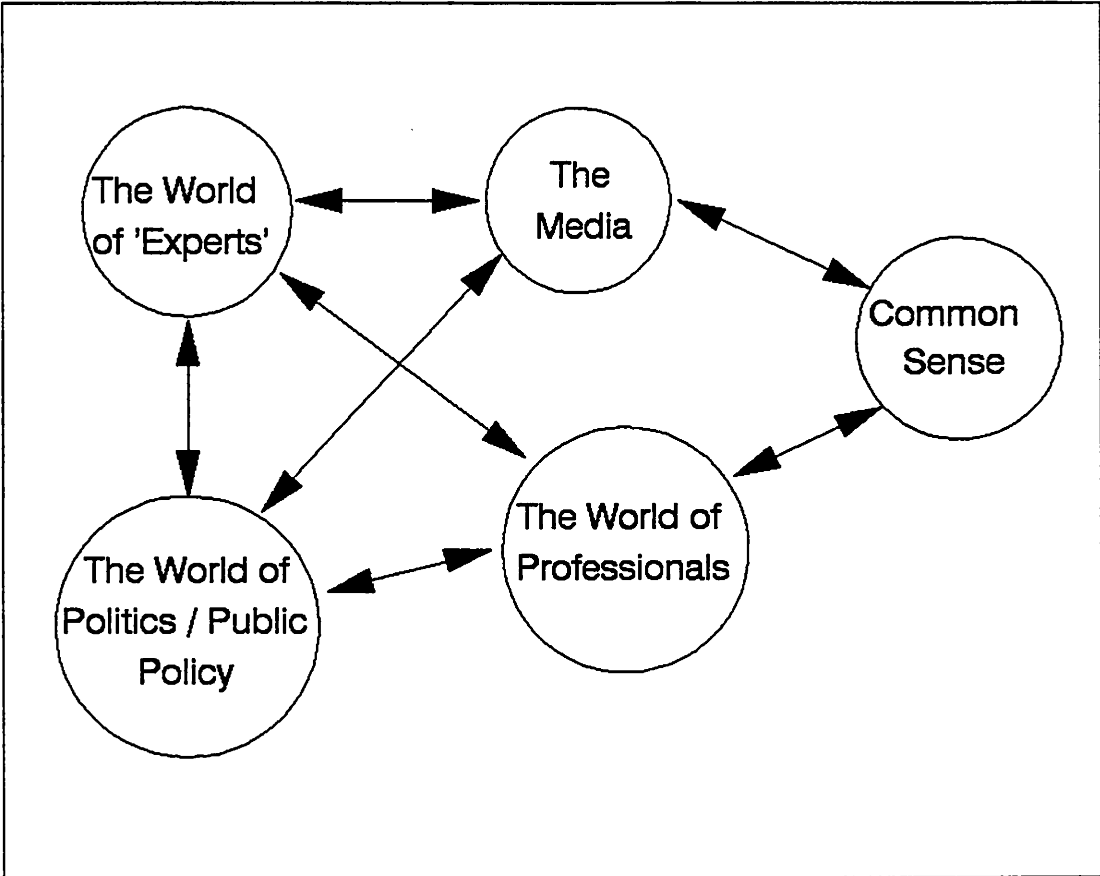
1.2 A Reformulated Model of the Social Circulation of Knowledge

Given the various problems discussed above, it seems timely to propose a new, reformulated model of the development and circulation of knowledge in modern society which overcomes the simplistic dichotomisations inherent in the original conceptualisation. Figure 3.2 below represents this model graphically. Several features are worthy of comment:

First, the new model includes more 'players' than the original one (see figure 3.1). Two new components or 'social arenas' have been added - the world of professionals and the world of politics and public policy. The arrows in the figure show the principle channels of communication between these spheres, although others may also be possible. Consideration of mental health professionals in the initial stages of this research led me to realise that the position of many professional practitioners could not be accounted for by Moscovici's original formulation of two distinct worlds of science and common sense. Professionals such as doctors, lawyers, teachers are vital players in the translation of knowledge and ideas between the world of science, research and expert knowledge, and the public domain. It is not only through the media (as the original model suggests) that lay people come to understand scientific and other expert knowledge, but through direct face-to-face contact with a whole host of professional practitioners - teachers, GPs, nurses, social workers and the like. This places professionals in a important position as 'vectors', carrying and translating knowledge and ideas between social spheres. Similarly, the social circulation of knowledge cannot be adequately understood without consideration of the role of politics which often plays a powerful part in shaping societal understandings and practices (for example, in the introduction of community care policies for the mentally ill). This introduces notions of power into our understanding of the development of social representations. Drawing on the work of Foucault (1980), the social practices of professionals can be seen as perpetuating ideological power in privileging and normalising certain definitions and reactions to, for example, sexuality, the body or the mind, and in so doing rendering other definitions unthinkable. Social practices which perpetuate, resist and renegotiate social power relations are lived out both within and between the various social spheres presented in Figure 3.2.

Another modification is that all the social spheres are now conceptualised as falling

Figure 3.2: Reformulated model of the Circulation of Knowledge



within the world of social representations. Previously, the world of science was conceptualised as split off from the world of social representation circulation and I have argued above that this was problematic. The 'world of social representations' can be considered to correspond to 'social reality' or the modern social world in its widest sense. Professionals, politicians, lay people and 'experts' all inhabit this social world, exchanging views through media discussions, gossip and conversations in pubs or over lunch. The various circles in figure 3.2 represent functionally different social spheres (the media, the lay public, politics etc), each with specific fields of expertise, rules and characteristics. But they are united by their common participation in a shared social reality, and their boundaries may be more fuzzy and overlapping than it is possible to represent graphically. Styles of knowledge generation associated with the development and circulation of social representations are in operation across all social spheres, although in some, namely the world of expert knowledge and possibly the world of professionals, this may coexist and compete with the epistemology of the reified universe.

Finally, because of ambiguities over what constitutes scientific versus non-scientific disciplines, the 'world of science' has been replaced with 'the world of experts'. This would then encompass not only researchers in the natural sciences, but those who claim to be 'experts' in any areas of the sciences, social sciences or humanities. This is not to deny that substantial differences may exist between, for example, economists, social anthropologists and astronomers. Nor that individuals in other social spheres (eg professionals, the media or politics) may also consider themselves as 'experts'. What differentiates those in this 'world of experts' is their claim to the advancement of understanding and esoteric theoretical knowledge independent of other agendas of a political or practical nature.

In summary, the model presented in figure 3.2 is, I believe, a more complex and comprehensive model of the circulation of knowledge in society than Moscovici's original model of the reified and consensual universes. Modern lay knowledge and common sense develop through a complex interaction between expert knowledge, the work of professional practitioners, politics, the media and historically based 'folk beliefs'. The model recognises that social representations circulate not only in the world of common sense, but across all social spheres. From this perspective, the theory of social representations could be fruitfully applied to a range of social spheres. The current

research focuses on the world of professional practitioners, and specifically those who work in mental health. In the following section specific features of the world of professionals and the 'professional social representations' which circulate in this world will be elaborated.

2 The Building Blocks of 'Professional Social Representations'

I propose the term 'professional social representations[1]' to refer to **the social representations which circulate in professional worlds and are held by professionals about the object of their work.** Teachers' social representations of children, mental health professionals' social representations of mental illness, representations of crime held by the police, lawyers' social representations of the law, and so on, constitute professional social representations. As systems of shared beliefs and taken-for-granted working practices, professional representations constitute the 'professional common sense' which is picked up implicitly through training and experience, and perpetuated in the organisation of a professional world. These professional representations are likely to be highly elaborated and characterised by specific features which merit theoretical as well as empirical consideration.

'Professionals' can be defined as occupational groups with special competencies who respond to central needs and values of society and are characterised by the following features: autonomy and prestige; specialised training; service orientation; the power to define specific spheres of social reality through self generated ideologies; and distinctive ethics which justify the privilege of self regulation (Larson, 1977). The model of professional social representations proposed here is designed specifically as a theoretical tool to aid our understanding of professionals whose work involves people[2]. Teachers,

[1] For elegance of expression this term may sometimes be shortened to 'professional representations'. The reader should assume that the two terms are equivalent and that the term 'social' remains implicitly in the shortened form.

[2] These have been referred to in organisational psychology as 'human service' occupations (Hasenfeld, 1992). Some writers on professionalism (for example, Toren 1972) characterise occupational groups such as social work, nursing and occupational therapy as 'semi-professionals' in the sense that their knowledge bases derive from several allied disciplines and are less unique than, for example, those of medicine or psychology. However, if one considers the enactment of unique practical skills and competencies as a defining feature, this distinction on the basis of theoretical knowledge becomes less valid, except as a way of describing differentials

social workers, nurses, the police, doctors all aim to change, advise or control people and aspects of their lives in one way or another. Their work is essentially moral, social and ideological. The decisions they make, their aims and goals their daily routines are implicitly imbued with value judgements of 'right' and 'wrong', of what is desirable, what is socially acceptable, what is 'normal'. Their work is part of social reality, and its effectiveness, quality and legitimacy are judged according to the cultural and social norms dominating in society at a given point in time. The work of these people-based professionals is also 'social' in that they work through the medium of relationships in which the 'object' of the work (the child, the mentally ill person, the law-breaker etc) is as much an active participant in the work as is the professional. All of these features suggest that the world and the work of professional practitioners would be rich and appropriate material for the theory of social representations which aims to conceptualise the social nature of beliefs, values and practices.

Within the ever increasing body of empirical studies using the theory of social representations, there have been several studies investigating social representations among professional populations (eg de Rosa 1991, Palmonari et al 1987, Serino 1987, Zani 1987). However, these studies have been more concerned with application of the theory, rather than with theoretical developments. I take the position that as the theory matures and expands, such theoretical considerations are both well over-due and increasingly necessary if the theory is to prove itself as a valuable tool for social psychological research in the years to come. If the theory of social representations is to expand its remit into aspects of society beyond lay thinking and common sense, we must do more than simply apply the original theoretical concepts - we must develop and expand them to take account of the characteristics of social worlds such as the media, 'experts' and professionals which differentiate them from common sense. Processes, contents and structures of the social representations which circulate in each of these social spheres are likely to differ according to the relationship between representor and the object to be represented. Taking the example of mental illness, politicians, mental health

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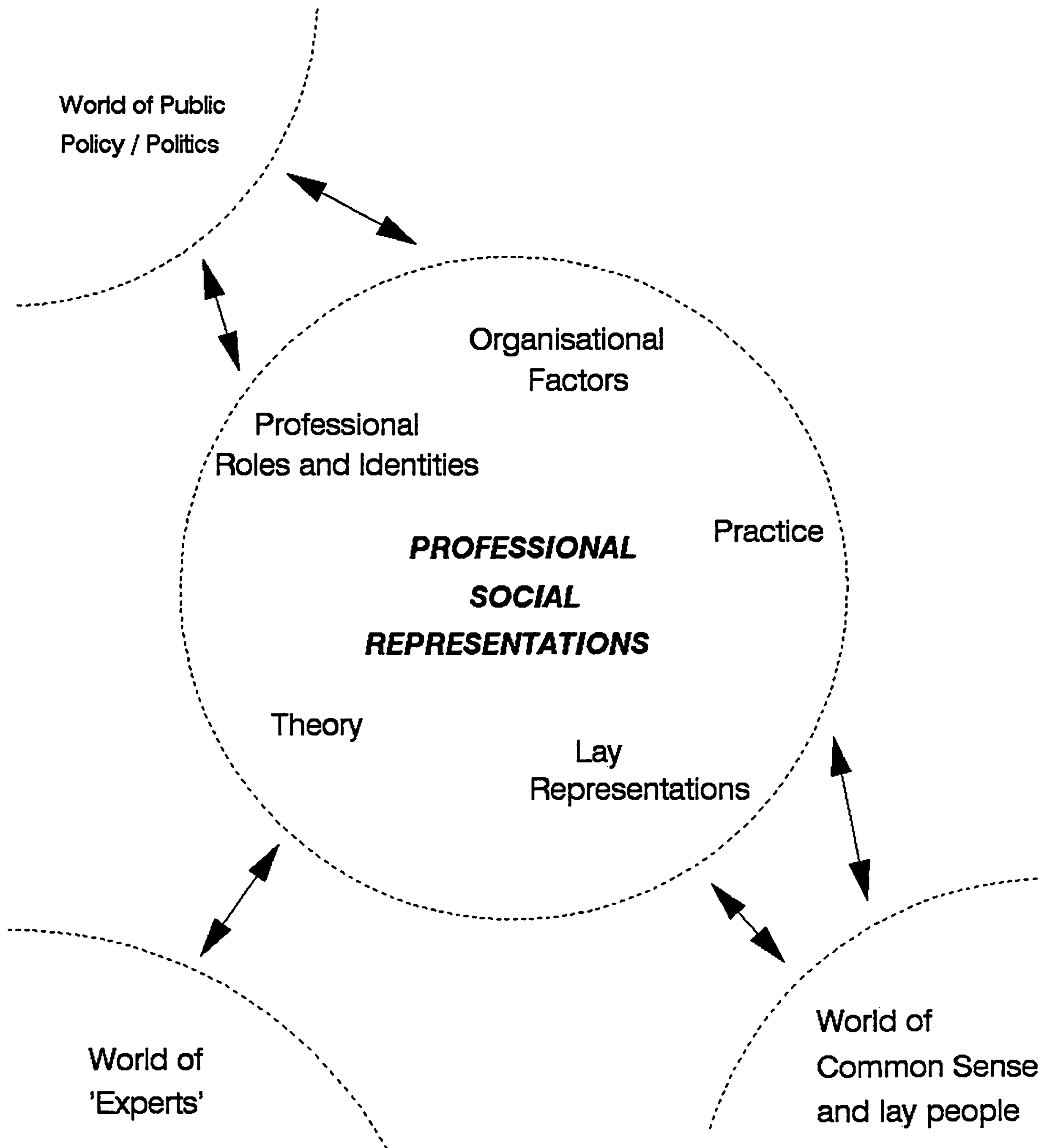
of status. Throughout this thesis I use the term 'professionals' to refer to all mental health disciplines which require specialised training. A further characteristic of these professions is that they have traditionally been employed by the State, although with privatisation and the reduction of the welfare state in recent years, this is no longer a defining feature. The limitation of this model to 'people-based' professionals does not imply that it is necessarily inappropriate to non people-based professional worlds such as accountancy or architecture. It may well be, albeit with some modifications. For the time being however, I leave this question open.

professionals and lay people have very different relationships with mental illness and the mentally ill. We should not, therefore, assume that representations of mental illness circulating in these worlds will show identical contents. Nor can we assume that these representations will be characterised by the same processes and internal structures, even if they are, nevertheless, united by common themes.

Figure 3.3 below builds on figure 3.2 in elaborating the proposed features of professionals social representations circulating in the world of professionals. (The outlines of this representational field and the worlds with which it is interlinked are dashed rather than solid in this figure, to indicate the fluid and unclear nature of these boundaries and divisions.) **It is proposed that professional social representations comprise five components:- theory, practice, professional roles and identities, lay representations, and organisational factors.** Professional practice - the day-to-day work of social workers, teachers, the police, doctors etc - is arguably the most important defining feature of professional representations, which differentiates professionals from lay people and 'experts' alike. Abstract theoretical knowledge of their field is part of professionals' training and is likely to form part of their subsequent social representations as professionals. Training also serves to socialise professionals into certain roles and professional identities. Professional roles and daily practice are necessarily shaped by their organisational context. Rather than seeing organisational factors simply as the contextual background, this models proposes that professionals' representations and experiences of the organisations and institutions they work in and form part of, and the beliefs and ideologies that these imbue, are part and parcel of professional social representations. The final element of professional representations is lay beliefs and knowledge, which professionals do not leave at the door when they enter the school, the hospital or the office and don their 'professional hats', but carry with them as members of society and as human beings.

At this early stage, the relationships between these five components of professionals social representations are not specified. The theory of social representations proposes that all representations are integrated structures of beliefs and actions (Wagner, 1994) whose elements may show compatibilities and consistencies, as well as inconsistencies, diversity and heterogeneity (Rose et al, 1995). Thus, rather than forming distinct sub-components, the inter-relationships between these elements and the consequent structure

Figure 3.3: Components of Professional Social Representations



of professional social representations may be considerably more integrated, complex and fluid than it is possible to present graphically. One of the purposes of the current study will be to investigate the relationships between these elements in more detail, as well as to provide an empirical test of this proposed model for professional social representations in the field of mental health.

This model of professional social representations aims to provide theoretical progression, while at the same time retaining the distinctive epistemology and basic assumptions of the theory of social representations. Having said this, theoretical speculation can often benefit from insights drawn from other perspectives. The development of this model does not limit itself to consideration of social representations literature, but casts a wider net, drawing upon literature and ideas generated by other theoretical perspectives and in areas such as sociology and organisational psychology. Sections 2.1 to 2.5 which follow take each of the five proposed components of professional social representations in turn, drawing on previous literature from a range of theoretical positions to elaborate the proposed nature of the elements of professional social representation in more detail.

2.1 Theoretical Models

A crucial feature of professional social representations which differentiates them from lay social representations is theoretical knowledge. Causal models and abstract conceptualisations developed through research and intellectual thought in the 'world of experts' can be distinguished from lay theories in being formalised, explicit and communicated through the written word and formal teaching. (In comparison, lay theories are implicit and communicated informally through conversations, the spoken word or routine practices.) A large part of professional training in any field is the formalised teaching and examinations which act as a process of socialisation into certain theoretical ideas and styles of thought. This body of knowledge includes both esoteric and academic theories and more exoteric 'theories of practice' (for example, models of teaching or social work practice, care strategies in nursing, theories of treatment interventions in clinical psychology) which use theoretical ideas to structure and guide professional practice.

Moscovici (1993) suggests that within the scientific community, theories can be considered as social representations. Like social representations, theories shape the practice of researchers, act as lenses through which research findings are evaluated, are produced collectively through continual debate and negotiation, and are an important aspect of group identity construction, their proponents often being fervent believers rather than simply holders of knowledge. This is a useful step towards applying the theory of social representations to social spheres other than common sense, but the current model of professional social representations suggests that it is preferable to consider theory as one of several components of these representational fields rather than as social representations *per se*. It is suggested that theoretical knowledge may serve two important functions in professional social representations:

Firstly, theories may serve an anchoring function in professional social representations, helping those who hold them to make sense of, orient themselves to, and gain a sense of familiarity and mastery in the world in which they work. Theories provide the names and categories which are required for anchoring to be achieved, structuring what professionals do, and how they think about what they do[3]. They play a part in practical decision making, in the ways professionals conceptualise their work and its aims, and in communication and debate amongst colleagues.

Secondly, theoretical models may offer professionals a way of justifying their work and their position, acting as useful rhetorical devices to legitimize professional practice. For people-based professionals whose work involves reacting (often at great expense to the tax payer) to phenomena such as mental and physical illness, crime or unemployment, which seem to endure regardless of how they are tackled, this legitimation function of theories may be particularly important. By holding abstract theoretical models which lay people do not, professionals can lay claim to their public position as 'expert' practitioners who are supposed to have knowledge and skill in a certain field over and above that of lay people. Practice in a professional capacity differs radically from actions as a lay person in that it is publicly accountable and carries with it social expectations to achieve certain changes. Theoretical models provide legitimation for variations in working styles

[3] This relationship between knowledge and action would also be predicted by models developed within the social cognition framework, such as the expectancy-value model of attitudes, intentions and behaviour developed by Ajzen & Fishbein (1980).

and may function to provide *post hoc* justifications for action within professional representations.

These two functions of theoretical knowledge in professional social representations suggest different relationships between theory and practice. Theory used as an anchor suggests a 'theory then practice' relationship. Whereas theory as a *post hoc* justification for action suggests 'practice then theory'. The empirical analyses in Chapter 6 aims to shed light on this relationship between theory and practice in professional social representations, and to investigate the nature and the role of theoretical knowledge in representations of mental illness held by mental health professionals.

2.2 Professional Practice[4]

The practice of professionals differs in several important ways from that of lay people, and these factors merit conceptual elaboration. As expert practitioners, professionals are in constant daily contact with the 'object' of their professional social representations, as personified in the mentally ill person, the criminal, the child etc. This necessarily places them in a very different position to the lay person, the politician or the 'expert'. Not only do they choose to have this contact, but it occurs within specific parameters of the professional - 'client' relationship, which as noted above, carries with it expectations and social accountability. While lay people may be heavily influenced by the media in the development of certain social representations (of crime or mental illness, for example), professional representations are shaped by a specific type of direct personal experience.

The day-to-day work of professionals is likely to be shaped by complex and dynamic interactions with the other four components of professional social representations - theoretical knowledge, professional roles and identities, organisational factors and lay representations or common sense. The current study aims to elaborate the nature of these

[4] The term 'practice' is used here in a 'narrow' sense to refer simply to what is actually done by individuals in daily working life, rather than in the sense used, for example, by Pierre Bourdieu whose wider notion of practice ('habitus') is compatible with the functioning of social representations (Doise 1985). Taken in its narrow sense, practice becomes an integral component of wider social representations.

relationships in professional representations of mental illness, using empirical analysis to investigate, for example, the interactions between working practices and organisational factors in a time of rapid policy and organisational change.

2.3 Professional Roles and Identities

Professionals approach the object of their work as a teacher, a doctor, or a nurse. In this sense their own professional identity is part and parcel of their professional social representations and neat subject-object splits cannot be made. For example, representations of children as blank-slates, innocent beings in need of love and protection, or unruly agents whose energies must be channelled and controlled would imply very different self-images and roles for teachers who subscribe to these representational perspectives.

Breakwell (1993) suggests that an integration of concepts from social identity theory (Tajfel, 1978) can enrich the theory of social representations by accounting for how and why particular groups or individuals respond to, reproduce or reject representations. Thus we would expect professional group identities and inter-group relations to play a part in the infiltration, acceptance or rejection of representations across different professional groups. In the world of mental health for example, social workers, psychiatrists and clinical psychologists define themselves in relation to each other and carve out their representational positions accordingly. Social representations can serve both inter-group purposes (enhancing differentiation or allegiances between groups, for example) and intra-group purposes (building group cohesion, aiding communication, and so on). Work by Hayes (1991) illustrates how the use of concepts from social identity theory is particularly useful to studying representations in organisational contexts, in which diverse sub-groups aligned with different representational positions are united within a common organisational culture.

2.4 Organisational Factors

The forth component of the proposed model of professional social representations is

organisational factors. From the specific local context (the school, the solicitors practice, the hospital, the day centre) to the wider institutional system (the education system, the legal system, the health service), professional social representations are both reflected in, and shaped by organisational factors. From the multi-level stance of social representations theory, organisations cannot be separated from the people who work in them, and the beliefs and representations which circulate in and structure these worlds. Organisational factors can therefore be considered as part of professional social representations, just as these, in turn, are part and parcel of the organisational systems in which they are lived out. Hospitals would not be hospitals without the medical professionals who work in them, nor would these people be medical professionals if they were not united by an organisational structure and by certain shared beliefs.

This perspective is compatible with several other approaches to the study of work organisations. For example, conceptual similarities between social representations theory and theories of organisational culture are noted by Kummerow & Innes (1994)[5]. In this vein, Hasenfeld (1992) approaches 'human service organisations (schools, hospitals etc) as collectivities which adopt and uphold the value systems of wider society through the daily routine of the people who work in them. Research conducted in hospital settings (eg Strauss et al, 1985) supports a model of these organisations as dynamic systems in which the structures that emerge to handle the work reflect negotiated order among the various actors (staff and clients), dominant ideologies and the nature of the work itself. Hasenfeld (1992) suggests that human services organisations are often experienced by those who work in them as constraining them from working as they would like to ideally, according to their theories and representations of their work, by imposing rules and regulations, organisational structures and limitations on resources. These control mechanisms are particularly complex and weighty because of the moral nature of the work and the associated requirement for work to be judged and perceived as fair and trustworthy. Control and regulation may be instituted internally (for example, record keeping, monitoring and standardised procedures) or externally through government

[5] They note that both approaches share their origins in the early work of Durkheim, both focus on collective, taken-for-granted and historical aspects of beliefs, and both highlight the function of collective belief systems in reducing uncertainty and anxiety. Organisational culture is defined by Schein (1985, p 9) as 'a pattern of basic assumptions - invented, discovered, or developed by a given group as it learns to cope with its problems of external adaptation and internal integration - that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.'

regulations or public inquiries. One could speculate that at times of rapid or radical policy changes this sense of constraint may be particularly acute, as new styles of working imposed by policy makers and managers clash with established working practices. At such times, imbalances of power between the various social actors (policy makers, professionals and lay people) are brought into sharp focus.

Another informative perspective is the human relations approach to organisational psychology which highlights how organisational functioning is a product of the complementarity between organisational goals and the personal needs of those who work in them. Thus, similar to social representations theory, intra-psychic, inter-personal and collective levels of analysis are integrated. Psychodynamic perspectives have developed this approach further, using systemic and group dynamic theories to highlight how organisations are shaped by the unconscious concerns of their members and the unconscious forces shaping the societies in which they live (eg Jacques 1955, De Board 1978). Jacques (1955) suggests that structures, processes and cultures in organisations can be understood as unconscious defense mechanisms used individually and collectively to cope with anxiety[6]. Social change is resisted by organisations and their members because it undermines established unconscious defense systems. This resistance may be particularly acute when change is imposed rather than chosen by organisational members. Given the linkages noted in Chapter 2 (section 2.2) between societal reactions to mental illness and defensive intra-psychic processes ('otherising' and the projection of fears of collapse and disintegration onto the mentally ill) these ideas may prove useful to understanding the content and processes of representations circulating in organisations whose work focuses on mental ill health.

These organisational factors will be the focus of analysis presented in Chapter 7, which takes the current organisational changes in mental health as its starting point, and seeks to investigate how these changes are evaluated and experienced by mental health professionals.

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[6] As an example, Menzies (1960) applies these ideas to a study of nursing staff in general hospitals. She suggests that strategies such as the depersonalisation of patients, the denial of personal feelings, and 'ritual task performance' in which work is conducted according to rigid task lists and discretion and initiative are discouraged, can be seen as coping mechanisms against anxiety, guilt and uncertainty engendered by the emotionally difficult nature of nursing practice.

2.5 Lay Knowledge

Teachers, doctors, social workers and the police may don their professional hats between certain set hours, but they are also members of society, who read the newspapers, chat with friends in pubs and sitting rooms, believe in superstitions and so on. It is argued that this common sense knowledge is too pervasive, too deeply rooted to be wiped out by the secondary socialisation of professional training, or left at the door when a person enters the school or hospital and becomes a professional for the duration of their working day. The proposed model of professional social representations conceptualises aspects of lay representations as part and parcel of professional representations. Not only do professional representations develop within social reality and the world of social representations, but these representations enter into the representations which circulate in professional worlds. If lay knowledge were not included, if it was conceptualised as entirely separate and excluded from professional representations, this model would risk reproducing errors made in the past by the theory of social representations, organisational psychologists and sociologists alike, in which the overlaps of common sense styles of knowledge with expert worlds and organisations have not been adequately recognised[7].

The existence and status of common sense or lay knowledge in professional representations will be investigated in the empirical analysis of data obtained from mental health professionals. At this stage, it is hypothesised that lay knowledge may be more implicit and hidden from view than other components of professional representations. This is suggested by the public accountability of professional practitioners, whose social legitimacy depends crucially on the public perception that they bring different types of knowledge and expertise to their daily work than the understandings of lay people. Lay understandings of children, mental illness or disease are unlikely to be verbalised by the professionals who work in these fields (especially if they carry with them negative connotations), but may nevertheless be implicit components in the construction of professional social representations. As an example, research into teachers' attributions of poor classroom performance to lack of motivation in boys compared to lack of ability

[7] Problems with social representations theory's original conceptualisation of the world of science have already been noted in section 1.1. Much of the work by sociologists (eg the anti-psychiatry writers) provides a rather simplistic model of professionals playing roles which perpetuate existing power structure (see Chapter 2, section 2.2). Similarly, organisational psychology has tended ignore the role of folk beliefs in organisations and the practices of those who work in them.

in girls suggests the influence of socially pervasive gender stereotypes or social representations which are not fully extinguished by professional socialisation (eg Dweck et al 1978).

2.6 Professionals as Integrators, Translators and Vectors

The previous five sections have elaborated aspects of the five components which, it is proposed, constitute professional social representations. These components are of different and potentially incompatible natures, encompassing abstract theoretical knowledge, daily routines of individuals, broad organisational cultures and ideologies, intangible common sense beliefs and professional identities. It is suggested therefore, that professional representations act to integrate and translate diverse spheres of knowledge, beliefs and actions. Following from this, a second proposal is that this reflects the difficult and unique social positioning of professional practitioners at the interface between the diverse social spheres of politics and policy directives, 'experts' and theoretical knowledge, and the lay public and their folk belief systems (see Figure 3.2). Often the agendas, directives and knowledge systems of these various social spheres are incompatible or even conflictual. Conflicts may emerge particularly at times of change, when the *status quo* is challenged by, for example, new developments in the world of experts or changes in policy directives. The discovery that AIDS affects both homosexual and heterosexual groups, the introduction of community care for the mentally ill, and changes to the National Curriculum are all recent examples of this. Such changes may spark crises of public legitimacy as professionals attempt to implement new solutions suggested by politicians and experts to enduring social problems such as mental illness, unemployment, or crime.

Translation of theories from the world of experts and of policy directives into day-to-day practical strategies is not easy as it requires reconciliation of different types of social knowledge. Policy directives and recommendations from theory may be ambiguous or over-general, and require active interpretation or reconstruction to be put into practice. What is abstract, conceptual and ideological must be translated into the day-to-day, the concrete and the interpersonal. This suggests that professional representations will be the site of compromises between the demands and directives of various spheres of knowledge

differing in nature and origin, and (given that incompatibilities may exist and harmonious integration may not be possible) inconsistencies, continuous negotiations and power struggles. As an example, teachers may struggle to reconcile local education policies of comprehensive schooling, with parents' demands for streaming, while attempting to put the various 'expert' recommendations into practice, considering the wishes of children, and balancing all these with their own beliefs and judgement based on classroom experience, personal values and professional training.

In translating and integrating diverse sources of knowledge, professionals act as 'vectors' between various social spheres. The term 'vector' is used to imply the communicative function of professional practitioners who, along with the mass media, are points of contact and exchange, or carriers of opinions and concerns between politicians, experts and the public. But, as the argument above highlights, the ideas and understandings which professionals disseminate between various social arenas do not remain constant through this communication process, but are re-presented or translated in form and content. Policy directives and research recommendations cannot be realised without agents to put them into practice. Professionals are the implementors of public policies and expert knowledge in the public sphere. It is through the work of professionals that lay people feel the direct impact of education reforms, community care policies, medical advances and the like. Teaching children about safe sex at school, visiting new mothers at home, stopping drivers who break the speed limit, charging £100 for an hour's legal consultation, giving the mentally ill depot injections and sheltered housing - these are all examples of how the work of professionals impacts directly on the organisation and daily routines of people's lives. Professional practice is a powerful shaper of lay representations which involves quite different processes from the ways that policy and expert knowledge filter into and interact with lay representations through the media.

One of the principle aims of the current empirical study is further investigation of these complex dynamics in the world of mental health. This will serve not only to extend our knowledge of the experiences, beliefs, knowledge and practices of mental health professionals, but also as an empirical test of the model of professional social representations elaborated in this chapter. The position of mental health professionals as vectors between 'expert knowledge', policy and the public sphere, and the resultant translations and negotiations on the part of mental health professionals that this position

requires, suggest that professional representations of mental illness are an interesting area of study, both in their own right, and as important shapers of lay representations of mental illness. The empirical analyses will aim to shed light on how diverse spheres of knowledge derived from various sources are inter-related within professional representations of mental illness, uncovering the integrations, compromises, tensions and inconsistencies that exist within these representational fields.

3 PROFESSIONAL SOCIAL REPRESENTATIONS AMONGST MENTAL HEALTH PRACTITIONERS

Having elaborated a general theoretical framework for social representational research focused on professional practitioners, this section focuses on the specific professional world with which the current research is concerned, namely the world of mental health professionals. Compared to the previous two sections of this chapter, this constitutes a shift in emphasis from general theoretical conceptualisations concerned with structure and process, to specific content and substantive issues. Thus, while sections 1 and 2 have positioned the current research theoretically, this section positions the study substantively. It begins with a review of the contemporary world of mental health professionals. This highlights aspects of this unique social sphere with which it is necessary to be familiar in order to appreciate the findings of current and previous empirical studies. In section 3.2 a selective critical review of previous research serves to locate the current study within the corpus of existing social scientific research on mental health professionals and their understandings of mental ill health. This material is drawn together in section 3.3 which postulates some initial observations about professional social representations of mental illness as characterised by multiple and diverse knowledge spheres, suggestions of rejection and psycho-social distancing, and debate, ambiguity and uncertainty.

3.1 The World of Mental Health Professionals[8]

The world of mental health practitioners or professionals through which mental health services for the population are provided is made up of a diffuse network of social actors and organisational structures whose daily practices and workings are underpinned by broad belief systems (or professional social representations) regarding the nature of mental distress and societal reactions to this phenomenon. In order to understand the nature and development of these practices and belief systems, it is necessary to know something of the groups of professional practitioners and bodies of 'expert' theoretical knowledge which populate this professional world.

Chapter 1 highlights how the second part of the twentieth century has seen dramatic changes in mental health policies in both France and Britain, associated with a widening of the remit of mental health services beyond the medical into the realms of the psychological and the social. This is reflected in historical expansions in the professional groups who work with the mentally ill and have carved out distinct areas of specialist practice in response to the historical dominance of psychiatry. Contemporary mental health services in Britain and France are delivered by multi-disciplinary teams of practitioners consisting typically of psychiatrists, psychiatric nurses, social workers and clinical psychologists. (Occupational therapists and case managers also form part of these teams in Britain.) Appendix 2 provides a review of the professions which make up mental health teams in Britain and France, considering their historical development, their knowledge bases and their contemporary practice. The very existence of these professional groupings within the contemporary world of mental health is in itself an informative indicator of how mental illness is socially represented. As Prior (1993) puts it:-

> '(M)ental illness is essentially defined through the sum total of practices which surround it. And given that, it follows that the organization of the division of labour necessarily reflects a great deal about what such illness is considered to be at any one time.' (p 77) ... '(T)he appearance of the roles of occupational therapist, social worker, community psychiatric nurse and clinical psychologist reflect both changes in the occupational structure and changes in our understanding of what mental illness is and how it ought to be organized. Indeed, the very

[8] Although the analytic focus of the current research is on professionals and their social representations, this is not to deny that people designated as mentally ill patients or clients are as important social actors as professionals in the enactment and negotiation of daily routines and social representations in the day centres, out-patient clinics and hospital wards which form the network of public mental health services.

existence of such roles underlines the fact that, in the closing years of the twentieth century, mental illnesses are far from being perceived as purely medical and organic problems.' (p 102)

Another indicator or point of access into contemporary professional representations of mental illness is through the bodies of abstract conceptual knowledge which circulate in the world of mental health. The role of this theoretical knowledge in professional social representations has been discussed in section 2.1 above, and will be one of the foci of the current empirical investigations (see Chapter 6). Theories of mental illness form the pool of abstract and 'expert' understandings into which professionals are socialised during training, and on which they draw in constructing their daily practice and their representations of mental illness.

Appendix 3 provides a brief review and commentary on the main bodies of theoretical knowledge which have developed in recent decades in the world of mental health in France and Britain. Five broad theoretical positions on mental illness are reviewed: medical; psychodynamic; social; cognitive-behavioural; and systemic[9]. These five perspectives are all generally accepted positions in the current expert literature on mental health. They are bodies of knowledge to which most mental health professionals have at least some exposure during training, and they constitute the bases of many of the current 'theories of practice' used in day-to-day mental health work. This corpus of theoretical knowledge has certain characteristics which are likely to have important implications for the development of professional representations of mental illness:

Firstly, the various theories of mental illness are diverse and constitute a heterogenous body of expert knowledge. Each one suggests very different conceptualisations of the

[9] Critical commentaries by social scientists on these theoretical positions have focused principally on the medical model. While there is not space in this thesis to consider these in detail, an interesting example is the work of Gaines (1992) who uses a cultural reading of one of the 'bibles' of psychiatric practice, DSM (The Diagnostic and Statistical Manual for Mental Disorders published by the American Psychiatric Association) to illustrate how psychiatric nosologies mesh with cultural notions of person-hood. Gaines suggests that the various mental illness categories imply failures of reason imbued with a moral dimension and associated with insufficiencies or excesses. Central to these illness categories is the notion of failures of self control. A concept of the ideal self based on Northern European Germanic Protestant notions of person-hood as rational and controlled is implicit, with the DSM system serving to place distance between this culturally idealized self and the mentally ill as 'other'. This analysis shows many parallels with the sociological and historical conceptualisation of mental illness as a dangerous form of 'otherness' reviewed in Chapter 2 (section 2.2). It illustrates how knowledge systems which develop within a specific professional sphere are social and cultural products and may not be equivalent in different cultural contexts.

nature of mental ill health, the aetiological factors involved (genetics, childhood trauma, social conditions, or family dynamics for example), and the practical strategies most appropriate in treating mental health problems. In social representational terms, this diversity suggests multiple possible ways of anchoring mental illness. The various theoretical orientations offer practitioners diverse and often contradictory guidelines regarding how to work with the mentally ill, suggesting strategies as diverse as administering medication, initiating changes in social circumstances, talking about early experiences or modifying behaviour.

Secondly, despite this diversity, the different theoretical positions are historically inter-related and these relationships are characterised by important power imbalances. As in any social sphere, the development of expert understandings is a social process. Theories of mental illness develop in reaction to other theories, diffuse within the community of mental health experts and practitioners, take hold, displace other models, are marginalised or fade into oblivion and history. While medical models have dominated the world of mental health historically, (arguably as a result of the power of medicine more generally in western society (Zola, 1972)), more recent theoretical perspectives such as social, cognitive and family systemic models constitute important challenges to the power base of psychiatry and the medical model[10]. Beyond these general trends which have occurred on both sides of The Channel, the development of theoretical perspectives and their relative power balances differs somewhat between France and Britain. In particular, there are significant differences in contemporary psychodynamic perspectives in France and Britain (see Appendix 3 for details). Psychodynamic perspectives hold much more sway in France, while cognitive-behavioural approaches have remained principally within the English speaking world.

Thirdly, these bodies of knowledge are not fixed but provisional, partial and continuously up-dated. Historically speaking they are relatively 'young', most contemporary expert understandings of mental ill health having developed in the later parts of the twentieth century. Even in this relatively short period, there have been considerable changes and

[10] As an example, Gilman (1988) and Boyle (1990) chart the historical development of theoretical models of schizophrenia, from Kraeplin's original proposal of the concept, through the ideas of Freud and Jung with an emphasis on linguistic and hermeneutic aspects, the anti-psychiatry movement, family systemic theories, and the new biological theories of the 1970s. Each of these perspectives developed in reaction to what had gone before, building on some ideas and rejecting others.

developments within each theory (for example Stevens (1983) and Turkle (1979) chart developments in psychoanalysis, while Gaines (1992) and Light (1982) analyze changes in psychiatric nosologies). Despite the backing of fervent disciple communities, no definitive 'proof' for any single theoretical perspective can be marshalled (even on the epistemological terms of their proponents). Similarly, no single perspective can provide a definitive understanding of mental ill health. The imperfect fit of mental illness into any single theoretical system allows space for constant debate within the community of mental health practitioners and experts. Jodelet (1991a) notes the implications of this in the construction of lay representations of mental illness:-

> 'there exists no real "hard core" of knowledge about this affliction and the scientific and medical world has been unable to agree on any homogeneous position. Thoughts, judgements, opinions on the subject frequently lead the thinker back to an autonomous social construction in which expert, legitimate knowledge plays only a minor role.... What is more, the vague and unresolved map of the psychiatric world offers the public little reassurance, a state which will favour the proliferation and survival of the vagaries of everyday common sense.' (Jodelet, 1991a, p 8)

In summary, the theoretical knowledge which circulates in the world of mental health can be characterised as diffuse, heterogenous, and provisional. The role that this type of knowledge plays within professional social representations will be an important area of investigation in the current empirical study.

3.2 Research on Mental Health Professionals

The world of mental health services, treatments and care strategies has been the focus of an enormous amount of analytic and evaluative research, conducted from perspectives as diverse as social policy evaluation, nursing studies, sociology, psychology and psychiatry. This review limits itself to research which can tell us something of **how mental health practitioners understand and conceptualise mental health problems**. Despite this volume of work on mental health services, it is somewhat ironic (given the argument put forward in section 1.2 above regarding the role of professional representations in the development of lay and societal knowledge) that social science researchers have tended to pay less attention to understandings of mental distress amongst mental health practitioners than to those circulating in the lay world. This section provides a critical discussion of an illustrative sample of research on mental health professionals conducted

from various perspectives. It focuses in more detail on those studies which are epistemologically compatible with the current research.

The Anti-psychiatry view

The 1950s and 1960s saw a huge proliferation of sociological work which developed labelling and deviance theories and radical anti-establishment positions to challenge the medical model of mental illness and promote an alternative social model of the mental illness category. The anti-psychiatric view of mental health practitioners has generally been that they are agents of the oppressive and coercive regime of the psychiatric system, and as such, subscribe to simplistic, medicalized and negative understandings of mental distress in which difference and abnormality are paramount and there is little or no attempt to understand the person's experiences (see Perrow 1965 or Weinstein 1982 for reviews of work by sociologists conducted in psychiatric hospitals). For example Goffman's (1961) ethnographic study of St Elizabeth's Psychiatric Hospital in Washington DC documents the details of how staff enact daily routines which contribute to the hospital as a 'total institution' in which inmates are stripped of all capacity to act in an autonomous, self determining way. Although Goffman is primarily interested in taking the patients' perspective, he conceptualises the psychiatric hospital as a place where both patients and staff loose their ability to act in autonomous ways. Hospital staff are characterised as locked into routine practices and ways of thinking which serve the needs of the institution and their own collective need to maintain the legitimacy of their social position. As a consequence, they are unable to interact with patients on their own terms, and are restricted in the flexibility of their reactions. In a similar vein, Rosenhan's (1973) study of 'being sane in insane places' describes how staff persistently interpreted the 'normal' behaviour of investigators posing as mentally ill patients as evidence of psychiatric illness. Rosenhan discusses the 'stickiness of psycho-diagnostic labels' which develop in the minds of professional observers and come to develop a life and influence of their own which shapes interpretations of a patient's past, present and future.

Critical evaluation of this type of research from a social representational perspective mirrors the comments made in Chapter 2 about the anti-psychiatry movement in general, and I will not repeat these arguments here. The anti-psychiatry perspective on psychiatric institutions and the people who inhabit them has been criticised for (among other things)

conceptualising staff simply as villains motivated by custodial rather than therapeutic goals (Perrow 1965), presenting a homogenized view which fails to account for individual diversity (Weinstein 1982), and promoting a 'vulgar version of the societal reaction perspective' (Killian 1981)[11]. In their focus on a systemic level of analysis, these approaches offer a valuable conceptualisation of the drastically unequal power relations between staff and patients in mental health services. However, this systemic focus also renders their accounts of how the people who work in these organisational structures make sense of and understand the nature of mental ill health relatively unsophisticated and simplistic. They fail to capture both the diversity of understandings within professional groups and the nuances of meaning associated with mental distress. (A cogent argument could also be made that developments in mental health care over the last three decades render these studies out-dated. However, while organisational structures have certainly changed dramatically, and anti-psychiatric writing has had a significant impact in shaping the very systems of which it is so critical, several recent studies of hospital closure in Britain (Korman & Glennerster 1990, Prior 1993, Tomlinson 1991) suggest that aspects of institutionalisation remain, even within small community-based services.)

Attitude Research

One of the most commonly used multi-dimensional measures of attitudes towards mental illness, the OMI (Opinion about Mental Illness Scale) was developed by Cohen & Struening (1962) using samples of mental health practitioners. The five dimensions measured by this scale are Authoritarianism (the mentally ill as different and inferior to 'normal' people); Benevolence (a kindly, paternalistic view); Mental Hygiene Ideology (adoption of a medical model); Social Restrictiveness (mental illness as a threat to society); and Interpersonal Ideology (a psychodynamic perspective). Most attitude research has tended to compare the various professional sub-groups and to search for factors which can predict and/or change attitudes to mental illness. Reviewing a number of studies (mainly conducted in the United States), Rabkin (1972) reports that lower

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[11] Killian comments that, 'it is not that the social processes on which sociologists have focused their attention in recent years are not real and significant. It is rather that so many sociologists have been as dogmatic and as self-righteous in promoting their versions of an ill-defined, uncertain, often intuitive body of knowledge as have psychiatrists in defending their myths.' (Killian, 1981, p 238).

status personnel (nurses and hospital aides) typically show more authoritarian and restrictive attitudes towards mental illness. Similarly, Schroder & Ehrlich (1968), replicating the study by Phillips (1966) (reported in Chapter 2, section 2.3) report that levels of rejection of the mentally ill measured by social distance scales are almost as high amongst psychiatric nurses as those of the lay public. Rabkin (1972) reports that those with more professional training (psychiatrists and clinical psychologists) are found in several studies to be more liberal and tolerant in their attitudes, although psychologists usually score low on the Benevolence dimension. Younger professionals and those with more education have generally been found to express the most liberal attitudes. Whilst several studies show that training and experience can produce attitude change amongst mental health practitioners, the usual problem of a weak association between attitudes and behaviour are also encountered.

Section 2.3 of Chapter 2 has already discussed the substantial epistemological and methodological problems of research using the concept of attitudes to study collective beliefs about mental illness. These points apply as much to research on mental health practitioners as to work on lay populations and will not be repeated here. While these studies may provide indications of the diversity and multiplicity of understandings of mental ill health which exist amongst mental health professionals, and are suggestive that many of these views are characterised by negativity and rejection, there are other studies which capture the complexities of social psychological aspects of professionals' understandings of mental ill health more successfully.

'Socio-Psychological' Perspectives[12]

A recent study which is highly relevant to the current research, both in terms of its social constructionist stance and in its focus on similar contemporary mental health services, has been conducted by the sociologist Lindsay Prior. In 'The Social Organisation of Mental Illness' Prior (1993) investigates how definitions of mental illness, as reflected and

[12] This section covers research which is generally compatible with the epistemological stance of the current study in taking account of both social constructive processes and the agency and diversity of individuals. Having said this, not all the authors of this research are social psychologists (for example, Prior is a sociologist and the work of Kirk & Kutchins is conducted from an organisational perspective). This is illustrative of the position of social representations theory and research located at the interface between several social scientific perspectives.

constituted in the organisation of mental health services, have changed through the twentieth century. The study draws on an imaginative range of historical evidence including architectural plans for the lay-out of psychiatric hospitals, the development of the various mental health professions, text-books used in mental health training and policy documents[13]. It also encompasses detailed investigations of specific contemporary hospital and community mental health services in Northern Ireland. These suggest that conceptualisations of mental ill health amongst mental health personal differ between hospital and community locations.

In the hospital context, the medical ideology reigns supreme - mental illness is seen as a problem residing within individuals which is treated and controlled with medication. There is a general consensus amongst the staff that the role of the hospital is first and foremost to treat disease, with any other functions serving a secondary role. The work of occupational therapists, social workers and CPNs, for example, is seen as necessary and essential, but secondary to the central work of the medical treatment of illness. The majority of problems are conceptualised by staff and patients alike as somatic problems or as problems derived from deficits within the individual. Thus, while the work of hospital nurses may be focused on patient behaviour as the prime object of observation, discussion and analysis, this is taken as an indicator of the 'real' psychiatric problems residing within the patient's body.

In comparison, professionals working in the community adopt a much wider concept of treatment which includes aspects of the person's life that would be considered peripheral to treatment in the hospital setting. This is associated with a generally broader view of the mentally ill person, and his or her needs and capacities. Such things as personal relationships, the interpersonal milieu of their living environment, mundane material conditions, and the role of purposeful, structured activities are considered by these professionals as central to their work of monitoring and reacting to mental health problems. While notions of disease and the use of medical treatments still feature, community based professionals' conceptualisations of psychiatric disorder give particular weight to the role of the family and social relationships in both the aetiology and the

[13] The findings of these historical investigations are discussed elsewhere (see Chapter 1, section 3.1 of this chapter, and Appendix 2).

treatment of mental distress. Thus, for CPNs for example, it is the home visit rather than the hospital bed which is the cornerstone of mental health work. Compared to their hospital based colleagues, the wider gaze of community based mental health professionals is directed towards social relations rather than simple biological characteristics of isolated individuals. Prior conceptualises this as 'the professionalization of the mundane' in which any aspect of daily life can be considered under the remit of mental health work, worthy of interpretation and open to manipulation in ways considered to be of 'therapeutic value'.

Prior notes how in the hospital setting, contact between professionals and clients occurs for the most part within tightly defined and formally structured settings, limited by time, space and purpose. The day-to-day life of the hospital consist of two parallel but distinct social worlds - the world of the staff and the world of the patients - differentiated by physical and symbolic boundaries and structures. This symbolic order of difference is also detected in community services, and is marked out through language, demeanour, dress, and the various physical locations (offices, store rooms, dispensaries and staff meeting rooms) to which staff but not patients have access. Thus, although patients may have moved from long-stay hospital wards to community based accommodation, their daily lives change very little with this shift. Prior notes how group homes in particular manage to retain many features of institutional life. The rules and structures governing the daily routines of patients' lives remain essentially the same, and for this patient population, community care is more a case of institutional substitution than of deinstitutionalisation.

Such use of physical space and the structure of daily routines to mark out a symbolic difference between staff and patients has been noted in other social psychological studies of the care of the mentally ill in both hospital and community settings (for example, Goffman 1961, Jodelet 1991a). It also accords with the author's own observations of numerous mental health services in both Britain and France, and highlights a pervasive tendency to construct a psycho-social difference between the mentally ill and those who care for them. Thus, although professionals' relationships and interactions with the mentally ill differ substantially from those of lay people, the enacting of collective routines and structuring of daily activities serve to enforce similar representations of the mentally ill as different and 'other'. However, while lay people may simply represent

mental illness as a strange and incomprehensible 'other', mental health professionals engage in a continual process of sense-making and attempts to understand mental illness. Prior notes how much day-to-day staff interaction centres around a constant interpretation and analysis of various aspects of patients' behaviour and cognitive and emotional responses to their social world. There is continual work amongst mental health practitioners of collectively constructing, comparing and renegotiating hypotheses about patients. In terms of the theory of social representations, this can be conceptualised as the work of anchoring or making sense of mental illness, which for professionals is not achieved effortlessly, but is never quite done, and must be continually worked at and revised[14].

This theme of enduring uncertainty regarding the nature of mental illness is drawn out from an organisational perspective by Kirk & Kutchins (1992), who describe mental health organisations as characterised by unusually high levels of 'internal uncertainty'. This refers to the consequences for practitioners of the contested and multiple nature of 'expert' knowledge about mental ill health, which is unable to provide widely shared and definitive guidelines for how to effectively help people presenting with mental health problems. While this uncertainty allows practitioners considerable latitude and space for creativity, these authors conceptualise much of the daily work in mental health organisations as attempts to manage ambiguity and uncertainty, and to reconcile this with the public image of professionals as practitioners who use specialised (scientific) knowledge to solve particular problems. Managers, for example, strive to create the impression that the organisation is pursuing carefully coordinated goals. Similarly, the use of diagnosis provides an illusion of 'technical rationality' which connotes systematic problem solving and provides practitioners with a 'scientific' rationalization of their actions. Endemic uncertainty in the world of mental health leads to the following situation:-

> 'Trained professionals are hired because they are supposed to know what to do with clients and how to do it, usually behind closed doors. Even if they do not know how to resolve the problems that clients present, they will at least act in a predictable way, usually by making diagnoses and providing medication or the talking cure; the predictability of the therapist's responses reduces uncertainty. Furthermore, internal organisational structures and procedures are created to clarify who is responsible for what tasks so there will be a minimum of

[14] This supports Billig's (1993) conceptualisation of anchoring as an active argumentative social process (see Chapter 2, section 1).

confusion and conflict.' (Kirk & Kutchins, 1992, p 165-166)

Another interesting and very detailed analysis of psychiatric systems and the people who work in them is a study conducted in three Chicago psychiatric hospitals by Strauss and colleagues (Strauss et al 1964). Beyond the insightful and detailed findings of this study (which this brief review cannot adequately capture), and despite the fact that its findings are now rather dated, this study is of importance for its epistemological compatibilities with the present research. The authors' conceptualisation of 'psychiatric ideologies' as belief systems that have important links to and consequences for the development of professional identities, are constantly negotiated in daily practice and staff interactions, and which inter-related with the structure and organisation of hospitals shows significant parallels with the model of professional social representations proposed in the current research. The findings of this study suggest again that multiple understandings of mental ill health derived from various theoretical perspectives circulate and interact in the world of mental health professionals. Three broad psychiatric ideologies are identified. These compete in staff interactions, and each generates its own morality and guidelines for practice. 'Somatic' or organic understandings of mental ill health are endorsed most by psychiatrists although these views are least popular amongst other mental health professionals. 'Psychotherapeutic' ideologies are most favoured by nurses although this group is also the least ideologically committed. The third ideology, a 'sociotherapeutic' understanding is endorsed most by social workers and rejected most by psychiatrists.

Previous work using the theory of social representations to investigate understandings of mental illness amongst mental health practitioners has mainly been conducted in Italy as part of the large scale multi-method project already discussed in Chapter 2 (section 2.1). Commonalities between the representations expressed by lay people (adults, children of various ages and students) and mental health professionals are reported by De Rosa (1991) in a study using word association tasks. Despite significant differences between the groups, common themes structuring the core representations of all respondents emerge from correspondence analysis of word associations to five stimuli - yourself, a normal person, a mad person, a mentally ill person, and a physically ill person. This reveals two dimensions of abnormality - normality and physical illness - mental illness. In all cases mental illness is associated with deviance and abnormality and contrasted to physical problems and to the self. This suggests a widely shared basic representation of

mental illness as a specific type of non-medical 'other', and supports the working model for the current research of lay representational themes as part of professional social representations (see figure 3.3).

Beyond these common core representational themes, several characteristics differentiate lay and professional representations of mental distress. Zani (1987, 1993) reports that compared to student populations, mental health professionals place more emphasis on the diversity of mental health problems as phenomena involving a range of symptoms manifested both in acute crises and on a long term basis. Professionals place more weight than students on social and environmental causes, and have more complex notions of treatment in which the principle aims are symptom reduction and increased adaptation to the social world. They emphasise the benefits of a range of treatment strategies, citing the use of psychotherapy, drugs, changes in social circumstances and hospitalization. Compared to students they show a stronger conviction that treatment can be achieved in a community setting. Differences between professional groups are also detected by the Italian study. For example, Serino (1987) reports some differences which parallel those reported in Rabkin's (1972) review of attitude research (see above): Psychologists and psychiatrists describe mentally ill and mad people in terms that imply less differentiation from self in comparison to the descriptions given by lay people. However, the representations produced by psychiatric nurses show more similarities to those of lay people, with difference and differentiation between self and the mentally ill remaining central to the representational structure. Zani (1987, 1993) notes that the biggest differences appear between clinical psychologists and 'medically based' professionals (psychiatrists and psychiatric nurses). While the language of psychiatrists and psychiatric nurses draws heavily on traditional nosographic terminology (terms such as agitated, delirious, psychotic), clinical psychologists make less use of traditional terms, and represent 'self' and 'normality' differently from nurses and psychiatrists. These professional differences can also be detected amongst students of psychology, medicine and nursing. Again, this offers support to the current model which incorporates the professional cultures and identities into which practitioners are socialised during their training as part of professional social representations.

Finally, Thommen et al (1992) use analysis of theoretical literature, professionals' comments on video playbacks of therapeutic sessions, and individual interviews to

investigate the social representations of therapists practising Rogerian and cognitive-behavioural therapy. Differences between the groups in perceptions of the client and the therapeutic situation, behaviour in therapy sessions, and the formation of the client-therapist relationships reflect the two theoretical positions. For example, cognitive-behavioural therapists focus on clients' goals and intentions, orient therapy sessions according to logical success-oriented action plans, and develop goal centred, teacher-pupil type relationships with clients. In comparison, Rogerian therapists focus more on clients' needs and expectations, and develop more empathic, companion-like relationships in therapy. This research suggests a close linkage between theoretical beliefs and practice, and a central role for theory in shaping practice. This will be one of the topics of empirical investigation in the current research (see Chapter 6).

3.3 Professional Social Representations of Mental Illness: An Initial Conceptualisation

Drawing together the findings of previous research on mental health professionals' understandings of mental illness, and the theoretical conceptualisation of professional social representations presented earlier in the chapter, some initial comments on professional representations of mental illness can be developed. Although much of the work reviewed in section 3.2 fails to provide an in-depth analysis of how contemporary professionals' social psychological understandings of mental ill health are built up through social practices, communication and interaction (research by Prior (1993) and Strauss et al (1964) being important exceptions), nevertheless some pointers to the nature and content of these professional representations are indicated.

A common theme which emerges is the **diversity and multiplicity** of knowledge spheres which are available to mental health professionals. 'Expert' understandings provide various ways of conceptualising mental illness as, for example, an organic illness, a learned problem of behaviour or cognition, or a product of emotional experiences in childhood. These bodies of knowledge appear to be integrated in various ways. In some cases research suggests that medical understandings reign, possibly to the exclusion of other types of understandings. This has been detected mainly in hospital settings (eg Goffman 1961, Prior 1993) and amongst medically trained psychiatrists (eg Strauss et al

1964). More frequent however, seems to be the development of practice-based belief systems in which there is coexistence and integration of several spheres of knowledge (eg Prior 1993, Strauss et al 1964, Zani 1987, 1993).

However, what is also clear is that the availability of these expert discourses does not render professionals' understandings of mental illness entirely different from those of lay people. Several studies indicate similarities between the beliefs and practices of professionals and those of lay people when confronted with mental distress. Signs of **rejection and the maintenance of psycho-social distance** from the mentally ill can be detected on a collective level in the daily rituals of institutional life (eg Goffman 1961, Prior 1993, Rosenhan 1973) and in the linguistic responses of individual practitioners (eg De Rosa 1991, Schroder & Ehrlich 1968, Serino 1987). Ritualised working practices, in which interactions with mentally ill patients are limited in time and space and rigidly defined according to professional-patient roles, serve to maintain and erect boundaries and to establish symbolic differences between practitioners and patients (or between self / in-group and the mentally ill 'other' / out-group). There is much in these studies to remind us that mental health professionals work within a socio-cultural context in which mental illness is feared and represented as 'other', and that these understandings permeate and live on through the representations circulating amongst mental health professionals. (This suggests at least initial support for the inclusion of lay knowledge within a model of professional social representations (see Figure 3.3).)

Within this social context, mental health professionals are in a unique position compared to other professional groups, in that they work with a phenomenon which generally evokes profound fear and mistrust. As the discussion in Chapter 2 illustrates, a common reaction to mental illness both individually and collectively is the creation and maintenance of psycho-social distance. But in choosing to work in close physical contact with the mentally ill, mental health professionals draw our attention to the complex meanings associated with mental illness and our reactions to it. Rather than simply being unanimously feared, mental illness can provoke ambivalent reactions from threat and fear to fascination, pity and intrigue. Motivations for becoming a mental health professional are multiple, but may revolve around a desire to understand this unfamiliar and un-understood aspect of human experience.

Debate, ambiguity and uncertainty are also themes which this material suggests may be central to professionals representations of mental illness. Theoretical understandings of mental ill health are provisional and partial, and studies suggest that mental health professionals spend much of their working lives engaging in continual attempts to manage uncertainty and negotiate ways of making sense of mental illness and the mentally ill people with whom they work (eg Kirk & Kutchins 1992, Prior 1993). Once we reject the simplistic and deterministic position of the anti-psychiatrists who see mental health practitioners as merely enacting repressive institutional regimes, it becomes possible to conceptualise how the multiple perspectives available to professionals make for complexity, diversity and potential lack of agreement regarding how the mentally ill should be treated and cared for. From this perspective, professionals' established daily routines could be seen as ways of striving for a sense of clarity and strategy in the face of considerable representational uncertainty. Despite their expert status, and their daily contact with the mentally ill, professionals' understandings of mental illness retain much of the uncertainty and sense of 'unknowingness' which characterises lay representations of mental illness. We should not expect to find a single, well-defined understanding of mental illness amongst mental health professionals.

This brief attempt to postulate some features of professional social representations of mental illness suggests there is much to explore in how mental health professionals understand mental illness. It opens up a realm of unanswered questions and unsubstantiated suggestions from which the empirical work in this thesis takes its starting point. Questions such as how the various theoretical perspectives are drawn upon by professionals in their understandings of mental ill health, its nature and its causes; what practical strategies of treatment and care various professionals in different context use; what the relationship between theoretical spheres of knowledge and professional practice is; how professionals conceptualise their work and roles; and how current policy changes and moves towards community based care are evaluated and experienced by professionals. The empirical analyses in Chapter 5, 6 and 7 offer answers to these and other questions.

CHAPTER FOUR

METHODOLOGY

This chapter has two aims. Firstly, it provides a description of the research methodology used in this research, sketching a path through the stages from initial decisions about data collection, to data analysis, and presentation of findings. It is my conviction that clear, transparent accounts of methodology are essential, in that they allow the reader to evaluate research findings with full knowledge of the procedures from which they are derived. The second aim is to discuss a number of issues related to methodology. In particular, this chapter considers the following issues:- relationships between the theory of social representations and empirical methods (section 1); the use and status of interview data (section 2.1); strategies of qualitative content analysis (section 3.1), with particular reference to the use of specialised computer packages (sections 3.2 and 3.3); and evaluation and establishment of the credibility of qualitative research (section 4).

The chapter begins with a consideration of the methodological and epistemological implications of using the theory of social representations. As Bourdieu et al (1991) remind us, theory and method are inseparable, and as social scientists we need to be clear about the epistemological implications of the techniques and methods of social research we use. Theories provide specifications or epistemological guidelines for empirical work. Similarly, the role of empirical research is not simply to collect data in a given substantive area, but also to advance and inform our understanding of a theoretical perspective.

1 Methodology and the Theory of Social Representations

In his discussion of theory and method in social representations theory, Farr (1993a, p22) notes that '(i)t is a singular feature of the theory that it does not privilege any particular method of research.' Moscovici declines to specify what methodological approaches are suitable for the study of social representations, advocating instead that such a new theory should rely on the creativity of researchers using a variety of methods. He is, however,

concerned to break away from experimental methods and their associations with the positivist epistemology of mainstream psychology. Instead he recommends techniques such as observation which focus on description rather than explanation, allowing researchers to capture the complexities and socially situated nature of social representations, thereby serving to strengthen links between social psychology and other social sciences (Moscovici, 1984, 1988).

A review of previous empirical work using the theory of social representations certainly demonstrates methodological diversity. In an attempt to capture the complex inter-relationships between the individual and the social, between process and content, and between word and deed, a combination of methods are often used. Such methodological triangulation is an important source of validity for qualitative research methods (see section 4). To give just a few examples: Jodelet (1991) used depth interviews, observations and questionnaires in her study of madness; Moscovici's (1976) study of psychoanalysis used questionnaires and analysis of the press; De Rosa (1987) used thematic analysis of drawings, questionnaires and paper and pencil tasks to investigate representations of mental illness; Zani (1993), in another study of mental illness, used free association tasks and semi-structured questionnaires. A range of other methods including ethnographic observations (Duveen & Lloyd, 1993), analysis of literature, films and architecture (Chombart de Lauwe, 1984), and experimental methods (Abric, 1984) have also been used to study social representations.

However, such methodological diversity should not lead to the conclusion that 'anything goes' in social representations research. If the interface between theory and method is taken seriously, there are some important epistemological assumptions of the theory which must be considered in relation to methods of data collection and analysis.

Firstly, echoing Moscovici, the theory is concerned with socially situated phenomena, and therefore requires methods which sample social life *in situ.*[1] Secondly, the integration of the individual and the social assumed in the theory of social representations has several important implications. Methods which sample not only the thoughts, words and deeds

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1 Having said this, it should be noted that there is also a growing strand of social representations research, based primarily in Aix-en-Provence, which makes extensive use of laboratory based and experimental methods.

of individuals, but also social institutions, culture and historical factors must be adopted. These social factors should be taken seriously as a central part of the research, not simply as background or contextual information. Thus individual-based methods should be seen as sampling social actors who cannot be separated from the social world in which they live. Individual-based methods are just one of many possible ways of tapping into social representations which can be found in the heads of individuals, in communication between individuals, and in social practices and institutions.

Thirdly, the social constructionist perspective of social representations theory implies that both process and content are equally as important aspects to be studied. While certain processes (namely anchoring and objectification) may be detectable across representations, methods must be sensitive to the unique content of representations emerging within specific social circumstances. Methods such as depth interviews, observations and focus groups, if used with care and sensitivity, are tools for in-depth analysis which can uncover the subtle, complex and implicit aspects of social representations (as shown for example in the use of interviews and observations by Jodelet, 1991). To this end, methods which produce qualitative data may be preferable. However, there is no reason why qualitative techniques must be used exclusively. Quantitative data can also provide fruitful insights into social representations, and a range of powerful multi-variate techniques can be used to chart complex structures and relationships within representations (see Doise et al, 1993).

Section 3.1 considers how the epistemological assumptions of social representations theory also shape the strategies of data analysis which are adopted in the current analysis. Before that, section 2 describes the methods of data collection used in the present research.

2 DATA COLLECTION

2.1 Primary Data Source: Semi-structured Interviews

Theoretical Perspectives on Interviews

The choice of semi-structured interviews as the primary methodological tool in this study is motivated by both practical and theoretical considerations. On a practical level, interviews with individuals are relatively easy to arrange. Given that the research focuses on professionals, whose working schedules are very tight, it would be extremely difficult to organise group discussions. While observational data has been used as a secondary technique (see section 2.2), observations of specific treatment encounters in mental health services are limited by strict codes of confidentiality and access.

In-depth interviewing is a technique which has been used previously in many studies of social representations (eg Jodelet, 1991; Herzlich 1973; Giami 1987). Farr (1982) conceptualises the interview as 'a peculiar form of conversation in which the ritual turn-taking is more formalised than in the commoner, more informal encounters of everyday life' (p182). He draws attention to the social and interactional nature of interviews, thus highlighting their appropriateness for studies of social representations in which the socially constructed and contextually embedded nature of beliefs and knowledge is recognised. Interviews should be understood as social events in which the interviewer is a participant observer. The data they provide should be interpreted against the background of this context.

The language-based nature of interviews offers direct access into the meanings, understandings and belief systems of social actors, while their 'open' nature allows these to be explored in depth. Conceptualising social representations as 'integral units of beliefs and action' (Wagner, 1994, p243), interviews can be seen as one route of access into these integrated systems, with equivalent status to observations of action. Wagner suggests we should consider behaviour (investigated using observational techniques) and beliefs (investigated primarily through language-based methods such as interviews and focus groups) as expressions of the same underlying construct or representation. '(E)ither

one could be used to describe the representation's content and structure: each has its merits and shortcomings as a data source.... Which one we finally use depends upon our familiarity with different methods.' (Wagner, 1994, p253). The interview schedule used in this research aims to recognise this integration within social representations by asking respondents to give accounts both of their beliefs and of their behaviour in day-to-day work.

Given this choice of method, one should also recognise the possible short-comings of using interviews as the primary data source. De Rosa (1988) notes that data collected through interviews may be shaped by self presentation and rationalisation, and cannot give access to symbolic or non-linguistic aspects of social representations. Farr (1977) also cautions against taking interviewee's accounts at face value: 'Attributional artifacts' on the part of both the interviewer and the interviewee may bias results, especially when investigating issues to which value judgements are attached. From a positivist perspective, it would also be possible to question the reliability and validity of data obtained through semi-structured interviews. Biases such as evaluation apprehension (Rosenberg, 1969) and demand characteristics (Orne, 1962) could be seen to apply equally well to interviews as to experimental settings in which they were originally developed. However, given the constructivist stance on which this research is based, such criticisms hold less weight. From this perspective, interviews can be seen as social situations in which participants construct accounts as expressions of their current social representations. While there will always be shortcoming associated with any method, it is hoped that awareness of these issues, together with the methodological and analytic strategies employed (triangulation of data collection, a reflexive stance, and transparency of analysis) will guard against possible biases.

Practical Issues: Conducting interviews

Location of interviews

Detailed descriptions of the services from which interview respondents were drawn are provided in Appendix 1. Interviews were conducted with professionals working in public mental health services in urban and suburban areas of London and Paris. The areas

chosen in each city are broadly similar in socio-economic terms and can be characterised as covering poorer suburban areas and more mixed central and urban areas. They are all areas associated with many social problems and high levels of deprivation.

In France interviews were conducted in three 'secteurs':- the first arrondissement of Paris, and secteurs 4 and 15 of Seine-St-Denis, the département covering the north east suburbs of the Paris area. In Britain, interviews were conducted in two district health authorities:- West Lambeth, and Lewisham and North Southwark. Given the considerable diversity in provision and style of mental health services across secteurs, it was felt necessary to use respondents from three 'secteurs' in Paris. In comparison, use of two district health authorities appeared to adequately represent mental health services typically found in the London area. Interviews were conducted in France in 1992 and in Britain in 1993.

Access to respondents

Access to respondents was obtained in France through psychiatrists connected to the École des Hautes Études en Sciences Sociales, and in Britain through connections with the London School of Economics. In both countries establishing initial contact was difficult and involved many telephone calls. However once the relevant consultant psychiatrists and 'chefs de secteurs' had agreed to participation of their services in the project, access to interview respondents was relatively unproblematic[2]. In each of the services I presented myself as a researcher studying for a doctorate in social psychology, conducting a study into the views of British and French mental health professionals regarding mental illness, its treatment and care.

Sampling

Sampling can be described as 'purposive' and based on 'natural' rather than statistical groups, defined in terms of broad affinities shared by group members (Gaskell, 1994). The various professional groups of psychiatrists, social workers, psychiatric nurses and

2 The role of psychiatrists as gate-keepers and heads of service indicates the dominance of psychiatry and medicine in contemporary mental health services.

so on can be defined as 'natural groups' in that they share certain professional values and ideologies while also forming part of the larger 'natural group' of mental health professionals. The aim in constructing the interview sample is thus not to replicate the actual numbers of different professionals in mental health services (where, for example, there may be only one psychologist and up to forty nurses), but to obtain samples which reflect the full range of professional positionings in British and French mental health services. The diversity of professional positions (at least eight distinct professional groups can be identified), and the range of different types of mental health services in each area (hospital wards, community day centres, day hospitals and so on) dictates that samples are relatively large (n=30 in each country). Identification of potential interview respondents relied on snowballing of connections in each of the services I visited. The majority of people approached were willing, open and interested research participants, and only a very small number of people declined to be interviewed. 'Non response bias' was therefore minimal. Table 4.1 shows the distribution of interview respondents' professional backgrounds and work locations[3]. A full list of each of the sixty interview respondents and their specific roles is provided in Appendix 4.

Design of the interview topic guide

Interviews were semi-structured: While they were guided by a set of broad questions, they were also allowed to develop according to the unique dynamics of each interview situation, such that respondents' comments initiated specific probes and follow-up questions. The interview topic guide consisted of a pool of questions which allowed access to respondents' social representations of mental illness through accounts of their daily work in caring for and treating the mentally ill. It was designed to be appropriate to the full range of professionals interviewed in both countries, and was constructed following several practice interviews (in France), which indicated that questions should be centred explicitly on the daily practical work of respondents. (The use of more general questions in pilot interviews often generated 'text-book' responses - descriptions

3 It can be noted from this table that some differences in the types of professionals involved in mental health services exist between France and Britain. Specifically, occupational therapists and case managers are included in the British sample, but do not form part of mental health teams in France. (See Appendix 2 for descriptions of the various mental health professions.)

of theoretical perspectives, policies and the like - which contained little of respondents' own views.)

Table 4.1: Breakdown of interview respondents according to profession and place of work

Professional Status	France	Britain
Psychiatrists		
Hospital	2	1
Community	2	1
Both	2	3
Clinical Psychologists		
Hospital	-	-
Community	3	3
Both	1	-
Psychiatric Nurses		
Hospital	3	2
Community	6	3
Both	-	-
Charge Nurses		
Hospital	1	1
Community	2	2
Both	-	-
Social Workers	5	3
Occupational Therapists		
Hospital	-	-
Community	-	1
Both	-	2
Community psychiatric nurses	-	2
Case Managers	-	2
Others	3[4]	4[5]
Totals	30	30

4 Movement therapist (hospital and community); receptionist (day hospital); nurse's union official, former psychiatric nurse.

5 Movement therapist (community); art therapist (hospital and community); psychotherapist, not psychiatry trained (hospital); program worker (community).

The pool of questions which provided the final topic guide for interviews is presented in Appendix 5. Questions are grouped into four broad areas:- daily practice; mental illness; the service in which respondents work; and community care. In the majority of cases this ordering of questions was followed. Initial accounts of their day-to-day work with patients served to put respondents at ease before they contemplated the harder, more abstract questions relating to mental illness. The final group of questions on community care was used with British respondents only. This revision mid-way through the research was made as it was realised that, at the time when the interviews were conducted (May - December 1993), community care constituted a major challenge to British mental health professionals, and to their social representations of mental illness. However, while French respondents were not asked explicitly about the impact of community care policies, their answers to questions regarding the services in which they worked often included references to recent moves towards care in the community. (This relates to issues associated with interviewing as a foreigner, discussed in the following section.)

Throughout the interviews the terms 'mental illness', 'the mentally ill' and 'patients' or 'clients' were used, as these are the terms most commonly used by mental health professionals. In the aim of focusing more on personal opinions than formal theorising, a 'naive' style of interviewing was adopted. This involved using lay rather than technical terms, and encouraging respondents to describe their personal opinions, their work and its aims in simple lay terms as if they were describing these to someone who knew nothing about care of the mentally ill. Probes and follow up questions encouraged respondents to reflect on the fundamental bases of their work and their taken-for-granted assumptions.

Conducting the interviews

All interviews were conducted at respondents' place of work, usually in a quiet location with no interruptions (although this was not always possible). Confidentiality was assured, and respondents were offered a copy of the interview transcript. Interviews were taped with the permission of respondents, using a small audio-cassette recorder and generally lasted between 45 minutes and an hour. The majority of respondents appeared to be relatively at ease in the interview setting. Although many clearly found some of the questions challenging, several respondents commented after the interview that they

seldom had the chance to reflect on the bases of their everyday work, and found the opportunity to do so useful.

A major issue in conducting the interviews in France was the fact of interviewing in a foreign language. While my French language skills were obviously sufficient to allow this to be possible, it still presented some difficulties, both in conducting the interviews and in the transcribing process. However, the position of foreigner also has some advantages. Specifically, it is much easier to take a naive stance in asking respondents to clarify how they are using terms or phrases. Responses can often prove extremely revealing, in that they force consideration of the 'taken-for-granted' assumptions behind terms used in everyday talk. A second issue which resulted from my position as a foreigner in France, is that respondents often contextualised their comments within detailed descriptions of the French mental health system and political issues in France. This provided valuable insights into respondents' evaluations and experiences of current community care policies.

Conducting essentially the same interviews in two different countries also revealed the impact of some interesting cultural differences. As a British person interviewing in France, I was struck by the relative ease with which French respondents discussed abstract, theoretical and philosophical issues compared to British respondents. While it is not in the remit of this thesis to go into the cultural factors which lead to this, it can be noted that French respondents generally seemed more at ease with expressing and verbally contemplating their opinions and beliefs than did British respondents.

Finally, the fact that these interviews were conducted with respondents 'as professionals' should be considered. One of my major concerns was to avoid obtaining accounts which simply mirrored the professional ideologies into which respondents were socialised in their training and professional development. I aimed to avoid this by stressing that I was interested primarily in each individual's own opinions and beliefs.

2.2 Secondary Data Sources

As a supplement to individual interviews, several secondary data sources are used. The purpose of these is to provide a view of the world of mental health professionals which differs from that provided by interview data and which can inform analysis and understanding of the primary data source. Social representations theory stresses the interplay between the individual and the social, seeing historical, cultural, and socio-political data are vital supplements to individual-based methods. Combining methods which use various levels of analysis has been a common strategy among social representations researchers (see section 1), and is advocated by Sotirakopoulu & Breakwell (1992) as a way of doing justice to the complexities inherent in the phenomena of social representations. The strategy of drawing on more than one data source has much to recommend it. Many authors (eg Flick 1992, Denzin 1978) have advocated the use of 'methodological triangulation' to enhance the credibility of qualitative research. Essentially this means combining a variety of methodological approaches to study the same phenomenon. Triangulation aims to overcome the inherent weaknesses associated with any one method and to provide a richer picture of the phenomenon under study. From a constructionist perspective, the strategy serves to add breadth and depth to interpretation and analysis, rather than enhancing the 'objective truth' of findings. Three sources of secondary data are used in this project:-

i) Documentary sources

A review of academic texts allows situation of the current research within specific historical and political contexts. Consideration of the historical bases of current day mental health services is vital if one is to fully comprehend the social meaning of current moves towards community care for the mentally ill. Government publications, official statistics, commentaries written by practitioners and social researchers, and literature produced by local health services for purchasers and users of services provide information on recent policy changes and implementations of community care both locally and nationally[6]. These various documentary sources offer access into an important

6 The historical and contemporary review in Chapter 1 is informed by many of these documentary sources.

component of professional social representations, namely the changing official roles, aims and ideologies of mental health services and the people who work in them.

ii) Observations

During the period of data collection there were many opportunities to casually observe the day-to-day workings of the services in which respondents were interviewed (although issues of confidentiality prevented direct observation of consultation or therapy sessions). This allowed familiarisation with the social world with which I was interacting, and was particularly important in France where I had no previous knowledge of mental health services. It allowed me to grasp the daily realities of mental health care and the work of my respondents, providing an important point of comparison with their accounts of their work which emerged in the context of interviews. This process of familiarisation and casual observation was greatly facilitated by the willingness of interview respondents and other team members to integrate me and allow access to many aspects of service functioning. For example, I attended several weekly team meetings in which care strategies for new and existing clients were discussed, I was shown around hospital wards and day centres, and visited occupational, art and music therapy sessions. At one day centre in France, I 'shadowed' a team member for a day, participating in group activities (food preparation and a picnic in a nearby park) and attending the daily staff meeting.

iii) Interviews with key informants

Prior to the main data collection period in each country, I conducted several interviews with 'key informants'. These people were chosen for their ability to provide a broad overview of mental health services and current issues within the world of mental health. In France I interviewed an academic psychiatrist, considered to be an expert on mental health service research, and a practising psychiatrist who was also involved in evaluative research. In Britain I interviewed an academic psychiatrist (again an expert in mental health service research), a district service manager, and a hospital manager. These interviews were important for several reasons. They offered a global perspective on mental health services in each country and provided personal contacts and guidance in selecting 'typical' services for data collection. Most importantly, they offered a perspective on the interface between official policies and daily realities in mental health care. This allowed me to anticipate many of the issues with which professionals were currently concerned prior to conducting interviews.

To summarise the approaches to data collection used in this research project, I return to the concept of triangulation. Banister et al (1994) identify five different types of triangulation: 'data triangulation' (collecting data from a range of actors and a range of contexts), 'investigator triangulation' (clearly not feasible in a PhD), 'triangulation of methods', 'triangulation of theoretical perspectives', and 'triangulations of levels of analysis' (using a combination of individual based, group based and societal based approaches (see Doise 1986)). The current research uses triangulation of data, methods and levels of analysis. These are summarised in Table 4.2.

Table 4.2: Strategies of Triangulation

Type of Triangulation	**Application**
Data triangulation	Interviews conducted - in two different countries - with a range of mental health professionals - in a range of geographical locations (2 district health authorities in Britain, 3 'secteurs' in France) - in a range of services (hospital and community based services)
Triangulation of methods	Primary data source: Interviews Secondary data sources: Documentary sources Observations Interviews with key informants
Triangulation of levels of analysis	Data collection and analysis integrates the following levels: - intra-psychic / individual - inter-individual - group - organisational / institutional - social / cultural

3 Data Analysis

The following sections provide a deliberately detailed account of the data analytic procedures used in this research study. I consider it vital that the reader should be given as clear an account as possible of how the link between data and findings has been constructed by the researcher. This issue of 'transparency' will be discussed in more detail in section 4, which argues that this is an important strategy in aiding evaluation of the credibility of qualitative research.

3.1 The Data Analytic Strategy

The approach to data analysis which is adopted meshes with the epistemological assumptions of the theory of social representations. Thus, it aims to investigate both content and structure, and to generate findings which are both specific and general. Analysis provides an in-depth description of the content of professional social representations of mental illness, and of the internal structure of these representations (ie inter-relationships and organisation of themes and domains within these representations), and is conducted with continual reference to the generic characteristics of social representations.

The analytic work of this study focuses on the primary data source - interviews with mental health professionals - and uses the secondary data sources (documentary sources, observations and interviews with key informants) to inform this analysis and interpretation. In order to achieve the type of in-depth analysis with which social representations studies are associated (and which I believe is one of their prime strengths), I adopt a strategy of analysing interview data which combines what are sometimes referred to as 'manifest' and 'latent' approaches to content analysis. Thus, a balance is struck between taking respondents' accounts at face value, and looking 'beneath' these to investigate implicit or unspoken themes. Numerous examples in the literature attest to the value of this approach. For example in Jodelet's (1991) study of madness, the most central themes of exclusion and difference in villagers' representations were hidden implicitly in talk and daily practice, but were not obvious in the manifest content of interviews. The potential impact of demand characteristics and social

desirability in the interview situation leads me to adopt an approach to analysis which is sensitive to underlying themes which may be unspoken, taken-for-granted, or taboo. I would also argue that the considerable social taboos and unease surrounding mental illness which have been demonstrated in numerous research studies (see Chapter 2), suggest that an approach which goes further than manifest content is required for this particular subject area.

I adopt an explicitly constructivist approach to data analysis. This recognises that there is not one 'objective truth' waiting to be discovered in the data, but many different 'stories' which could emerge from interpretations of such a rich and complex data corpus. The story that this analysis constructs does not aim to be an exhaustive 'map' of the data. Rather it is a perspective on the data founded on the theory of social representations. No doubt other readings of the data based on other theoretical perspectives would be possible.

However, having adopted a constructivist position, I am also concerned to avoid relativism. I do not believe that all possible accounts which could be produced from this data set have the same status. Issues surrounding the evaluation of qualitative research are discussed in section 4. In the meantime, suffice it to say that I aim to produce an account which has credibility, based on theoretical grounding and methodological procedures, and the interactions between the two. Therefore, my approach to data analysis combines a theory-driven (deductive, 'top down') approach, with a data-driven (inductive, 'bottom up') approach. My view of the data is from the perspective of social representations theory and the previous research findings in this area. However, I also adopt an approach which 'lets the data speak', and which allows the data to inform (ie both support and challenge) our understanding of its substantive area, and the theory of social representations itself. In concrete terms, this approach requires a system of analysis which is flexible enough to capture the variations and richness of the data, while at the same time allowing the researcher to synthesize, integrate and ultimately make sense of its complexities through linkages with prior theoretical concepts. This process is greatly aided and enhanced by the use of specialised computer software (discussed in the following sections).

The reader will find parallels in the procedures described in section 3.3 with the Grounded Theory model of inductive qualitative data analysis proposed by Glaser & Strauss (1967). In particular, parallels can be seen in the development of a flexible and open-ended indexing system which can tolerate ambiguity and uncertainty, thus avoiding premature closure and encouraging both creativity and a close relationship with the data; in the use of memos during coding and data exploration to record emerging characteristics of categories; and in the gradual linking of categories, often in hierarchical relations involving various levels of abstraction. The advantages of this analytic strategy are summarised by Henwood & Pidgeon (1995, p117): '(T)he value of the methodological strategies of the grounded theory approach is that they help to keep researchers on an analytic path, while committing them to be extremely wary of simply reproducing their pre-existing perceptions, ideas and concepts unchanged.' However, the current approach is only partially inductive, and I concur with Bulmer (1979), Bryman (1988) and Bryman & Burgess (1994), that the notion of theory-neutral data analysis in which the researcher suspends all prior theoretical knowledge and preconceptions, is open to some doubt. It implies, rather naively, that theory and method can be separated, a position I have argued against earlier in this chapter[7]. Furthermore, it is not the aim of the present research to be entirely inductive, as it departs explicitly from the theory of social representations.

The analytic strategy integrates qualitative and quantitative approaches. While qualitative analysis of the content and themes of interview respondents' accounts is the principle strategy, it is also possible, given the large number of interviews conducted (thirty in each country), to supplement this with quantitative analyses. Descriptive statistics and comparisons of frequencies can be extremely informative indicators of the dominance, relative occurrence and co-occurrence of themes and patterns within the data. They offer a means of surveying the whole corpus of data which supplements the depth and detail of qualitative investigations. However quantitative analyses should be interpreted with a degree of caution. There are two reasons for this:

7 With respect to this argument, it is worth noting that recent revisions of Grounded Theory accept that the researcher must have a perspective from which to begin their analysis (see Henwood & Pidgeon, 1995).

Firstly, the theory of social representations does not equate the frequency of expression of a theme with its importance or relative influence. Indeed often what is absent from social representations is just as interesting as what is present. A theme may be absent from a discourse for many reasons - it may be taken-for-granted, associated with taboos or sensitivities, or considered to be irrelevant. For example, Moscovici (1976), in his study of representations of psychoanalysis in 1950s France, found a striking absence of the concept of libido. He proposed that libido had been filtered out of lay representations as an unacceptable aspect of psychoanalytic thought within the context of Catholicism and strong social taboos against the open discussion of sexuality. Analysis of data should therefore consider both what is present and what is absent. The second reason for treating quantitative analyses with some caution is technical and relates to how interviews are segmented into text units. The details of this procedure are described in section 3.3. Essentially, text units are not all of the same size (they vary from two to ten lines of text). This means that quantitative analyses can offer rough indications of relative frequencies, rather than precise measurements.

However, quantitative analysis can be useful for another reason. Not only can it provide backing for qualitative analyses, but it can also be used as a methodological tool, to check the credibility of analytic procedures. For example, in the initial stages of the current analysis, quantitative checks on the amount of data indexed into broad themes were made at intervals, allowing the researcher to establish that data codification was being conducted in a reliable and consistent way (see section 3.3).

3.2 Computer Support for Data Analysis: QSR-NUDIST

The data analysis for this research was conducted using the computer package 'QSR-NUDIST'. While computer technology clearly provides a way of organising and managing the large volume of data with which the current project is involved, the use of computer packages for qualitative research has other important implications. This section reviews these issues, offering responses to some contemporary debates based on the experience of using QSR-NUDIST in the current research. This is followed by a description of the principle features of QSR-NUDIST which illustrates how this package can support and facilitate the strategy of data analysis described above.

'CAQDAS[8]': A Revolution in Qualitative Analysis?

The rapid development of CAQDAS programmes in the last five years is an exciting and challenging development in qualitative research. For a field that has traditionally distanced itself (often on epistemological grounds (Kelle 1995)) from the technological revolution which has transformed quantitative research, the introduction of computer technology represents a radical new departure. Although many of the packages have been developed by members of the qualitative research community themselves, there is currently a 'healthy scepticism' towards these programmes, even amongst the developers themselves. For example, Seidel (1991) (developer of 'The Ethnograph'), warns of the 'analytic madness' that may derive from the misuse of computer technology.
It is indisputable that the use of computers opens up possibilities for the management and analysis of large volumes of data. While Fielding & Lee (1991) suggest that this frees researchers to put their mental energy into analytic rather than mechanical tasks, and Mangabeira (1995) notes that the speed of qualitative research can be enhanced, Seidel (1991) warns of the dangers of an infatuation with the volume of data. I would concur with the former of these view points. There are strong theoretical reasons why a sample of sixty interview respondents is required for the current research, and given the volume of data that this generates, the use of a computer package, not only in storing and organising data, but also in allowing selection of data for fine-grained analysis has proved indispensable.

A second area of debate centres around how the nature of qualitative analysis is affected by the use of computers. It is clear that CAQDAS programmes are more than just tools. They are innovations which change and shape the very process of qualitative research. Many authors argue that CAQDAS programmes can enhance the rigour and creativity of qualitative analysis, and can lead to new ways of interacting with data (eg Fielding & Lee 1991, Kelle 1995, Mangabeira 1995, Richards & Richards 1994a, 1994b, Weitzman & Miles 1995). The use of these packages may also have important political implications in enhancing the credibility of qualitative research within a social context dominated by the positivist approach of natural science. However, concern is also voiced that use of

8 'Computer-Aided Qualitative Data Analysis'. The use of this term in the literature on computer technology and qualitative analysis refers to packages such as 'The Ethnograph', 'Textbase Alpha', 'HyperRESEARCH', 'ATLAS-ti' and 'QSR-NUDIST'.

computers may distance researchers from their data (Seidel 1991), may encourage 'quick and dirty' qualitative research (Fielding & Lee 1991), and may implicitly encourage the styles of working favoured by their authors (Mangabeira 1995).

A third concern is the issue of segmentation of data. All CAQDAS programmes involve the segmentation of data into text units of various sizes. In so doing, there is a danger that the contextualised meaning, temporality and narrative structure of data are overlooked. Most packages attempt to overcome this problem, at least to some extent, by providing systems of linkages between text segments and their original context. (ATLAS-ti also offers direct linkages between text segments known as 'hyperlinks'). However, in my view, segmentation remains one of the most significant drawbacks in the use of CAQDAS programmes.

In response to these comments, I would to stress the flexibility of these packages, which allows each one to be used in potentially myriad ways. CAQDAS programmes are not fixed entities about which absolute judgements can be made. Viewed thus, these potential strengths and pitfalls becomes issues that researchers should be aware of. It is vital, particularly at this early stage in their development, that a reflexive stance on the effects of using of computer packages on processes of qualitative analysis is maintained. There is no guarantee that computer programmes will not be used for 'quick-and-dirty' research, but this lies more with the researcher than with the package itself. Similarly, the researcher could become distanced from the data, but this again depends on how the programme is used. While the epistemological preferences of their authors can be clearly detected (for example, QSR-NUDIST and The Ethnograph are based on a Grounded Theory approach, while ATLAS-ti derives from linguistic analyses), my personal experience has been that the power and complexity of these packages overrides their origins and does not tie the user to these strategies, but rather opens up infinite possibilities for analysis. Thus, for this research I have been able to construct a style of analysis using QSR-NUDIST which combines both inductive and deductive approaches to the data[9].

9 In a recent study of the use of CAQDAS programmes ('The effects of technology on research culture: the case of computer support for qualitative data analysis' conducted by The Centre for Research into Innovation Culture and Technology, Brunel University), the current research is presented as a case study of the 'reappropriation' of CAQDAS packages by new generation qualitative researchers who have developed ways of using these packages to suit their own needs.

Technological innovation is a double-edged sword. The power and potential of CAQDAS packages is considerable, but given their flexibility, the quality of the research conducted using them derives ultimately from the intelligence, sensitivity and analytic rigour of the researcher, rather than from the specific features of any particular package. Interpretative analysis is a semantic not an algorithmic process, and computers will never be able to take over the interpretive work which lies at the heart of qualitative analysis. However, their powerful ability to manage, manipulate and structure data material and the conceptualisations emerging from this interpretative work, can enhance the process of qualitative analysis. It seems likely that there is an exciting future ahead in the development of computer assisted qualitative data analysis which is currently in its infancy.

QSR-NUDIST[10]

Early CAQDAS programmes such as 'The Ethnograph' and 'Textbase-Alpha' are essentially 'code-and-retrieve' systems which facilitate the mechanical aspects of analysis, but offer little more. NUDIST is one of the new generation of qualitative data analysis packages sometimes referred to as 'code-based theory-builders' (Weitzman & Miles, 1995) which facilitate and encourage a more complex interaction between researcher and data through their ability to index and inter-relate data and concepts in multiple and flexible ways (ATLAS-ti and HyperRESEARCH also offer these facilities).

The NUDIST package provides facilities not only to code data, but also to manipulate conceptual and text-related codes (referred to in NUDIST as 'nodes') within a hierarchical indexing system in an extremely flexible way. This second facility - the main strength of NUDIST - allows qualitative data analysis to become an on-going process, rather than simply a two-stage process of allocating text segments to codes followed by explorations of the patternings this produces. The analysis process becomes a continuous cycle of data exploration, coding, and manipulation and development of the

10 The name 'NUDIST' stands for Non-numerical, Unstructured Data Indexing, Searching and Theorising. 'QSR' refers to the programme distributors Qualitative Solutions & Reserach Ltd. This review describes Version 3.0 of the programme.

indexing system informed by these investigations. The package provides facilities to explore data in three ways[11]:-

i) Using string or pattern searches, which search the text for specified words or phrases, and allocate the relevant sections of data to a node.
ii) By scanning through data documents and allocating text units to nodes.
iii) The results of investigations of data currently coded in the existing indexing system can be used to create new nodes.

The power of NUDIST lies in its flexible indexing system. A tree structure of hierarchically related nodes can be developed, in which each node is conceptualised as the 'parent', 'sibling' or 'child' of other nodes[12]. Thus the meaning of any one node derives not only from the working definition of this node used by the researcher, but also from its relationship to other nodes. Within this indexing tree, nodes can be considered either as textual level codes for data, or at a more conceptual level, as theoretical ideas, which do not necessarily reference text directly. Any text unit can be indexed at as many nodes as needed, allowing the researcher to take account of co-occurrences of themes.

The indexing system does not have to be well thought out at the beginning of the analysis process. Rather, the package is designed to encourage creative analysis by allowing the indexing system to develop as the researcher explores different aspects of the data. Thus the structure of the indexing system reflects the state of the analysis at a particular point in time. All major changes are date stamped allowing the researcher to chart the history of the project's development. There are no limits to the size or depth of the indexing tree, and it can be continually reorganised by moving, deleting or merging nodes at any point in the analysis. Memos can be attached to each node, allowing the researcher to record on-going thoughts about a node, its definition, or its relationship to other nodes.

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11 The current user-interface of NUDIST (version 3.0) is problematic in that although some direct coding of text is possible, the researcher tends to be 'taken away from' the original data documents, and works much of the time with segmented pieces of text.

12 Compared to ATLAS-ti, the possible relationships between nodes in this hierarchical structure are somewhat limited. However, other relationships between nodes (for example mutual exclusivity) may be implicit in the researchers own conceptualisation of the indexing structure. Thus, as I have argued above, reflexivity allows the researcher to overcome many of the potential limitations of these packages.

The indexing system can be thought of as a representation of the researcher's theoretical conceptualisations of the structure and content of the data.

A series of powerful index system searches based on Boolean operators (intersects, unions, overlaps etc) allow the researcher to test hypotheses and ask questions of the data. These searches can provide answers to questions about patternings of themes within the data set, and about co-occurrences and relationships between nodes. The ability to store the answers to these investigations as nodes within the indexing system (known as 'system closure') allows data analysis to become an on-going process in which questions addressed to the data are used to inform subsequent analysis and findings. A text editor is incorporated in the package allowing write up of findings to be conducted simultaneous with data exploration.

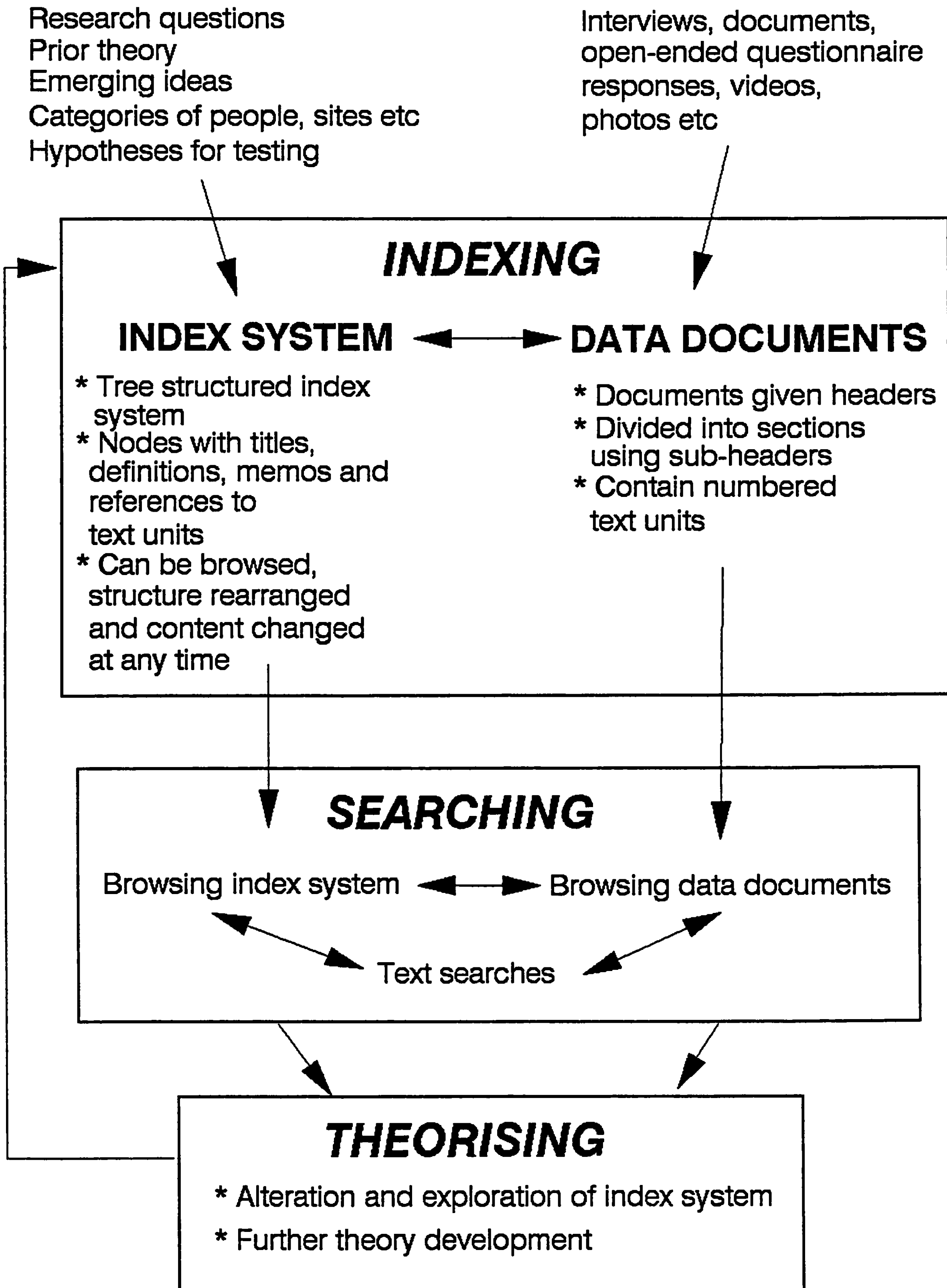
Figure 4.1 shows the data analysis process, as conceived by the authors of NUDIST, in diagrammatic form, illustrates the inter-relationships between indexing, searching and theorising which are possible using NUDIST[13].

3.3 Analysis: Development and Use of an Indexing System

In order to explore the nature of the professional social representations expressed in individual interviews, analysis must facilitate the answering of three broad inter-related questions: Firstly, what themes can be extrapolated from professionals' verbal accounts of their work and their understandings of mental ill health? Second, how do these vary across different respondents? Respondents can be categorised according to nationality, according to professional groupings, and according to whether they work in hospital or community based settings. These provide several *a priori* ways of splitting and comparing the data during analysis, (although as will be seen later, few clear-cut differences between groupings made in these ways are detected). Thirdly, how do the various themes inter-relate? In other words, are themes regarding for example, practical

13 This is based on a diagram contained in the Introductory Workshop on the QSR-NUDIST Qualitative Data Analysis Software (1995) Qualitative Solutions & Research Pty Ltd: Melbourne, Australia. This document has also been used to inform earlier parts of section 3.2. Descriptions of the development and use of the NUDIST package are also provided by Richards & Richards (1994a, 1994b) and Weitzman & Miles (1995).

Figure 4.1 The process of data analysis using QSR-NUDIST



strategies and theoretical understandings associated or do they appear in patterns independent of each other?

To answer these questions requires investigations both across interviews and within each interview narrative, an analytic process which necessarily evolves over time and involves considerable lack of clarity and ambiguity. Qualitative data analysis involves constant uncertainty, inspiration, reworking and questioning. It requires considerable personal involvement from the researcher in confronting complex patternings and exploring the semantic intricacies of the data, yet being able to step back from these to see them within a wider picture, and ultimately to make some credible interpretations and abstractions. QSR-NUDIST offers support for this fluid and evolving process by allowing the researcher to search and explore the data in several ways, to modify the indexing system continuously on the basis of these explorations, and to record on-going ideas using memoing facilities attached to nodes and documents. It is difficult to tie down this process into clear, tightly written specifications. However, in the name of enhancing the transparency of this research, this section attempts to provide a descriptive account (which is necessarily a reconstructed narrative) of the process of data analysis.

Initial indexing

Analysis using QSR-NUDIST requires segmentation of data into text units. This was done according to 'units of meaning' of a maximum of ten lines, with a new text unit being created every time the respondent moved on to a new idea, theme or issue. Text units of this size allow both contextualisation of themes and relatively fine-grained analysis. However, the significance of the exact size of text units, and the decisions made in devising these is reduced by the facility in NUDIST for multiple coding of each text unit. Contextualisation of text units is provided through the use of headers and sub-headers, with the major questions serving as sub-headers dividing interview transcripts. Thus, any text unit can be identified as part of a particular interview and as a response to a specific question.

The first stage of the analytic process was essentially a data management strategy, designed to categorise the large volume of data into several broad thematic areas. These categories were developed through pilot work with a sample of 10% of interviews (three

interviews from each country). This aimed to establish a set of indexing codes to account for broad themes within the data in a consistent and logical way, and to exclude from this initial indexing data which, for the purposes of current investigations, can be considered 'irrelevant'. Fourteen broad categories were created. The first of these describes 'base data' for interview respondents (professional status, nationality and location of work). The remaining thirteen categories (which are usually mutually exclusive) reflect both variations in the data and the theoretical orientation of the research. Based on the model of professional social representations proposed in Chapter 3, the creation of these codes recognises that professional social representations of mental illness are likely to consist of a combination of theoretical and practical sources of understanding which coexist with other knowledge / belief systems, specifically those relating to professional identities and the institutional setting in which respondents work. These initial indexing categories are presented in Table 4.3 together with working definitions which emerged from pilot work.

Careful checks were made during pilot work on the content of each indexing code, establishing that data assigned to each code accurately reflected its working definitions. Checks on non-coded data confirmed that this data can be considered 'irrelevant' to the current enquiry and that informative data was not being discarded[14]. These checks on non-coded data were repeated once the whole corpus of data had been coded with any relevant data being reincorporated into the indexing system.

This initial indexing resulted in 75% of text units being coded. An equal amount of French and British data was included. However, this accounted for a slightly higher percentage of British than French data (83% of text units for British data and 68% of text units for French data). This can be explained by differences between interviews conducted in the two countries. French interviews are longer and contain more data which is not considered to be relevant (for example descriptions of French health and social services and current social problems). In Britain, shared knowledge of these social systems is usually taken for granted. It is also apparent from interview transcripts that when interviewing in my own language I was able to direct interviews more successfully than when interviewing in a foreign language.

14 Un-coded data includes, for example, references to other work, comments on social problems, local and national politics, details of respondents' personal lives, and misunderstandings between interviewer and respondent.

Table 4.3: Indexing categories created in initial stages of analysis

Code Number	Name	Working Definition
1	Base Data	Indexing of professional status, nationality and location of work
2	Daily Practice	Descriptions of day-to-day work
3	Treatments	References to practices which can be considered as treatment / care
4	Models	Theoretical models which inform practice / understanding
5	Assessment	Assessments of mental health and treatment choice
6	Aims	Aims of treatment / daily work
7	Outcomes	Impacts of treatment / care strategies and evaluations of these
8	Role	How respondents see their role
9	Personal	Personal qualities needed and effects of work on the person
10	Professional	Comments on respondents' profession / other professionals / relationships between professionals
11	System	The psychiatric system and community care
12	Mental Illness	Descriptions / conceptualisations of mental illness
13	Causes	Perceived causes of mental illness
14	Cure	Comments on the concept of cure applied to mental illness

The relative use of each of the 13 codes was approximately equal for French and British data, with the exception that a greater proportion of British text units were coded under 'system'. This is accounted for by more detailed questioning of British respondents regarding the implementation of community care policies (see section 2.1). Quantitative

analyses were used to check the reliability and consistency of this initial indexing. Counts of text units assigned to each code were made at three points:- after completion of the pilot work; when half the interviews had been coded; and when initial coding had been completed for the full set of interviews. At these three points, the overall percentage of data coded, and the frequency of use of the 13 codes were found to be constant. This suggests consistent use and definition of the initial codes which form the bedrock of subsequent analysis.

Subsequent Analysis

Having established an initial framework for segmenting and organising interview data, subsequent analysis set out to explore the content of these broad themes in more detail. This involved a spiralling process of analysis in which fine-grained exploration of each theme opens up new questions and avenues of investigation, the results of which can be fed back into and integrated into the developing 'tree structure' of nodes. This on-going process makes it possible to move to increasingly higher levels of abstraction in making sense of the data, while simultaneously generating an increasingly complex indexing tree to capture the complexities and nuances of the data.

This spirally process is best illustrated through an example: Investigations of the data on treatment strategies highlighted the use of psychotherapies as an important practice. Thus a node was created which contained all references to the use of psychotherapeutic strategies. Following this, retrievals of text units indexed at this node suggested quantitative differences in the numbers of French and British respondents using psychotherapies. This also suggested that psychotherapy was being used and conceptualised in qualitatively different ways in the two countries. These differences revolve around the concepts of 'coping' and 'listening' which were then investigated using word searches. The results of these searches were used to create new nodes which were integrated into the developing indexing structure in the area of 'aims of work', and were used in subsequent fine-grained analysis in this area[15].

15 The results of this analytic example are presented in Chapter 6.

This example illustrates how NUDIST facilitates a combination of quantitative and qualitative investigations. It also shows how, although sheer volume of data dictates a strategy of addressing each broad thematic area in turn, an integrative approach can nevertheless be adopted. The results of explorations in one area inform and feed into other areas, such that themes can be detected across the interview narratives. This guards against segmentation and helps develop a more conceptual level of understanding. Through this process, the initial 'flat', non-hierarchical indexing system provides the starting points for an increasingly more complex 'tree-structure' of hierarchical codes. Adding subsequent layers or 'children' to this indexing system allows analysis of a particular theme to become successively more fine-grained. Other explorations were conducted during this process by posing questions such as 'how do British respondent's views of the causes of mental illness compare to those of French respondents?' or 'do the various professional groups conceptualise the aims of their work in different ways?' To answer these question, new nodes which divided existing nodes according to the comparison being made were created. These allowed examination and comparison of the relevant text units. Nodes could then either be integrated into existing tree structures or deleted as required. Another frequently employed investigative strategy was to use the range of 'Boolean operator' facilities offered by NUDIST. For example, it is possible to investigate the intersects and the unions of two or more indexing nodes, to collect together all the nodes within a specific sub-tree, or to restrict analysis to documents indexed at a particular node. Using NUDIST's text editor facility, the results of these investigations, together with relevant interview extracts were transferred directly into text documents which formed the basis of the three analytic chapters.

The final version of the indexing 'tree structure' is presented in Appendix 6. This emerged from a on-going process of development and reorganisation in which nodes were continually merged, deleted and moved within the tree structure. Thus the final tree structure reflects my final conceptualisations of the data, and is informative in understanding the analysis presented in subsequent chapters.

4 Ensuring Credibility in Qualitative Research

The final section of this chapter is devoted to consideration of what I believe is a vital issue for qualitative research: How can the credibility of such research be evaluated and ensured? My first concern will be the definition of terms in relation to this issue. Following this, section 4.2 considers some strategies of evaluation and suggestions for good practice made by other qualitative researchers. Finally, section 4.3 demonstrates how the credibility of the current research has been ensured. Having recognised the complexities of the issue of research credibility, which it is argued should be seen as fluid and dynamic rather than a static criterion, the credibility of this research is best assessed through several criteria. Strategies of triangulation, researcher reflexivity, checks on the consistency and internal validity of coding strategies, and transparency will be cited.

But first, why is this issue of the credibility of qualitative research so important? Many authors (eg Farr, 1993a; Henwood & Pidgeon, 1992) point to the dominance of positivism in the Anglo Saxon social sciences. Particularly in psychology, the role of qualitative research has been undervalued[16]. Farr (1993a) notes that in the English speaking world, the dominant position of positivism requires researchers to be explicit about the methods they have used. Consequently, evaluations of French social representations research have been lowered by the fact that French researchers are traditionally less concerned to present clear accounts of their methodology. Other authors (eg Silverman, 1993; Bryman, 1988) note that much qualitative social science research has an anecdotal quality, with little or no attention paid to how its credibility can be evaluated. If qualitative research is to continue to gain ground in the social sciences, its authors can no longer afford to avoid issues of the credibility of their methods and findings. We must work at establishing strategies for good practice in qualitative research and developing criteria for evaluation which are appropriate to the epistemological and methodological bases of our research.

16 Although in modern social psychology the rise of approaches such as discourse analysis, social representations theory and feminist research, among others, has done much to raise the profile of qualitative research over the past decade.

4.1 Defining 'Credibility'

A review of literature on qualitative research methods demonstrates a profusion of terms relating to the evaluation of research. 'Quality', 'trustworthiness', 'validity', 'authenticity', and 'credibility', are some of the terms which are often used interchangeably. However, these terms are used to signify broadly the same issue. This can be defined as the interaction between theory, data collection and interpretation of the data. The data collected, and the strategies of analysis used should interact closely with the theoretical perspective of the research. In other words, theory should suggest certain approaches and techniques of data collection and analysis, while data should be able to offer support, refutation, or refinement of the theory.

To avoid confusion, I have chosen the term 'credibility' to refer to this linkage between theory, data collection and interpretation. The choice is somewhat arbitrary, but I wish to avoid the term 'validity' as it may carry connotations of the measurement approach to evaluation developed within psychometrics. There are parallels between 'credibility' and 'construct validity', defined by Anastasi (1968, p114) as 'the extent to which the test may be said to measure a theoretical construct or trait'. However, this concept and many other criteria used to evaluate research from a positivist perspective are essentially static, in that they rely on numerical measures which are used to evaluate the whole research process. I would argue that what is needed is a more dynamic concept of credibility. The relationship between theory and data is two-way and fluid. Research should be considered as a dynamic process in which the meaning of data and its relation to theory is never fixed, but develops and changes through the life-time of a research project. Similarly, any single piece of research fits into an on-going body of related research and theoretical debate, through which both theories and methods develop. Consequently the credibility of research cannot be evaluated 'once and for all'. Evaluations can be made at certain points in time, but these are liable to change, such that research can only ever be said to be 'provisionally credible'[17]. Furthermore, evaluations are always made in relation to the researcher's <u>aims</u> in conducting the study, rather than in absolute terms.

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17 Banister et al (1994) describe this issue as 'inconcludability' and make the following comment: 'While a positivist who believes that it is possible to capture facts and arrange them in mathematical form will see inconcludability as a fatal problem, qualitative researchers who follow the changes in meaning in the course of research will both understand and welcome the opportunity for others to supplement their account.' (Banister et al, 1994, p12).

I would argue, therefore, that credibility is best assessed through a variety of criteria, which consider this complex issue from different perspectives, and at different points in the research process. This is the approach I have adopted in the research reported here. Before presenting these strategies, however, a brief review of how other researchers have tackled the evaluation of qualitative research is necessary, in order to contextualise my own choice of evaluation methods.

4.2 Evaluating Qualitative Research

Although there is little agreement amongst qualitative researchers as to how their methods should be evaluated (Kelle & Laurie, 1995), two broad perspectives can be identified. The first is to apply the standard positivist criteria of reliability and validity. This approach has been advocated as a way of assessing content analysis by, for example, Krippendorff (1980). The second perspective (which has gained more ground in recent years) advocates that the application of the standard positivist criteria of reliability and validity to qualitative research conducted within a constructionist epistemology is problematic (eg Banister et al 1994; Henwood & Pidgeon, 1992; Flick, 1992; Silverman, 1993), and that more appropriate criteria must be established. I would agree with this argument that the epistemological stance of most qualitative research is not compatible with the measurement approach of the classic tests of reliability and validity. This is because meaning, with which qualitative analysis is primarily concerned, is never fixed and cannot, therefore, be quantified in a single static measure. However, I would add a qualification, which essentially locates my argument mid-way between these two positions. Epistemological differences should not, I believe, be used as an excuse for the whole-sale rejection of previously well-established techniques. Some of the positivist criteria for evaluating research methods can be usefully combined with other non-positivist criteria for evaluating qualitative research. In particular, as I have demonstrated in the current research, evaluations of the consistency and internal validity of coding techniques can prove useful tools. What I would object to is the exclusive use of these criteria of evaluation for qualitative research.

Given this starting point, what other strategies of good practice which can help ensure the credibility of qualitative research without using standard positivist criteria have been

proposed? One of the most frequently cited strategies is 'triangulation' (eg Banister et al 1994, Flick 1992). Various types of triangulation and their aims have been discussed in section 2.2 and it not necessary to consider them further. Another commonly cited strategy is 'researcher reflexivity' - the researcher's constant vigilance to ways in which research activity inevitably shapes and impacts upon its findings (eg Henwood & Pidgeon 1992, Lincoln & Guba 1985). This can take a variety of guises, from the interactions of researchers with their object of study during data collection, to the influence of strategies used to analyze and make sense of data. One of the benefits of a reflexive approach is that the researcher is able to produce 'transparent' research findings. Transparency (also referred to as 'documentation' (Henwood & Pidgeon, 1992) or 'codification' (Barton & Lazarfeld, 1969)) refers to the clarity with which the path from data to findings is presented. Transparency does not in itself ensure credibility. Rather, it is a practice which enables readers of a research report to evaluate credibility on their own terms. It is also an important way in which knowledge about the practicalities of how to do qualitative research can be disseminated within the research community.

The list of proposed strategies designed to enhance the credibility of qualitative research is probably endless, and it is not my intention to provide an exhaustive review. Three other approaches which are commonly advocated by researchers searching for non-measurement based criteria of evaluation will be mentioned:- respondent validation, 'fit' with the data, and generalisability. Respondent validation refers to 'acceptance' by the participants in the study of the researcher's interpretations. This criteria has been advocated by, among others, feminist researchers, as an attempt to redress power differentials between researchers and those who participant in research. While 'giving something back' to participants is a desirable aim, this criteria of evaluation can also be problematic. There may be times when the perspectives of researcher and respondents simply do not match, for example when studying the beliefs of fascist groups (Billig, 1977), or when taboo and unspoken themes which may not form part of participants' conscious experiences are uncovered by the researcher (eg Jodelet 1991). Depending on the nature of the research project, respondent validation may be a useful strategy, but it is not sufficient on its own to ensure the credibility of research findings.

Researchers taking an inductive approach to qualitative research often cite 'fit' between findings and the data as an important criterion for validity (eg Henwood & Pidgeon

1992). This is certainly an important issue, although the term 'fit' risks implying that what is contained in the data corpus is fixed and static, rather than open to several possible readings. However, unless one is taking a radically inductionist approach, connections between data and findings are not the only relevant links. Findings should also correspond with theoretical perspectives, in such a way that they can offer insightful support, elaboration or disconfirmation of a theory. This relates to the final criterion of evaluation - generalisability. Does the research offer contributions to knowledge which can be generalised beyond the specific data set on which it has focused? In qualitative research generalisability is usually understood in terms of concepts and theories, rather than in the quantitative sense of generalising from sample to population.

4.3 Strategies for Credibility in the Current Research

Given this range of suggestions for good practice in qualitative research, what procedures have been implemented to ensure the credibility of the findings reported in this thesis? Based on the arguments developed in the preceding two sections, a range of strategies are brought into play, some of which derive from classic measurement approaches, whilst other are more typically associated with constructivist epistemologies. Each of these offer a different perspective on the research process and together they address credibility at various points during the life-span of the project.

Triangulation of data, methods and levels of analysis, and the use of quantitative approaches to supplement an essentially qualitative enquiry have already been discussed. Reflexivity, requiring continual questioning of how particular strategies may shape findings has been maintained throughout the research process. For example, awareness of how demand characteristics and social desirability may play a part in constructing interview accounts has been discussed in section 2.1. A variety of techniques employed during the process of data analysis also demonstrate a reflexive stance. These include searching for the existence of patterns or themes in more than one domain, investigating

deviant or unusual cases, exploring data which does not fit with developing conceptualisations, and consideration of rival explanations of findings[18].

Several techniques employed during data analysis ensure the reliability and internal validity of processes of coding and investigating data. In the initial stages of data analysis, checks were made on the consistency of use of the thirteen broad codes (see Table 3). Data allocated to each code was examined to establish that its content matched working definitions of codes. The content of non-coded data was also examined to ensure that interesting data was not being lost from further analysis. The circular process of data analysis described in section 3.3 aimed to produce a final indexing system with internal logic and consistency, which could provide a detailed mapping of both themes within the data corpus, and my own understandings of structures and relationships within this. These strategies are designed to ensure close linkages between findings, data and theory, ensuring that findings are able to inform understandings of both the substantive area of mental illness and the theory of social representations.

The use of this comprehensive range of validity checks is particularly important given that only one person has been involved in data analysis. I have had to police and evaluate my own strategies. While the use of multiple coders is a strategy frequently advocated to enhance the validity of qualitative research, the on-going interactive process of data analysis and exploration which this project has involved makes this option unfeasible. However the fact that this process has involved constant reworking of themes and finding, as data is explored and re-explored from different perspectives has ensured that checks on analysis equivalent to 'test-retest reliability' have been incorporated into the process of data analysis (although this criteria cannot be measured or evaluated formally).

Finally, this chapter has presented as transparent an account as possible of the path taken from initial decisions about data collection, through data analysis, to the final write up of findings. This will enable readers to evaluate the strategies adopted in this empirical work, and hopefully to be clear 'where the findings come from'. The production of a

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18 Miles and Huberman (1994), Chapter 10 provide a comprehensive review of strategies of data exploration designed to enhance the rigour and authenticity of analysis, many of which were adopted during the data analytic work of the current research.

clear account of the process of data analysis is aided considerably by the use of 'QSR-NUDIST', which encourages qualitative data analysis to become a recordable process. I believe that the expanding use of computer software for qualitative data analysis will do much to enhance the transparency and quality of qualitative research in the future.

Ultimately, all research is based on a relationship of trust between the researcher and the reader. Readers must decide for themselves on the credibility of this research. I hope, however, to have presented sufficient evidence using a range of criteria, for readers to be convinced of the credibility of the findings which are presented in subsequent chapters.

A Note on the Presentation of Findings

In the analytic chapters which follow, conceptual arguments are backed up with extracts from interviews interspersed in the text. These are chosen as typical illustrations which serve to concretise and bring the findings to life, as well as to enhance the transparency of analysis. Whilst there is clearly a need to be concise, the opposing requirement to capture narratively constructed meanings, together with a moral obligation to respondents to re-present their views in the best way possible, means that specific statements must be contextualised within the narrative structures from which they are drawn.

Extracts from French interviews have been translated by the author with verification where necessary by a native French speaker. Personal identifier numbers for respondents are included with each extract, and the reader may check the profession and location of work of each respondents in Appendix 4. The following abbreviations are used:-

F = French respondent
B = British respondent
I = Interviewer

CHAPTER 5

CONCEPTUALISING MENTAL ILLNESS: SOCIAL DEFINITIONS AND AGNOSTICISM

The empirical analysis of this thesis begins by exploring the very bed-rock of professional social representations of mental illness - the notion of 'mental illness' itself. How do professional practitioners in France and Britain conceptualise mental ill health, its nature and its causes?

The chapter illustrates how professionals' most basic understandings of mental ill health are far from fixed and clearly established, but are fraught with debate, questioning and uncertainty. Section 1 shows how professionals represent mental illness as a polymorphous category whose boundaries cannot be clearly defined, and within which an important binary opposition between 'neuroses' and 'psychoses' is set up. Section 2 explores how the various forms of mental illness are understood in relation to three defining themes - difference, distress and disruption. These themes delineate the territory on which practitioners' on-going debates about the nature of mental illness are played out. They also unite in defining mental illness in essentially social terms. In other words, mental ill health is understood as a problem of social life, defined in relation to social norms, and impacting upon social relationships. In section 3 the focus turns to professionals' understandings of the causes of mental illness. This highlights the agnosticism which permeates professional social representations of mental illness. Professionals construct complex but provisional representations of a web of causal factors which integrate ideas originating in various theoretical perspectives. Whilst echoes of both theoretical knowledge and lay understandings of mental illness permeate all the exploratory areas in this chapter, this analysis highlights how these knowledge systems are translated, re-presented and integrated within professional social representations.

In previous social representational research some authors (eg Abric 1984, De Rosa 1987) have conceptualised basic themes such as those explored in this chapter as the 'core' or 'figurative nucleus' of a social representation. However, for this research which proposes a more complex model of professional social representations structured in terms

of various inter-related spheres of knowledge, it is more useful to conceptualise basic themes as the 'bed-rock' of these representations. The multiplicity, agnosticism and essentially social definitions of mental ill health which this initial analysis reveals are themes which are echoed in many aspects of professional social representations of mental illness, and which reoccur throughout the empirical analyses of this thesis. This three-dimensional rather than two-dimensional conceptualisation of social representations is congruent with the position of Rose et al (1995) who argue that it is useful to differentiate various levels of consensus within social representations. A degree of implicit consensual reality provides the underlying ground rules for representational debate and dissensus which is lived out at 'higher' levels through daily talk and practice. This model allows the researcher more space to chart fluidity and inconsistencies between components of the representational field than is possible if the core-periphery structure is adopted. It is the underlying taken-for-granted bases of professional social representations which is the focus of this chapter.

1 Mental Illness: A Polymorphous Category

Consistent with the expectation that professional social representations will be highly elaborated, we find that professionals understand mental illness not as a unitary phenomenon, but as a polymorphous category in which various types of mental ill health are compared and contrasted. The most important differentiation within this heterogenous field is between 'psychoses' and 'neuroses'. This binary opposition permeates the entirety of professional representations, and is therefore a distinction which we will return to at several points in subsequent sections of this and the following chapters. Seventy five percent of interview respondents refer to neurosis and / or psychosis at some point during the interview, (although these are not terms used by the interviewer). No differences between French and British respondents or between professional groups can be detected in this respect, suggesting that these are meaningful terms across the world of mental health practitioners, regardless of status or orientation.

The terms 'neurosis' and 'psychosis' occur in both medical and psychoanalytic discourses on mental ill health[1]. Undoubtedly, the centrality of these terms simultaneously in two expert knowledge systems which have wielded such power and influence in the twentieth century accounts for their important role in structuring contemporary professional representations. However, neither of these expert knowledge systems provide clear, unambiguous conceptualisations of neurosis and psychosis. Within the medical / psychiatric paradigm, 'neurosis' and 'psychosis' serve as important descriptive tools, but their exact definition remains elusive[2]. Similarly, the proliferation of psychodynamic theorising has produced divergences and lack of consensus. The semantics of the term 'psychosis', for example, varies considerably between Freudian, Kleinian and Lacanian thinking. This debate and uncertainty in expert discourses is translated into professional social representations, opening up a space in which professionals construct their own understandings of neurosis and psychosis. As will be shown in section 2, these understandings are based on binary oppositions created around the theme of difference.

Beyond these important umbrella terms, professionals refer to various other forms of mental ill health. 'Schizophrenia' and 'manic-depression' are commonly cited mental health problems (referred to in 60% and 37% of interviews respectively), which seem to have the status of 'prototypical psychoses'. (These are also found to be the most commonly named illness in lay representations (Räty 1990).) Through their collective association with specific experiences or 'symptoms', these terms serve to concretise forms of 'psychosis', an initial step towards objectifying the abstract concept of mental illness within professional social representations. They may also function to aid communication between the professionally diverse members of mental health teams,

1 The distinction between neurosis and psychosis made in nineteenth century German psychiatry was imported into the psychodynamic domain in the original writings of Freud. Despite their fundamentally different approaches, Laplanche & Pontalis (1983) argue that psychodynamic thought is largely at one with the clinical boundary lines between neurosis and psychosis made in medical psychiatry.

2 For example The Oxford Textbook of Psychiatry (Gelder, Gath & Mayou, 1989) (one of the most commonly used psychiatric texts in Britain) states that the classificatory labels 'neurosis' and 'psychosis' are problematic because of lack of clearly agreed criteria, little commonality of the conditions embraced by the terms, and the fact that more specific diagnostic classifications are more informative. However, it notes that 'although psychosis has little value as a category in a scheme for classifying mental disorders, it is still in everyday use as a convenient term for disorder which cannot be given a more precise diagnosis because insufficient evidence is available' (p79). Similarly, the major internationally used psychiatric classification systems DSM-IV (The American Psychiatric Association, 1994) and ICD-10 (World Health Organisation, 1992) shie away from the clear definition of the terms psychosis and neurosis, while nevertheless retaining the terms on a descriptive level.

allowing them to agree on <u>what</u> they are talking about even if their views on treatment and aetiology diverge[3]. Similarly, phobias, anxiety and obsessions are referred to as specific forms of neurosis. 'Depression' (a term used in 70% of interviews) has a more ambiguous status associated with both sides of the neurosis / psychosis divide, and described both as a mental health problem in its own right, and as a symptom of other forms of mental illness.

Use of these specific illness terms is generally more common amongst British interview respondents compared to those in France. This may reflect the greater influence in Britain of the medical model of mental illness whose historical dominance has left its legacy in the language of mental health professionals (although the use of terms originating in medical discourses cannot be taken simply as in indicator of subscription to a medical model). It is also possible that this is a reflection of the socio-political context of mental health care in Britain, in which there is much public scepticism surrounding current community care policies and the competency of professionals. The use of expert terminology which differentiates their language from lay discourses may help professionals enhance their credibility as 'experts' and justify their professional practice (the justificatory role of theory in professional social representations is discussed in more detail in Chapter 6).

In contrast, the term 'madness' (which is rarely used in a serious sense by British mental health professionals) retains legitimacy in the world of French mental health professionals[4]. As the interview extracts below illustrate, the term 'madness' (la folie) is associated with 'psychosis' and is used by French professionals to signify states of delirium and behaviour perceived as bizarre, dangerous and radically outside of social norms. The semantics of 'madness' among French mental health professionals parallel those detected in research on lay representations conducted in Spain by Ayesteran & Paez (1986) (see Chapter 2, section 2.1).

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3 This relates to the anchoring function of theoretical concepts which is explored in Chapter 6, section 3.

4 As an indication of this cross cultural difference, the terms 'mad' and 'madness' occur in 18 of the 30 French interview transcripts (and 61 text units), compared to 5 interviews (and only 10 text units) in the British sample. Text units refer to 'units of meaning' which are generally between three and ten lines long.

'It has been the case that I've called a psychiatric patient mad. But I'm talking about a particular point in time, not a permanent state of the person. That is, a point when the clinical signs are particularly critical. For example, for someone who has a manic depressive psychosis, I'd consider him to be ill, but when he starts to have a manic episode I'd want to say that he's mad.' (F2)

Generally speaking, the people who are called mad in the French system are the psychotics. People termed neurotic aren't mad. That's how it is.' (F4)

Despite this relatively elaborated lexicon of mental ill health in professional social representations, uncertainty and questioning remains. This is revealed on a very basic level by debates over the most appropriate terminology and the extent and boundaries of these semantic categories. Use of the term 'mental illness' is often questioned during interviews, and it is clear that although this term is a recognised anchor, it is far from secure and uncontested. Several interview respondents take a critical stance on the term 'mental illness' which they associate with a medical model, implications of biological causation and abnormality, and neglect of subjective experiences and suffering:-

'One of the reasons why I don't use the term mental illness or disagree with it, is that I think for me when someone's in distress or they're coming with symptoms, that those symptoms are all things that make sense and I think that if you call it an illness you're almost trying to make it something that doesn't make sense. You know, it's something wrong, so lets make it better.' (B2)'

'It must be said that the notion of "mental illness" is itself something which one should have a critical view of. Because the word "illness" doesn't take full account of psychic suffering.' (F13)

B15: You can't ask the question what is mental illness without also looking at what are the boundaries of mental illness ...... For me mental illness would be those psychological difficulties that I would believe have at least some significant biological underpinning, which can explain why people are presenting in the way they are. So I would be including the psychotic illnesses. I consider psychotic illness as illness. So schizophrenia and manic depressive illness. But after that I don't use the term illness. You would find people who would view anorexia as a mental illness - I don't think it's an illness. Or alcoholism as an illness - I don't think it's an illness.
I: What would you say those sort of things are?
B15: Psychological difficulties. I use illness in a very specific way.

In their search for a more appropriate language, professionals may use terms such as 'psychological difficulties', 'mental health problems', or (in France) 'madness'. But whatever terminology they adopt, professionals' polymorphous representations of mental distress have fuzzy and ill-defined boundaries. They find it difficult to specify what constitutes mental illness and what does not. This implies a continuum of mental health and illness, as opposed to a view of mental health and illness as qualitatively different

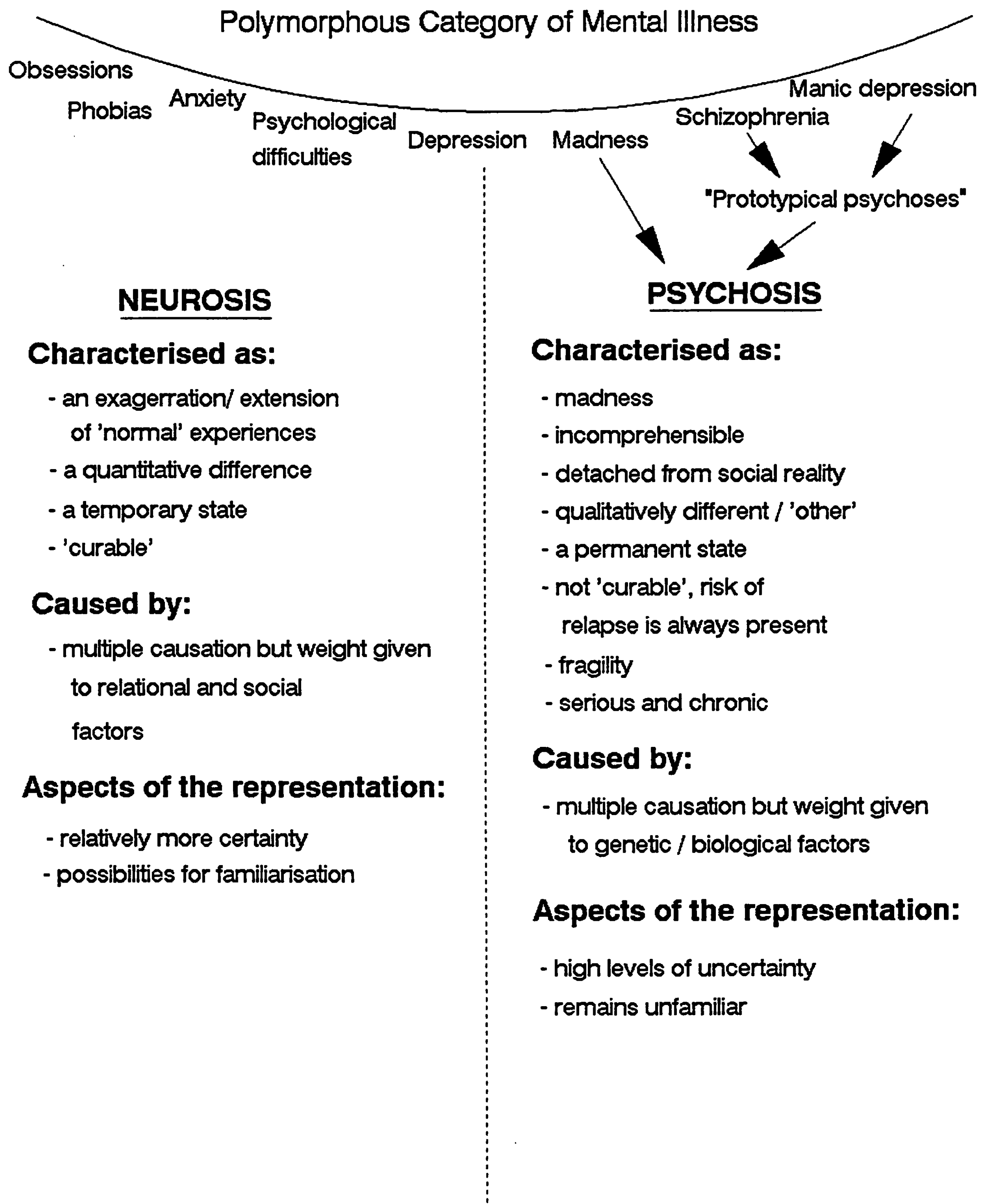
states. These 'different kinds of difference' are part of the binary oppositions constructed between neurosis and psychosis. Figure 5.1 below summarises the semantics of different forms of mental illness in professional representations. The themes presented in the bottom part of this figure, and the debates which surround each of these are explored in more detail in sections 2 and 3 which follow.

2 SOCIAL DEFINITIONS OF MENTAL ILLNESS: DIFFERENCE, DISRUPTION AND DISTRESS

Having established that mental health professionals represent mental illness as taking multiple forms, we turn in this section to how these forms are represented. Through what themes do professionals understand the nature of mental ill health and differentiate its various forms? Analysis of interview narratives highlights the agnosticism which pervades professional representations of mental illness. Questions asking respondents to describe the nature of mental illness often proved the hardest part of the interview, evoking much reflection by interview respondents. Similar difficulties in eliciting lay beliefs about mental illness through verbal accounts are reported by Jodelet (1991a)[5]. For lay people and professionals alike, there is something essentially intangible about the notion of mental distress which defies clear articulation. Whilst it seems un-surprising for lay people to deny psychiatric knowledge, the carry over of such claims to ignorance into the world of professionals is striking given their academic training and social position as experts. Despite this expert status, professionals are highly aware of the difficulties of trying to capture and describe the abstract concept of mental illness. This collective sense that the true nature of mental distress cannot be known with certainty is a key feature of professional representations of mental illness.

5 '(M)any detours were needed before we could get through to these conceptions ... We passed through concrete descriptions of cases, comments on events, behaviour, expressions, real-life narratives etc. These conceptions always emerged indirectly, sometimes without the interviewees knowing it, and were almost invariably preceded by an absolute refusal to admit any psychiatric knowledge.' (Jodelet, 1991a, p150). These comments resonate with the experience of collecting interview data with professionals, and highlight the analytic difficulties of capturing taken-for-granted or non-verbal belief systems. To gain access into these, techniques which go beyond manifest verbal responses (for example, observational data and more interpretative styles of analysis) must be employed. The design of the interview schedule, the analytic strategy, and the use of secondary data sources facilitate this process in the current research.

Figure 5.1: Professional Representations of Neurosis and Psychosis



But this 'unknowing' is not absolute. Rather it is played out around three inter-related key themes: Difference, distress and disruption[6]. These provide the foci for professionals' on-going debates about the nature of mental illness. By weighting these themes differently and by creating bipolar oppositions revolving around these conceptual axes, professionals are able to distinguish and compare various forms of mental ill health.

The underlying theme which unites these notions of difference, distress and disruption is an essentially social conceptualisation of mental illness. In trying to capture what it means to be mentally ill, professionals construct a model of the person as a social being. The mental health of an individual is not understood in isolation, but in relation to the social context, its norms and expectations for behaviour, life-style and experience. Difference is clearly a comparative evaluation, based on notions of 'normality'. Similarly, disruption entails a break with social and/or personal life-style norms. Even the theme of distress (which could be defined simply in intra-psychic terms) is given a social gloss, in that it is perceived as deriving not only from internal states, but from social experiences (for example, alienation from others or stigma).

Integrating these themes might lead to a statement that mental illness is conceptualised in professional social representations as **experiences which are different, abnormal and distressing, and which disrupt the person's life and levels of social functioning.** Yet such a simplistic statement suggests a misleadingly fixed and stable representation, and fails to capture the debate, ambiguity and unanswered questions which exist around each of these themes. These are presented in graphical form in Figure 5.2, and explored in more detail in the following three sections.

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6 In quantitative terms, these three themes occur in the descriptions of mental illness given by both French and British respondents of all professional origins, and can be detected in 82% of interviews. The remaining 11 (out of total of 60) respondents produced a variety of replies to the question 'what is mental illness?' Most common amongst these were replies based on causal models (ie explanations rather than descriptions), perhaps motivated by the desire to present oneself as a competent 'expert' in the interview setting.

Figure 5.2: Mental Health Professionals' Conceptualisations of Mental Illness

DISTRESS

derived from:

- internal state (eg sense of loss of control, fear)
- social position (eg isolation, feeling misunderstood, stigma, sense of being different)

Questions: - Are the mentally ill distressed or distressing?

MENTAL ILLNESS

DIFFERENCE

= incomprehensibility, disconnection from social reality, fragility (weakness?)

Questions:

- quantitative difference / similarity (neurosis?) or qualitative difference (psychosis?)?
- understandable or incomprehensible 'other'?
- temporary or permanent?

DISRUPTION

= disruption of

- life compared to personal and social norms
- relationships
- coping strategies

Questions:

- disruption or different way of living?
- not coping or a way of coping?

2.1 Different Forms of Difference

The resounding message of research reviewed in Chapter 2 is that difference and 'otherness' are at the heart of societal understandings of mental illness, and that the power of these themes is both reflected in and perpetuated by individual and collective reactions to mental illness and historical practices of marginalisation. Much of the research reviewed in Chapter 3 on mental health institutions and the people who work in them also finds themes of difference created symbolically in the daily routines of mental health services and the understandings of professional practitioners. It is no surprise therefore, to find difference as an important representational theme in the current research. But analysis also reveals the complexities of this notion of difference in professional social representations. If to be mentally ill is to be somehow different, abnormal or 'other', what kind of difference is this? Is this a permanent difference between people, or a temporarily different state? Is mental illness an exaggeration of 'normal' ways of being, or a qualitatively different phenomenon? What implications does this have for the ability of other people to understand the experiences of the mentally ill? Are the various forms of mental illness similar in these respects? These questions, all centred around the notion of difference, are issues with which mental health professionals continually battle, and for which they are able to produce only provisional and tentative answers.

Quantitative versus Qualitative Difference?

> 'A great word when you're going through your training is empathy. I don't think I can ever honestly empathise with somebody who is mentally ill. I can't experience what it's like to have auditory hallucinations. Everybody has a certain degree of paranoia, but I don't think anyone can experience what actual pathological paranoia is. So I think you can only do your best, you know what I mean - you can only try and assume what that person is feeling, but I don't think you can ever take on board what that person's experience actually is. It's not a real experience, you know, you can't possibly understand what a mentally ill person is going through.' (B6)

> 'Mental illness ....it's being outside reality, it's being completely cut off from the outside world. It's about rejecting something, shutting oneself away in one's world. Whether it's depression or schizophrenia....it's escaping from the outside world' (F12)

These two interview extracts illustrate the representation of mental illness as a radically or qualitatively different phenomenon. This qualitative difference is defined in both phenomenological and consensual terms. It is the experience of mental illness, and the

perception of this as outside of the norms which constitute social reality that renders mental illness qualitatively different. From this perspective, to be mentally ill is to be 'outside of reality', to have experiences that other people do not have, and therefore to be abnormal. Professionals perceive a gap between their own (and 'normal') experiences and those of the mentally ill, and this gap renders full understanding of mental illness difficult or impossible. Mental illness, from this perspective, remains fundamentally unknowable. This representational theme supports the suggestion made in Chapter 2 (section 2.4) that mental illness is associated with perceived failures of conventional folk theories of mind or notions of the 'generalised other'. Being unable to imagine what it is like to be mentally ill offers no way of applying a theory of mind based on one's own subjectivity, with the result that the mentally ill person remains unpredictable and un-understandable.

This 'qualitative difference' parallels themes in lay representations of mental illness as a radically different 'other' which are detected by Jodelet (1991a) and many other authors. It is also perpetuated by numerous structural features of mental health services in which symbolic differentiation between staff and patients is marked out through daily routines and the use of physical spaces[7]. However, what differentiates these themes of 'otherness' in professional representations from those in lay understandings is that (at some level at least) they do not exist as an unquestioned reality. Although symbolic difference is instituted structurally, professionals take a reflexive stance on their own social representations - their knowledge is taken as provisional rather than taken-for-granted. There is recognition of some of the social and psychological processes which may be involved in constructing representations of mental illness. For example, some professionals recognise how constructing the mentally ill as 'other' may be a defensive strategy for denying the possibility of mental illness in oneself. The second of these interview extracts shows how some professionals are also actively involved in challenging

7 For example, in psychiatric hospitals and many community centres the eating facilities for staff and patients are usually separated. Similarly, toilets facilities are often designated for staff or patient use. The fact that staff have open access to patient designated areas (canteens, day rooms, sleeping facilities and so on), whilst many staff-only areas are off-bounds for patients highlights how this construction of a psycho-social distance between staff and patients also imbues power inequalities. Goffman (1961), Prior (1993) and Rosenhan (1973) also comment on the construction of symbolic differentiation between staff and patients in mental health services.

views of mental illness as un-understandable, and renegotiating more 'meaning-full' representations of mental ill health[8]:

> 'To talk about mental illness is bit of a defense. In other words, to say that another person is ill and I'm not, whereas actually we're all involved in it, each with our own difficulties.' (F10)
>
> 'It's very difficult not to be "them and us", which is I think in this kind of setting so easy - they are the people who have got mental illnesses and we're alright. And I often think there's a lot of misunderstanding of cultural aspects, religion coming into it - different backgrounds, different languages, different ways of expressing things. ... I have found something quite interesting in working with people who are defined as being very psychotic, that the content of what they say sometimes makes sense. It doesn't necessarily make sense initially - you have to get to know the person, get the circumstances, get the background, the social history of the person.' (B13)

This reflexivity amongst professionals offers support for Markova's (1992) suggestion that 'scientists', who are generally aware of the problems and limitations of their knowledge systems, take a more critical stance on their own theories than lay people, who are more willing to accept scientific knowledge as ontologically real.

The status of mental illness as definitely and unananimously 'other' is also called into question by the coexistence of a 'quantitative difference' theme within professional social representations. For example:-

> I: How would you describe what mental illness is?
> B5: It's a continuum from what normal life experiences are. The problem is defining what is normal I guess. So there's no easy answer to that. An exaggeration of perhaps many things that occur for people who are normal in inverted commas. An exaggeration of some of their behaviours, some of their emotional responses to things.
>
> 'For me mental illness is something extreme, an extreme of normality in inverted commas. What turns normality into pathology is extremity, an extreme position....What I mean is, I don't think we should say that its something different, that's not true.' (F17)

From this perspective, mental illness is an exaggeration or extension of other experiences. Mental health and illness are conceptualised as a continuum rather than as distinct categories. This poses questions of where on this continuum mental illness 'begins', an issue which remains unanswered in professional social representations (see section 1).

8 This is associated with much of the work of the contemporary users' movement in Britain, who campaign to promote more benign and empathetic social representations of 'meaning in madness'. (This issue is discussed in more detail in Chapter 8.)

Conceptualising mental illness as a quantitative difference opens up the possibility for 'similarity' as well as difference: Parallels can be drawn between experiences of mental illness and other more 'normal' experiences. There is scope for understanding, for making sense of mental illness by anchoring it into one's own experiences, for applying conventional theories of mind.

Evidence for this 'quantitative difference' representation of mental illness has been reported elsewhere, by Prior (1993) in his study of the contemporary social organization of mental illness in Northern Ireland (see Chapter 3, section 3.2). Prior (1993, p46) argues that 'psychiatric illness is now regarded as an abnormality in only a quantitative rather than a qualitative sense - as something which differs from normality in degree, rather than in kind.' However, whilst Prior claims that the 'quantitative difference' model has superseded a more archaic 'qualitative difference' model, the current research suggests that the latter has continued life and currency in professional social representations. This coexistence of different types of difference is also detected by Räty (1990) in a social representational study on Finish students (see Chapter 2, section 2.1) in which qualitative difference is associated with danger and incomprehensibility whilst quantitative difference is associated with less threat and an ambiguous boundary between normality and pathology. It also accords with the multiple coexistence of diverse understandings of mental illness found in many other studies (for example, De Rosa 1987; Glasgow University Media Group 1994a; Strauss et al 1964).

Temporary versus Permanent Difference?

A second question centred around the theme of difference concerns temporality. Is mental illness a temporary state, a difference which people can move in and out of, or is it a more permanent difference? In other words is the difference which is mental illness a state or a trait? Again, uncertainty surrounds this issue and both these positions coexist within professional social representations, often being used to differentiate between types of mental ill health, especially neuroses and psychoses (see below). However, the balance is more in favour of views of mental illness as a permanent, trait-

like difference[9]. Mental illness is frequently described as a chronic and long-term problem, a state which may lie dormant, but which is liable to manifest itself throughout the person's life. As will be seen in Chapter 6, this has important implications for the daily work of mental health professionals which is conceptualised as a long-term endeavour involving 'maintenance' rather than 'cure'.

Fragility (Weakness?)

> 'I've worked with patients for a good number of years, and they've stabilised, but I would never swear that they won't come back again. There are always relapses because it's linked to personalities which are often fragile, and sometimes it only takes something small for things to go wrong.' (F14)

> 'I have some psychotic patients, and it's true that for those patients there's a different structure, a different kind of fragility. Cure for psychotic patients - I think that basically they stay the same, even though they may not have delusional episodes, they still have quite a distinctive structure. In fact they often take medication, or come into hospital, and even if they leave without any delusions, there's a particular structure which is still there.' (F13)

When a view of mental illness as a permanent trait-like difference is combined with themes of qualitative or fundamental differences, associations with 'fragility' are often expressed. This is particularly associated with 'psychotic' illness. This notion of fragility hides within it another important semantic which remains unspoken: Fragility is often used in a way that implies weakness. The following interview extract betrays this hidden theme[10]:-

> I: How would you define this fragility that you talk about?
> F17: Some people would say that it's a weakness, but I don't think so. That's very derogatory. It suggests that being strong is the ultimate, but that's not true. Anyway...it's true, I think, that in everyday language fragility means weakness. Often there is a sensitivity, so that if you are fragile in yourself, you may be more affected by things in social life, you may be less able to protect yourself. For me, at the moment, fragility is extreme sensitivity

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9 As a quantitative indicator of this balance, 49 respondents (out of a total of 60) express the 'trait / permanent difference' position compared to 23 respondents who express the 'state / temporary position'. However, the majority of this second group (17), <u>also</u> express the 'trait / permanent difference' position.

10 This interview respondent is unique in verbalising many of the tacit assumptions within professional representations. Her position as a newly qualified psychiatric nurse struggling to assimilate the norms and values of mental health work apparently provides a more reflexive stance on many taken-for-granted and taboo issues in professional social representations, and her interview responses were much less guarded and censored by self presentation than those of some other respondents. The use of this single interview as a vital resource in going beyond what is explicitly verbalised in an interview situation illustrates how thematic analysis of this form cannot rely solely on quantitative measures such as the frequency with which a theme is expressed.

to things. It's not unusual to come across very sensitive personalities who are very fragile people. I don't know, but in the end the term "fragile" is pejorative.

This suggests that professionals may represent mental illness implicitly as a form of weakness or moral inferiority, but that this is reconceptualised into the more socially acceptable notion of fragility. The work of Gilman (1988) discussed in Chapter 2 highlights how 'otherness' in social representations can take various forms (for example, exotic others, dangerous others or benign others). Amongst professionals as well as within the lay community (Raty 199), mental illness is often represented as a weak or fragile other, which is implicitly, but importantly inferior to 'normality'. This is supported by the fact that 'fragility' at the level of the person is also an important theme in professionals' causal models of mental ill health (see section 3 below). Paradoxically, as we will see in section 2.4, there are also some implicit suggestions that mental illness may be a powerfully dangerous or threatening form of otherness.

Neurosis and Psychosis

These different types of difference (quantitative versus qualitative and temporary versus permanent) coexist in professional social representations both within and between the representations expressed by individual practitioners. The commonest way they co-occur is as a means of differentiating and creating binary oppositions between 'psychosis' and 'neurosis'. Firstly, as the interview extracts below illustrate, psychosis is associated with qualitatively different experiences whereas neurosis is described as a quantitative form difference. The psychotic person is described as living in a world of their own in which they lack 'insight' or the ability to recognise consensual views of the world and their dislocation from this. This renders psychosis a more serious or severe form of mental illness. In contrast, neurotic problems are described as paralleling other experiences and are associated with a greater ability to recognise violations of social norms.

I: How would you describe what mental illness is?
B4: Mental illness is... it depends on the severity really. Neurotic illness, neurotic illness blends into normality. It's two or more standards deviations from the norm of behaviour. And psychotic illness - well psychotic illness is completely split off from the norm.

'The patients, especially the psychotics, the schizophrenics, they are quite simply on another planet, they live on earth, but they're strangers on earth.....The neurotics, who understand.....are people who simply have difficulties coping with their inner drives, but they

are perfectly grounded on this earth ..... the neurotic state is a normal state, it's a state of suffering, it's the state of being human.... Human suffering is neurotic suffering, the normal person is neurotic.' (F24)

'There are parallels between what goes on in neurosis and what goes on in psychosis but it seems to me that the two things are different. I might have, say, an overvalued idea, a bee in my bonnet about something which might be similar to a psychotic who's got a delusion, but they're not the same. So I find the border line between what we would say is mental illness and normality very difficult to define. I suppose I feel that at some stage someone who is psychotic passes through some kind of a barrier which is beyond the ordinary, the acceptable neurotic experience. There's something about neurotic experience which is comprehensible to all neurotics, and yet there are aspects of psychosis - this an idea of Jaspers - which are incomprehensible, which is beyond our understanding.' (B10)

(Re: neurosis) 'C'est la folie du mec normal.' (Its madness in a normal guy) (F7)

Secondly, neurosis and the specific illnesses associated with this umbrella term (phobias and obsessions for example) are more often described as a temporary state-like difference which may affect the person for a single discrete period. In contrast, psychosis and specific psychotic illnesses (schizophrenia and manic depression) are frequently described as trait-like differences which set people permanently apart from others and may recur throughout their life-span. For example:-

'Perhaps this distinction doesn't exist, perhaps it does, I don't know. In any case, my reference points are neurosis and psychosis. Within the neurotic state there are certain clinical expressions which can be got rid of, which can be cured. In psychosis there are certain raw forms which may disappear and the person may be able to adapt to them in some way. So psychosis is more serious, you can care for someone with psychosis, you can improve their quality of life, maintain them, ease the expression of their difficulties, but, as far as we know, for the time being, you can't cure them.' (F2)

Cure for the psychoses is a very questionable issue. I think it's possible to maintain people in an affectively flattened state, where the overt florid symptoms are under control, but the residual negative stuff tends still to be present invariably, which effects people's ability to socialise etc. I don't think that pharmacology cures people with psychotic illnesses. I think it enables them to function in society at a debilitated but nonetheless reasonably functional level. For many other mental health problems, there are strategies now. For want of a better word I'll describe them as neurotic disorders. These are much more amenable to various techniques. I think you can cure neurotic processes. But psychotic processes and depressive illnesses very often, I think you're constantly on a holding operation with them. (B22)

Again, the roots of these conceptualisations of neurosis and psychosis can be traced in both classic medical psychiatry and psychodynamic theorising. Despite the definitional divergences and uncertainties noted in section 1, splits between neurosis and psychosis in terms of difference and 'insight' are expressed relatively unanimously and confidently in both medical and psychodynamic texts. For example, the Oxford Textbook of Psychiatry (Gelder, Gath & Mayou, 1989) offers three possible criteria for the definition

of psychosis:- greater severity, lack of insight, and inability to distinguish between subjective experiences and reality. ICD-10 (World Health Organisation, 1992) and DSM-IV (American Psychiatric Association, 1994) define neuroses as problems in which insight and reality testing remain intact, and gross social norms are not violated. The anti-psychiatrist Laing (1982) argues that one of the defining features of classic psychiatric thinking is to see a 'veritable *abyss* of difference' between 'normal' people's mental life, and that of the schizophrenic or psychotic person, such that empathy and understanding are deemed impossible. In other words, medical psychiatry supports the view that conventional folk theories of mind, which are based on rationality and assumed to be the norm, cannot be applied to people suffering from psychotic forms of mental ill health. Similarly, in psychodynamic theorising, neurotics and 'normals' are typically clustered together and set against the psychotic personality which is regarded as fundamentally different (and as a consequence, less amenable to the psychoanalytic method)[11]. Psychodynamic definitions of neurosis and psychosis rest on one or more of the following criteria: degree of 'seriousness' of symptoms; disturbances of the capacity to communicate; contact with reality; awareness of the problems; and social adaptability (Laplanche & Pontalis, 1983). There is also some evidence that these differentiations have social meaning as part of contemporary common sense, even if they are not described using the expert terms 'neurosis' and 'psychosis' (for example, analysis of mental illness representations in the Greek media conducted by Bastounis, 1996).

In summary, although representations of various forms of mental illness are united by themes of difference and abnormality, they are simultaneously differentiated according to the nature of this difference. There is a tension within professional representations between coexisting views of mental illness as, on the one hand, something fundamentally different, disconnected from reality and falling outside of social norms and understanding, and, on the other, mental illness as an understandable extension or exaggeration of normality. Sometimes mental illness can be successfully understood and familiarised by anchoring it into commonly shared or 'normal' experiences. At other times this link disappear, no anchors into 'normal experiences' are found, and mental illness remains an incomprehensible and unfamiliar 'other'. If a split can be made, it is between neurosis

11 For example, Freud (1962) comments '(t)he neuroses have no psychical content that is peculiar to them and that might not equally be found in healthy people. Or, as Jung has expressed it, neurotics fall ill of the same complexes against which we healthy people struggle as well.'

as 'similarity' and psychosis as 'otherness'. Depending on its form, mental illness appears to oscillate between being familiarised as 'similarity' and remaining an unfamiliar and un-understandable 'other'. This coexistence of contrasting themes illustrates the ambiguity, uncertainty and multiplicity which characterise professional representations of mental illness. It is argued in Chapter 8 that this ambivalence and uncertainty is an important source of the threat which imbues social representations of mental illness. Ambivalence challenges understandings of mental illness as definitively 'other', and undermines 'safe' differentiation and distancing from the self of this psycho-socially feared phenomenon.

2.2 Disruption

> I: I'm interested to know what for you personally, your concept of mental illness is?
> B9: I see it, I suppose, as an illness where your perception changes in such a way that you cannot function to a level that you normally function at. Something that actually changes your ability to be and to live as you normally live. What seems to be important is how the person fits or doesn't fit with social norms.

> 'Mental illness is showing symptoms which prevent the person who has the symptoms leading a satisfactory life. There are some people who have symptoms and manage to live with them. There are others for whom they're invalidating or for whom they carry a level of psychic suffering which is difficult or unbearable.' (F30)

> 'Mental illness is not being able to make decisions which effect your life. Not being able to cope in society. And being unable to ask for help probably.... I don't think there's a clear definition. Probably some people would say it was showing certain signs and symptoms - I don't think so. It's some sort of coping thing, brought on by a lot of different reasons.' (B11)

The second key theme of professionals' conceptualisations of mental illness is disruption. Like the theme of difference, disruption provides an essentially social understanding of mental illness. What is central to the state of mental ill health is not the presence of 'symptoms' *per se*, but their impact on a person's life. To be mentally ill is to have your personal and social life disrupted. This is frequently described by British respondents as problems of 'social functioning' or 'coping'. Mental illness is something which disrupts relationships and the person's ability to live life in a way which is acceptable, both in relation to their own life-style norms and in comparison to social norms. It is this disruption of day-to-day life that much of the work of mental health professionals targets (see Chapter 6), suggesting that professionals envisage these features of mental distress as relatively changeable and fluid.

Again, however, this is not a fixed and unquestioned representational theme, but one which inspires debate and reflection. There are echoes here of the anti-psychiatric / sociological position on mental illness as an unacceptable form of social deviance, and the moral and coercive ramifications of mental illness as disruption are not lost on professionals. In their explicit interview narratives, some professionals attempt to counter the more implicit themes of lacking, inability and weakness and the need for this to be made socially acceptable. Mental illness is reconceptualised by a minority of interview respondents, not as a lack of social functioning or coping skills, but as a way of coping in itself. There is an attempt here to revalue difference, and to offer a point of access or 'anchor' into what is generally taken to be an un-understandable way of being by applying rationality-based folk theories of mind. What appears to be different is not necessarily incomprehensible, but can be understood as the implementation of certain strategies which may be familiar and make sense to the representor. For example:

> 'For me, madness is another way of managing compared to what is the usual way. Generally speaking that's what it is, but it's as good as the position that everyone else has most of the time, it's just another way of coping with things.' (F4)
>
> I: What does the concept of mental illness mean for you personally?
> B20: Well I suppose I think of it - off the top of my head - as an individual's psychological and physical system coping with the environment. Coping with various demands and pressures from outside, from the environment and also from the individual's response to that. And I suppose I think of the person as a system that is a mind and a body, and the solution to the stressful situation is a dysfunctional one. The managing, the coping mechanism is dysfunctional - it has large unfortunate consequences in some areas of life. So I see it as way of coping I suppose.

2.3 Distress

The third key area which completes the triad of 'social' themes through which basic conceptualisations of mental illness are constructed is distress. Descriptions of mental illness as involving distressing experiences are found in the interview narratives of respondents from across the range of professional groups in both France and Britain. Feelings of fear, often associated with a sense of loss of control, hopelessness and depression are most typically cited. As the second of the interview extracts below illustrates, professionals can use a person's report of distress as a tangible, pragmatic criterion for mental illness, which effectively by-passes other more complicated and uncertain issues surrounding the nature of mental ill health. But distress is also given a

social slant in that it is conceptualised both as a direct subjective experience, and as a feeling deriving from the person's position in relation to others. For example, the mentally ill are frequently described as experiencing a sense of alienation and misunderstanding, prejudice and stigma by others, together with an awareness of falling outside social norms. In other words, distress is a potent combination of subjective experiences and 'self as object' evaluations which are tied up with themes of difference and disruption. For example:-

> I: Could you describe how you see the state of being mentally unwell?
> B26: It's a nightmare. It's strange - the worst thing that people experience and talk about mostly is the tremendous sense of isolation and being alone, and being misunderstood, and nobody can actually understand what they are going through. And it's frightening, the absolute terror of it all. And not being in control of their lives. It's as if the illness is controlling them and they have no control over it. A lot of people describe it like a blackness around them - like a shroud. Lots of people come up with different descriptions, but they all sort of tie in. And also the guilt about suffering mental illness and stigma and all those types of things. And being different. And seeing themselves as not functioning as other people, not being normal - "I'm not normal, there's something wrong with me."
>
> I: What would you say mental illness is for you?
> F9: That's a difficult question you're asking, it touches more on philosophy .... we're not really used to asking ourselves those sort of questions! For me, for the time being, mental illness is something very concrete - it's someone who comes to see me and says 'I'm suffering, I don't feel right in myself, things aren't going well, help me'.

This theme of distress adds further complications to the 'otherness' theme explored in section 2.1. The recognition of distress requires an ability to empathise - a link between the self and the experiences of the mentally ill person, between representor and what is represented. Rather than remaining an incomprehensible 'other', the existence of distress as one of the core themes in professional representations suggests that, to some extent at least, professionals are willing and able to represent mental illness in ways which parallel rather than contrast with their own subjective experiences. Distress provides a way of making sense of mental illness by anchoring it into one's own subjectivity. 'Similarity' wins over 'otherness'.

This theme is also a radical departure from lay representations in which the distress of the mentally ill person is typically negated. In lay knowledge the mentally ill are usually represented as distress<u>ing</u> (typically in inspiring fear) rather than distress<u>ed</u>, and this is an important constituent of mental illness as a feared and rejected 'other'. In comparison, in professional representations there is a tension between these subjective

and objective forms of distress. In their daily practice, professionals face the moral dilemma of how to respond to people who are more distressing (to their family, or to society in general) than subjectively distressed themselves. Their expert status often demands that they are the final arbitrators in this ethical issue. As our 'key' respondent F17 (see footnote 10) suggests, this throws up questions about the whole *raison d'etre* of mental health work. Perhaps this is why many professionals do not reflect on the representational themes which they live out in daily practice, and struggle to articulate these ideas in the interview setting[12].

> 'What does it mean to care for a mentally ill person? ... It's a double edged sword, because you see the real psychotics and the schizophrenics, and they're not asking you for anything, these guys, they're fine. There are some, of course, who do suffer terribly, but there are others who seem to be almost euphoric all the time, who seem to be completely happy. In fact, I think that the care work we do is a response to a demand which isn't theirs. What are they asking from us? It's very rare for the patient to say 'get me out of this'. .... We can't tolerate the suffering of others, we can't tolerate them having a deviant attitude. In fact, what I think we're trying to do is to readapt them to the system which we belong to ourselves. But, having said that, fortunately I don't work believing that, because if I did, I don't think it would be possible. That would be like saying, in a way, that madness is alright, that it's alright not to do anything with madness. If you think philosophically, that's what we're doing - readapting someone who doesn't necessarily want to be readapted.' (F17)

2.4 Danger?

Social representations of mental illness detected in research with lay people are replete with themes of danger and violence associated with reactions of fear and threat. What happens to these representational themes when lay people become professionals? Does their professional training and experience eradicate themes of danger, or does this endure in some way within professional representations? On an explicit level, the theme of danger is not a defining feature of professionals' representations of mental illness in the ways that difference, distress and disruption are. It seems that professional training serves to reduce associations with violence and physical danger from a core characteristic which is synonymous with societal understandings of mental illness, to one of many representational themes in the world of mental health professionals. For example, the

12 On a pragmatic level, pressure of work also prevents mental health professionals taking a more reflexive stance on their day-to-day practice.

risk of suicide or violent behaviour by patients is referred to by interview respondents as just one of many aspects of their daily work.

However, physical violence is not the only form of danger which emerges from professionals' narratives. There are also references to a more implicit form of psychological danger. This emerges from the potent combination of two psychologically threatening aspects of mental health work - proximity to the distress of others, and uncertainty. References to the stressful nature of mental health work are common, and it is clear that practitioners' daily work requires much psychological investment. Practitioners often talk about the need to be strong, to have personal equilibrium and to protect oneself. The distress of others can become too distressing if it is allowed to permeate the boundaries between self and other. Mental health professionals work with a constant sense of psychological risk and threat to the integrity of the self associated with the distress of others. This sets up a tension between the needs of self and the needs of others associated with the notion of being a 'professional carer'. Later in the thesis (Chapter 8) it will be suggested that one of the principle functions of professional social representations is to aid the reconciliation and integration of such tensions and paradoxes.

The following interview extracts illustrate this sense of both physical and psychological danger which derives as much from a sense of uncertainty and unpredictability as from the difficulties of being confronted with physical violence and distress in others.

> 'I think I'm going to stop working in psychiatry because it's a job which is too difficult. ... There are some very difficult cases in which the person is always in a state where you have to keep a distance and protect yourself, and it's really hard to learn anything about them so you can help them. And you don't always succeed - you can be confronted with patients who kill themselves, with people who spend their lives in psychiatric services, with extremely violent patients. And you're always wondering if you've done the right thing - when you go home you're wondering "what is he going to do?" ... You have to protect yourself. And you have to come to the realisation that you can't stop a patient from killing himself, that you're taking risks. Like when you send a violent patient back to his family, you're placing trust in him, but you can't prevent everything.' (F13)

> I: What personal qualities do you think you should aim to have to be a good professional working in mental health?
> B19: I think you need a very good sense of your own self identity. Because I think that quite often people that you see are very vulnerable, very damaged, very disturbed. .... I think you need to be quite a strong person, especially if you're working with people with long term needs. Because it can feel a bit gloomy otherwise.

'You need to have stamina. You need to be able to expose yourself to the pain of others, and here [a 24 hour community centre] you are a lot less protected from that than in hospital work, in my experience. You need to be flexible as well, you need to be adaptive.' (F2)

The model of professional social representations proposed in Chapter 3 conceptualises lay knowledge as a component of the representational field, which may exist in a more hidden or implicit form than other aspects of professional knowledge (see section 2.5). This data offers tentative support for this theoretical prediction, illustrating that the theme of mental illness as a dangerous, threatening and powerful form of otherness is not absent from professional representations. Neither is it explicitly verbalised, but hidden more subtly within professional discourses of risk. Paradoxically, mental illness is associated with both fragility or weakness and danger / power, another example of the ambiguities which surround mental illness. This analysis also suggests that there is not merely a reduction in the importance of danger themes compared to lay understandings, but that danger is reconceptualised in ways which are congruent with the agendas and concerns of professionals. Whilst professionals recognise that the risk of physical violence and danger may be less than is commonly supposed by the lay population, they are concerned, as publicly accountable 'experts', with the need to specify risk. Their daily work involves a stressful combination of being unable to control or definitively tie down this risk, together with their psychological proximity to the distress of mental illness, and a professional responsibility for the safety and well-being of their patients and those who associate with them. Danger in professional social representations is reconceptualised into discourses of stress and risk.

3 Multi-causal Models: An Agnostic Stance

Section 2 has established that professionals' basic conceptualisations of mental illness are essentially social, and that the debate which permeates these representations revolves around themes of difference, distress and disruption. From this starting point, we turn now to how professionals understand the causes of mental ill health. Two essential features of these models are multiplicity (of causal factors) and uncertainty. Firstly, mental health professionals construct eclectic explanatory accounts of mental illness which integrate ideas from diverse theoretical origins. Whilst various spheres of esoteric, 'expert' knowledge are re-presented within professional representations, these models also

show some similarities with lay understandings of (mental) health and illness. Secondly, an agnostic stance to the causes of mental ill health is typical. Mental health professionals assume that their aetiological models are nothing more than provisional, and that definitive understandings of the causes of mental illness are not possible. Despite their status as 'experts', interview respondents feel that their knowledge of the aetiology of mental illness is limited[13].

These characteristics support initial expectations regarding professional representations of mental illness set out in Chapter 3, section 3.3. Diversity and multiplicity of knowledge spheres has been detected in previous research on the world of mental health, and the provisional, partial and continually changing nature of expert knowledge and theoretical systems was also noted. Furthermore, multiplicity and uncertainty are related. It is because of their uncertainty regarding expert knowledge of causal factors that professionals generally opt for an eclectic position. For example:-

> I: What about your ideas of causes of mental ill-health?
> B3: Well I'm as little of an expert as anyone else on that. I'm sure you know there are various theories and schools of thought about contributive factors. I don't have my particular hobby horse that I would think, oh this is what I think - it's definitely environment and I exclude everything else, or it's definitely brain chemistry or whatever. I'm sure it's elements of all those things. And nobody actually knows enough to say it's definitely this. So in a way you work with all of them. I'm sure all of them have relevance and application at different times and with different clients. Some are more obvious causes with some clients than with others. So I'm open to all that stuff definitely - environmental, genetic, chemical, etc. But I don't have my own pet theory that I use as a tool to work with.

The absence of definitive expert knowledge opens up a space for professionals to construct their own causal models of mental illness which integrate ideas originating in several theoretical perspectives whilst also retaining a compatibility with common sense belief systems. Section 3.1 below explores these models and their components in more detail. Although when looking across the whole sample of interview data, a common

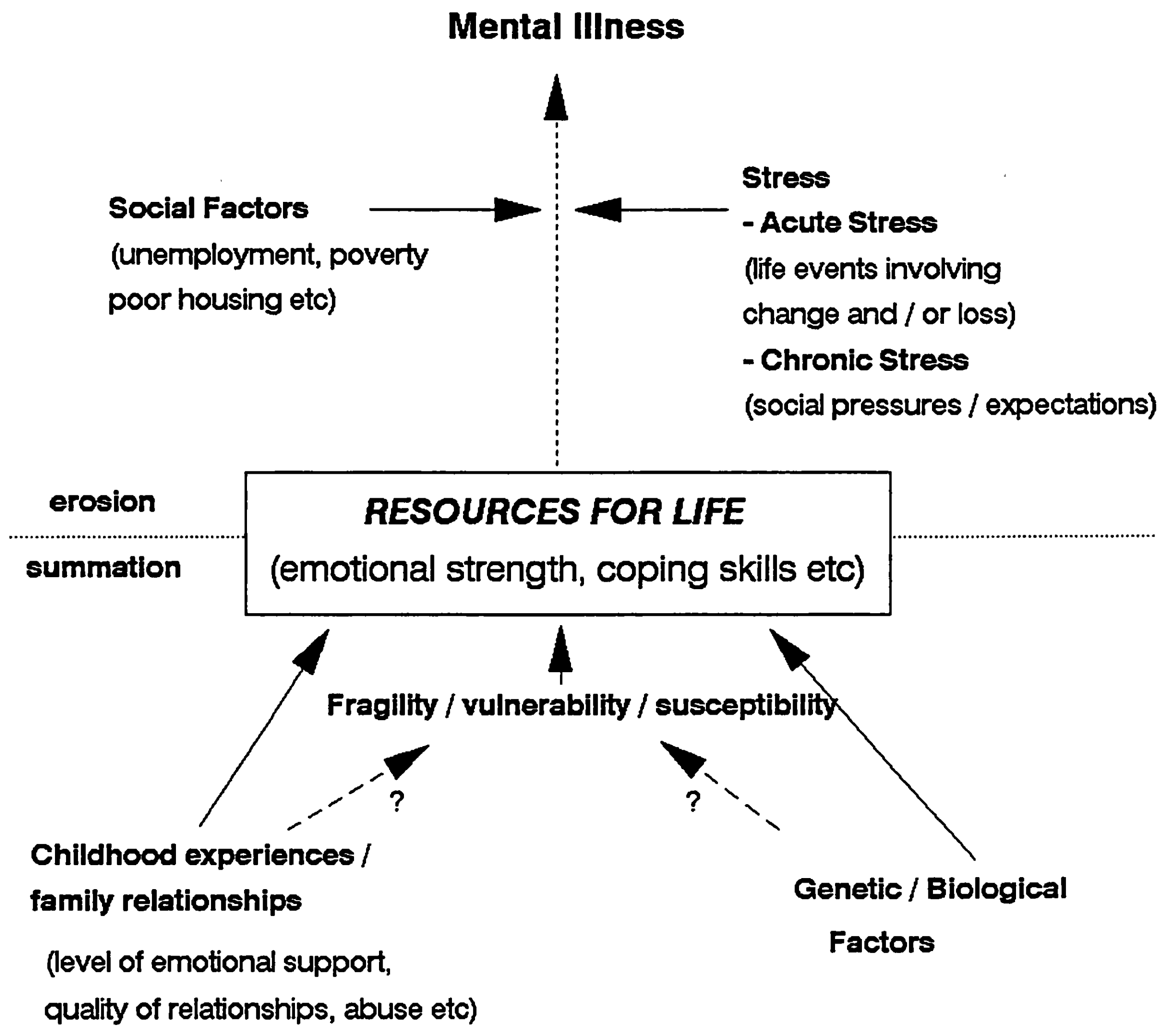
13 These two features of professionals' causal models are demonstrated quantitatively in the allocations of text units to data analytic codes. For example, when asked in interviews to speculate about aetiology, 38% of respondents state explicitly that they don't know or are very unsure about the causes of mental health problems, (although the majority of these respondents (16 out of 23) then go on to offer some tentative suggestions about causal factors). A common strategy is to justify this uncertainty by reference to the limited state of expert knowledge and the inconclusive nature of research findings in the field of mental health. Multiplicity and eclecticism is demonstrated by the fact that of the 53 respondents who provide at least some account of the causes of mental ill health, 42 refer to two or more causal factors, and 28 to three or more potential causes.

causal model uniting professionals of different disciplines in both France and Britain can be elaborated, significant variations on this theme also exist. In particular, French and British professionals typically give different weights to various causal factors. These cross-cultural differences are discussed in section 3.2. Secondly, differential weightings of the components in this model are another important way in which various forms of mental illness are compared and contrasted. Again the most significant differentiation is between neuroses and psychoses. This is the focus of section 3.3.

3.1 Building and Eroding Life Resources

Despite their agnostic stance, professionals nevertheless construct hypothetical models which implicate a relatively consistent web of factors in a 'bio-psycho-social' model. Their basic causal model is summarised graphically in Figure 5.3 below. This illustrates how professionals' causal understandings take a 'balance sheet' format, consisting of the summation and negation of factors which increase or decrease the likelihood of mental illness. Factors 'within' the individual are played off against aetiological factors in the social environment. The former, which can be termed a person's 'resources for life', are made up of the combined effects of childhood experiences, family relationships and genetic / biological factors. Problems in either or both of these areas are associated with the notion of fragility or vulnerability, which equates to diminished life resources. This stock of emotional strength and coping skills is what individuals take with them into the social world. Experiences within the social world, particularly difficult social circumstances and stress, are seen as potential eroders of a person's life resources. If the person has fewer resources to draw on, is 'fragile' or 'vulnerable', they may act as contributors to the risk of mental illness or as 'triggers' which may provoke the onset or relapse of mental illness. Other people whose internal resources are stronger tackle these hurdles more successfully, and so do not become mentally ill. This model of contributory factors which interact over time provides professionals with an implicit computational device to assess how and why a person becomes mentally ill. Mental illness can be explained as the outweighing of a person's 'resources for life' by factors which can contribute to mental illness or erode mental health.

Figure 5.3: A Multi-causal Model of Mental Illness



This integrative computational causal model includes notions of the family, childhood experiences, biology, stress and fragility. Professionals typically account for mental illness using two or more of these factors such than none of them is seen to explain mental illness on its own or lead directly to mental health problems. The analysis which follows explores each of these concepts and their origins in expert theories of mental illness in more detail.

Most important is the theme that family relationships and childhood experiences can lead to mental illness in later life. This is detected in 73% of interview transcripts (n=44, 21 in France, 23 in Britain) and is often cited as the principle causal factor. For example:-

> I: What ideas do you have about causes of mental illnesses?
> B2: I think there are so many different causes, but that it very often goes back to having had poor or inadequate care at an early stage. And I think that it's not that everyone who has had inadequate care at an early stage will then go on to develop mental illness, but I think if you then aren't able to establish meaningful relationships or some sort of safety around you, then you're very vulnerable to stresses, to losses, because you haven't got any experience of something solid behind you really. I think that it very often goes back to that, and particularly if someone has been in a situation where in whatever way, they've been abused - it makes one more vulnerable.

> I: What do you see as the causes of mental illness?
> F6: It's difficult, often it goes back to early childhood. Usually there have been some emotional deficiencies. Emotional deficiencies - lack of affection in important areas. Often people haven't had any orientation at the parental level, from their mother and father who often may not have been around, they may have been brought up by someone else, so that from the very beginning they didn't have the things that a person needs for a stable life in the future .... People also talk a lot again about childhood abuse and the absence of bench marks, which can lead to social alienation.

Aspects such as difficult family dynamics, relationships with parents, lack of emotional support and various other experiences during childhood are often cited as causal factors. References to child abuse (psychological, physical and sexual) are common, particularly amongst British respondents, perhaps reflecting the high social profile of child abuse in Britain during the period when interviews were conducted. Theoretically, the origins of these views are multiple. While many interview respondents, especially in France, offer psychodynamic accounts of how early family experiences are associated with mental illness, there are also traces of learning theories and family systemic approaches which implicate the family in suggesting the impact of early socialisation and of communication patterns and dysfunctional family dynamics. The continual implication of the family

throughout the last hundred years of mental health care is charted by Prior (1993) who notes how the various features of family life have received attention according to the *zeitgeist* of the times. In this study, the focus is generally on relational and emotional features of the family. This suggests a 'relational' understanding of mental illness which complements themes of mental illness as a social phenomenon, and is also detected in the importance professionals place on relationships in the care and treatment of mental illness (see Chapter 6).

However, another way in which the family is implicated by mental health professionals is through genetic inheritance. The origins of these views can be clearly located in the medical model of mental illness, to which modern explanations in terms of organic factors (chemical imbalances and brain structure) can also be attributed (although notions of an organic basis to mental illness can also be traced further back into pre-medical belief systems). After early family experiences, genetic / biological factors are the second most commonly cited causal explanations, provided by just over half of interview respondents (n=32). However, as sections 3.2 and 3.3 illustrate, the use of these causal accounts varies as a function of the nationality of the speaker and the type of mental health problems referred to. Specifically, medical accounts are more commonly used by British respondents (by 25 out of 30 British respondents compared to only 7 French respondents), and (by professionals in both countries) when explaining illnesses falling under the umbrella term 'psychosis'.

The notion of 'fragility' which is used by professionals to describe mental illness also occurs in their explanatory accounts (detectable in 28% of interviews). 'Fragility', 'vulnerability' or 'susceptibility' are ways of differentiating the mentally ill as people who are weaker than others and who lack the strength and coping skills necessary for social life. Notions of fragility feature in common sense understandings of mental illness[14], and cannot be attributed to any specific expert theories. In some cases, professionals anchor fragility into modern genetic theories or psychodynamic views of the impact of early childhood experiences. However, for the most part, the origins and specific nature of this fragility are left unarticulated. For example:-

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14 For example, organic or character weaknesses and their opposites, 'inner strength' / strength of character are implicated in the genesis of mental illness following trauma in the lay community studied by Jodelet (1991a).

I: Why do you think it (mental illness) affects one person and not another?
F8: I don't know. People talk about fragility, perhaps at the genetic level. That wouldn't be a direct cause of mental illness, but it would be a fragility which you might have within you, which risks evolving into a manifest pathology that might come out if the fragility is activated by an unfavourable environment.

'Why some people are affected more than others? - that is something I see - a member of a family will have mental illness and not others - and I think maybe one of the reasons is to do with the personality of that individual, and maybe how emotionally strong he can be. People get hardened emotionally as a way to protect themselves, and sometimes people can't. And if they can't, they get an influx of messages, emotions that they can't defend themselves against. ... I think we have ways of coping with things. We can cut off to protect ourselves. In some cases I think people don't have a cut off point. So they get affected more emotionally, which can make them tip.' (B13)

Against the effects of genetic / biological factors, family relationships, childhood experiences, and the notion of fragility, professionals bring a second set of causal factors into play. Various forms of stress and social factors are conceptualised as potentially provoking or increasing the risk of mental illness. These accounts (detectable in 65% of interviews) range from a few radically social accounts of mental illness which draw on critical left-wing and anti-psychiatry arguments (ie that mental illness is a form of deviance or is the product of the maintenance of an underclass within the capitalist system)[15] to, more typically, accounts which implicate social stressors as contributory factors in multi-causal models. Factors such as unemployment, poverty, poor housing and social and cultural marginalisation are cited. The notion of 'stress' provides the link between a person's social circumstances and their mental health status. Stress is described both as a chronic state associated with general social circumstances, and as an acute reaction to a particular situation or event. Life events revolving around change and loss (for example, bereavement, change or loss of job, moving house and ending close relationships) are often described as 'triggers' to mental illness or to a relapse of mental health problems. The following interview extracts give a flavour of the role of stress and social factors in professionals' causal narratives:

'It [mental illness] is constitutional, which is why it's important to know about people's family histories, and also it's to do with relationships. Having said that, I would be perfectly willing to discuss how that is obviously affected by the kind of area you live in, the state of your flat etc. Nevertheless, many people can live in very deprived situations and don't end

15 Although hints at anti-psychiatric views are found in several interview narratives, two British respondents adopt this more radical stance. Interestingly, one (a CPN) also describes, at another point in the interview, how much of his daily work involves the administration of long-acting medication. This illustrates both the coexistence of diverse themes and the weak links between abstract beliefs and practice within professional social representations (see Chapter 6, section 3).

up ill. I can't see that as a total explanation. But obviously there are stressors which play a part. Like unemployment, money worries.' (B20)

'Well, you know...to find a cause for mental illness is extremely difficult. People talk generally about stress... in the sense that it makes the person confused with respect to the meaning he's given to his life up till then. For example....suppose you had taken a certain direction in your life, and then something destabilises you, an enormous stress, which means that all of a sudden your life makes no sense any more, you say to yourself "what's the point" etc. I think that at that point we can say there's a cause there. But your neighbour, to whom the same thing happens, may not show the same mental illness as you...' (F8)

While professionals' accounts of the role of social factors in mental illness can be traced quite directly to expert theories and research highlighting the social origins of mental health problems (most famously, Brown & Harris, 1978), stress discourses can be traced across a much more diffuse range of both expert and lay knowledge systems. Almost all expert models of mental illness implement the concept of stress in some way, usually as a mediating factor linking aspects of physiology, cognition or experience to factors in the outside world. Stress is conceptualised both biologically / physiologically (for example, Sterling & Eyer 1981; Toates 1996) and psychologically (for example in the literature on life events (eg Cochrane & Robertson 1973)). It is also becoming an increasingly important concept in expert discourses on general health and illness. As Helman (1990) notes, the concept of stress has undergone a dramatic increase in importance in all areas of western medicine over the last fifty years, conceptualised variously as a causal or contributory factor in illness, a factor which reduces resistance to health problems, or as an inadequate adaptation to change. 'Stress' is also a key concept in lay discourses, as several studies have shown (for example Furnham & Bower (1992) on lay understandings of schizophrenia, Stainton-Rogers (1991) on lay models of health and illness). Lay concepts of stress are typically of a diffuse and invisible 'force' which mediates between the individual and their social environment, and which is combined in lay thinking with older explanations for disease and misfortune (Helman, 1990). Young (1980) argues that the notion of stress in contemporary western society is congruent with the rise of individualism in emphasizing individuals' responsibilities for their health status and down-playing social determinants. The position of stress in professionals' aetiological models of mental illness should be understood, therefore, as a manifestation of more global ways in which contemporary western societies make sense of the links between the experiences of individuals and the social environment.

Similarly, the general structure of the explanatory model of mental illness detected in this research shows consistencies with other lay belief systems, reminding us of the location of professional knowledge within a broader tapestry of culturally and historically rooted systems of thought and social practices. Although professionals' accounts of the causes of mental ill health are phrased in the language of modern expert knowledge, the concepts they implicate echo those of more archaic pre-medical and pre-scientific lay belief systems. For example, the notion of erosion of internal resources by the social environment emerges consistently in western lay understandings of physical and mental illness (for example, Herzlich, 1973[16] and Stainton-Rogers, 1991 on lay concepts of health and illness; Jodelet, 1991a on madness; Hallam, 1994 on lay and expert notions of anxiety). The outside world as a depletor of individual resources or source of attack - whether this is by germs, stress, or physical factors - is a common theme. It suggests an antagonistic and oppositional relationship between the individual and society, and couches explanation of illness in essentially social terms. Implicit within this is a collective representation of modern society as potentially hostile and a source of demands on the individual, and of social life as the successful negotiation of external challenges. It is invariably the modern, urban, social environment and its association with excesses and imbalances, rather than the natural or rural environment which is implicated as a source or provoker of illness. Individuals need internal strength and resources to cope with the demands of social life and those who are weaker, more fragile or have less robust internal resources may succumb to mental or physical illness. Forms of illness may be partially understood in terms of factors within the isolated individual, but they are more fully explained, by lay people and professionals alike, as the result of on-going interactions between the person and the social world. The tension between the individual and the social in these models is consistent with the basic values of modern western individualism, in which the person is assumed to be a bounded, independent and unitary being, and in which a strong separation between the individual and the social world is made.

16 There are particularly strong parallels with the 'reserve of health' representations detected by Herzlich (1973) as one of three coexistent understandings of physical well-being amongst middle-class Parisians. Similar to a person's 'resources for life', a 'reserve of health' (physical robustness and a resistance to fatigue and illness) is seen as constitutional, developed in childhood and potentially eroded by life-style.

3.2 Franco-British Differences: Psychodynamic and medico-social models

The causal model elaborated above encapsulates how both British and French mental health professionals account for mental illness by drawing upon and integrating several expert discourses. However, when the sample of interview respondents is split along national lines, some interesting cross-cultural differences emerge in the weighting and combination of hypothetical causal factors. These suggest a differential impact of the various expert theoretical positions on mental ill health on either side of The Channel.

Professionals in France place relatively more weight on childhood experiences as the principle cause of mental health problems in later life[17]. That French professionals draw on ideas originating in or consistent with psychodynamic theories confirms the dominance of psychoanalysis as an influential and widely diffused social representation in contemporary French society (Turkle, 1979). Even though several French interview respondents and key informants perceive a recent diminishing of interest in psychodynamic ideas in the world of mental health in France (with a corresponding perceived rise of medical and cognitive approaches), the legacy of the huge proliferation and influence of psychodynamic ideas in France during the post World War II decades is clearly detectable in interview accounts with professionals in the 1990s. In comparison, psychodynamic themes are only one of several expert discourses which are voiced by British respondents. British professionals place relatively more emphasis on both medical and social factors in constructing their causal accounts of mental illness[18]. A bio-psycho-social causal model is most favoured by British respondents, the most common combination of causal factors cited in interviews being genetics / biology, childhood experiences and stress / social factors (this combination is detectable in 16 British interviews).

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17 This is indicated in the data both thematically and quantitatively. In quantitative terms, although references to childhood experiences and family relations occur with equal frequency in British and French samples, there are relatively fewer references to other causal factors by French respondents. Of a total of 11 respondents who cite only one causal factor, nine of these are French respondents who use psychodynamic themes alone in their explanatory accounts.

18 This is confirmed quantitatively by the relative use of data codes. Chi-squared tests show that the greater frequency of the 'genetics / biology' code in the British sample compared to the French sample is statistically significant at $p<0.001$. References to social factors and to stress are also significantly more frequent in the British sample ($p<0.01$).

Many of the discourses implicating social factors (for example, poverty, unemployment, bereavement, stress, prejudice and so on) have their origins in academic and research activity conducted in the English language. These include the anti-psychiatry movement, labelling theories, social psychiatry and associated research into social support and life events. The Anglo-American origins of these knowledge systems offers a plausible reason for why social factors feature more heavily in British professionals' accounts of the causes of mental ill health. However, the greater influence of medical explanations, which derive from a genuinely international paradigm is more complex.

There are several indications that in the British world of mental health, unlike in its French counterpart, the medical model has the status of a dominant paradigm. Medical terminology is more common in the language of British professionals (see section 1), and even for those British respondents who reject medical terminology or explain mental illness in other ways, medical approaches are a constant reference point. Despite a profusion of other expert theories, the power and influence of medical perspectives in Britain remains considerable, exerting itself as a 'default' against which alternative perspectives must define themselves, and as a perspective which professionals find it hard not to take account of. Of the 30 British respondents, 25 draw upon medical discourses in some way. This group includes all the British psychiatrists, psychiatric nurses and psychologists interviewed. (Those who do not refer to medically based causes are occupational therapists and social workers.) The differences between British and French professionals are particularly marked amongst psychiatrists, the professional group that might be most expected to endorse a medical perspective. Compared to references to genetic / biological causes by all the British psychiatrists in the interview sample, five of the six French psychiatrists make no explicit references to medical causes. Although psychiatrists in both countries go through a similar medical training, it seems that medical theories have a stronger impact on the causal models of British psychiatrists. In comparison, French professionals (from all disciplines) appear to be freer to talk about mental health problems in non-medical ways (as 'madness'), and to construct causal models of mental illness which take no account of medical perspectives (even though, as we will see in Chapter 6, they make as much use as their British colleagues of medical treatments).

3.3 Explaining Neurosis and Psychosis

As well as these cross-national differences, professionals' causal representations vary according to the specific form of mental distress being accounted for. These explanatory accounts reinforce the important distinctions professionals perceive between neurotic and psychotic illnesses. This differentiation is set up, not through the use of different causal models for different types of mental distress, but through the differential weighting or importance accorded to specific factors within the generic causal model described in section 3.1. Broadly speaking, neuroses are attributed more to relational factors and experiences in the social world (for example chronic stress, or traumatic life events). For psychoses there is a greater tendency to cite genetic / organic causal factors. Not surprisingly, this split is also detectable in the expert literature. For example, DSM-IV (1994), ICD-10 (1992) and The Oxford Textbook of Psychiatry (1989) all limit biological / organic explanations to psychotic disorders, typically defining 'neurotic' problems in negative terms as the absence of demonstrable organic disorder. A second important distinction is that professionals' uncertainty is markedly higher in relation to the causes of psychotic illnesses, compared to their causal models of neuroses. For example:-

> 'The neuroses are relatively well charted now. Their causes are those formative and emotional moments during the period of growing up which went wrong or were associated with bad experiences. It's really causes of an emotional nature in the widest sense. Psychosis is something completely different. For psychosis I would be very cautious. I have absolutely no idea where psychosis comes from.' (F24)

> 'There is chemical imbalances in the brain - that's been proven. I'm talking largely about schizophrenia and psychotic type illnesses. Obviously things like anxiety states, I believe that anxiety states and neurotic states are based on life events and life circumstances. I think a whole lot of things like that come into play - like poverty, just basically having a very, very hard life, can probably provoke an anxiety or neurotic state, or depressive state.' (B6)

> 'I see psychosis very much in a biochemical way, in a genetic way, but certainly precipitated and influenced by environmental factors to a very large extent. Things like life events, bereavements, social stresses, loss of any sort really, financial difficulties, family difficulties. In somebody who is medically predisposed to mental illness. ... Much wider issues I think are at the root of a lot of neuroses. Certainly past personal events, upbringing and family circumstances are very much more in my mind, contributory to neurotic illnesses although they are also very, very important in psychotic illness as well.' (B8)

The combination of a greater sense of ignorance, and the importance attributed to genes and biology serves to reinforce the construction of psychosis as a fundamental and un-knowable form of otherness. It builds on the notion of psychosis as a qualitatively

different, permanent, trait-like phenomenon which is likely to reappear throughout a person's life. The genetic make-up of a psychotic person marks him out as different from birth. It also implies that people without this different form of genetic make-up, brain structure or chemical imbalance are safe from psychotic break-down. Although professionals are unable to cite any definitive proof, the suggestion of a genetic basis for psychosis, implicit in contemporary scientific interest in bio-technology and genetic research, may be psycho-socially attractive: Not only could this offer a way of anchoring the elusive and intangible notion of mental illness, but it also suggests that people suffering from what are seen as the most serious, dangerous and undermining mental health problems could be definitely identified and categorised as 'other' and different from self / in-group. However, the flip-side of this argument is that explaining neurotic problems more in terms of social circumstances or relational difficulties opens up the possibility of neurosis in anyone. The representation of neurosis as an exaggerated form of 'normal' experiences, which is temporary and relatively open to change, may render this a more acceptable and less fearful possibility.

To summarise the themes which have emerged in this chapter, it seems that there is something essentially intangible and unknowable about mental illness which generates an agnostic stance, not only amongst lay people, but within the professional community. At a most basic level, professionals are fundamentally uncertain about questions such as what constitutes mental illness, where the boundaries of mental illness lie, and what causes mental health problems. As we will see in Chapter 7, in their requirements for rapid and radical changes in working practices, contemporary community care policies have the effect of amplifying the uncertainties which permeate this professional community. This is in sharp contrast to society's expectations that mental health professionals have some kind of definite and privileged understanding of mental illness. Whilst the explicit debate and reflexivity which characterise professionals' interview responses is a testament to the active nature of their social representations and their continual struggle to make sense of and grasp the elusive notion of mental ill health, they only ever seem to arrive at provisional and tentative understandings.

Nevertheless, practitioners in France and Britain across the range of professional groups are united in perceiving a common battle-ground and reference points for the debate over making sense of mental illness. Their understandings are united by the assumption that mental illness is a social phenomenon. In other words, the mental health problems of an individual can only be understood with respect to the social world in which they participate. Mental illness is represented as experiences and social behaviour which are in some way different from the norm, distressing (to either the person or to other people), and disruptive of social life and personal relationships.

Beyond the universality of these most basic conceptualisations, professionals construct causal understandings of mental ill health which borrow from the various theoretical perspectives differently depending on their nationality. The influence of psychodynamic theorising is felt more amongst the French sample, whereas in Britain echoes of medical and social perspectives are more strongly detected. Beyond this, it is not possible at this representational level, to differentiate practitioners further in terms of their professional groupings. Interview respondents typically construct multi-factorial understandings of the causes of mental illness which borrow from (but do not simply reflect) several modern expert knowledge systems, whilst retaining some consistencies with lay understandings of health and illness. It seems that no one theoretical system provides a sufficiently rich and definitive account of mental illness for professionals to anchor their understandings into a single expert model unconditionally. Despite the potential incompatibilities of these knowledge forms in their pure forms (for example, in the ways they conceptualise and explain mental health problems), they are successfully combined within professional representations. The integrative 'balance sheet' models that professionals construct are sufficiently complex to allow them to account for why mental illness occurs in one person and not another, and for why different individuals experience different forms of mental distress. These causal belief systems highlight a 'relational' theme which complements professionals' understanding of mental illness as a social phenomenon. Mental illness is both explained and described as something associated with problems or disruptions in relationships. As will be shown in the following chapter, this 'relational' understanding is lived out in professionals' practical work with the mentally ill in which they conceptualise professional-client relationships as the building blocks of any treatment strategy.

In comparison to common sense understandings, the themes in this chapter do not suggest a blanket rejection of mental illness based on fear and suspicion. Professional representations allow more space for ambiguity and ambivalence regarding the theme of difference and 'otherness'. The notion of the mentally ill as fundamentally and permanently different and 'other', which is at the core of common sense understandings, is present in professional representations, but is most often limited to problems defined as 'psychotic'. Professionals construct mental illness as an ambivalent form of otherness, a phenomenon which is paradoxically both weak and powerful. Themes of internal fragility and weakness, as both descriptions and explanations for mental illness, coexist with the power of mental illness to generate disturbance in others, and stress and psychological burden in professionals. The mentally ill are both fragile and dangerous, liable to an ill-defined risk of violent or unpredictable behaviour. For professionals, mental illness is not definitely 'other' - 'otherness' coexists with its opposite - similarity. The later is most frequently associated with problems defined as 'neuroses'. Ways of making sense of mental illness by anchoring it into other more 'normal' experiences and empathising with the experience of distress are part of these professional representations of mental illness as a polymorphous category.

The polymorphic nature of mental illness based around the distinction between neurosis and psychosis, the triad of difference, distress and disruption, and the characteristics of uncertainty and eclecticism are basic themes which underpin all aspects of professional social representations. The following chapter illustrates how these themes and characteristics are lived out in the daily practical work of mental health professionals.

CHAPTER 6

WORKING WITH THE MENTALLY ILL: SOCIAL MANAGEMENT AND INFORMAL ECLECTICISM

Having charted the semantic bed-rock of professional representations of mental illness in Chapter 5, this chapter investigates how these themes are lived out in daily professional practice. What do professionals aim to do in their daily work with the mentally ill? What treatment strategies do they utilise? What is the role of theory in daily practice?

The chapter is structured to address each of these questions in turn. It shows how, just as professionals' basic understandings of mental ill health are essentially social and multiple, so they construe their own work as a social endeavour involving a range of treatment strategies. Section 1 focuses on how this is perpetuated in professionals' goals of the social management rather than eradication of mental health problems. Within the limits that the perceived enduring nature of mental illness creates, professionals aim to improve their clients' quality of life and conformity to social norms. Section 2 focuses on the treatment strategies that professionals enact in their day-to-day work in order to achieve these aims, highlighting how agnosticism is extended into daily practice and is associated with the use of multiple treatment strategies. Professional-client relationships are seen as the bedrock to the diverse practical strategies employed in daily work. Section 3 addresses the specific issue of the relationships between theory and practice. It illustrates how professional practice is often essentially atheoretical, but that despite this disjunction, theory serves several important functions within professional social representations.

In terms of the theoretical model of professional social representations proposed in Chapter 3, the analytic focus of this chapter is on the substantive content of components of the representational field, and their functions and inter-relationships. The chapter casts a broad net over the relationship between mental health professionals and mental illness, focusing primarily on professional practice as well as elucidating the functioning and positioning of theory. It also touches on professional identity construction, thus highlighting the relationship between representors and what is represented.

1 Aims and Goals: Improving life quality within the parameters of mental illness

In order to understand professional practice as the enactment of social representations, it is necessary to elucidate the motivations, aims and goals which underpin the treatment strategies and routine practices of daily professional life in mental health care contexts. Figure 6.1 summarises graphically how professionals represent their work in interview narratives. It shows that professionals' ultimate concern is with enhancing the life quality of their mentally ill clients. This is achieved through a two-stage process, involving initially, assessment and attempts to understand a client's problems, followed by the implementation of strategies aiming to bring about various types of change. These changes depend upon, and are limited by, constraints imposed by mental illness and by the social environment. Whilst individual practitioners may have different specific aims[1], this generic model of professional practice exists as a consensual and relatively taken-for-granted reality within communities of mental health practitioners in both France and Britain. Professionals' principle concern is with the mentally ill as social beings, and they see themselves as legitimately involved in myriad aspects of their clients' daily lives. As one respondent puts it:

> 'the main difference between psychiatry and general health care is that you see a person and you look into their life really, rather than just seeing a collection of symptoms.' (B4)

The sub-sections which follow explore the related components of this model of practice. Section 1.1 focuses on initial assessment strategies. This is followed in section 1.2 by an exploration of the various types of changes which professionals regard as feasible goals to work towards.

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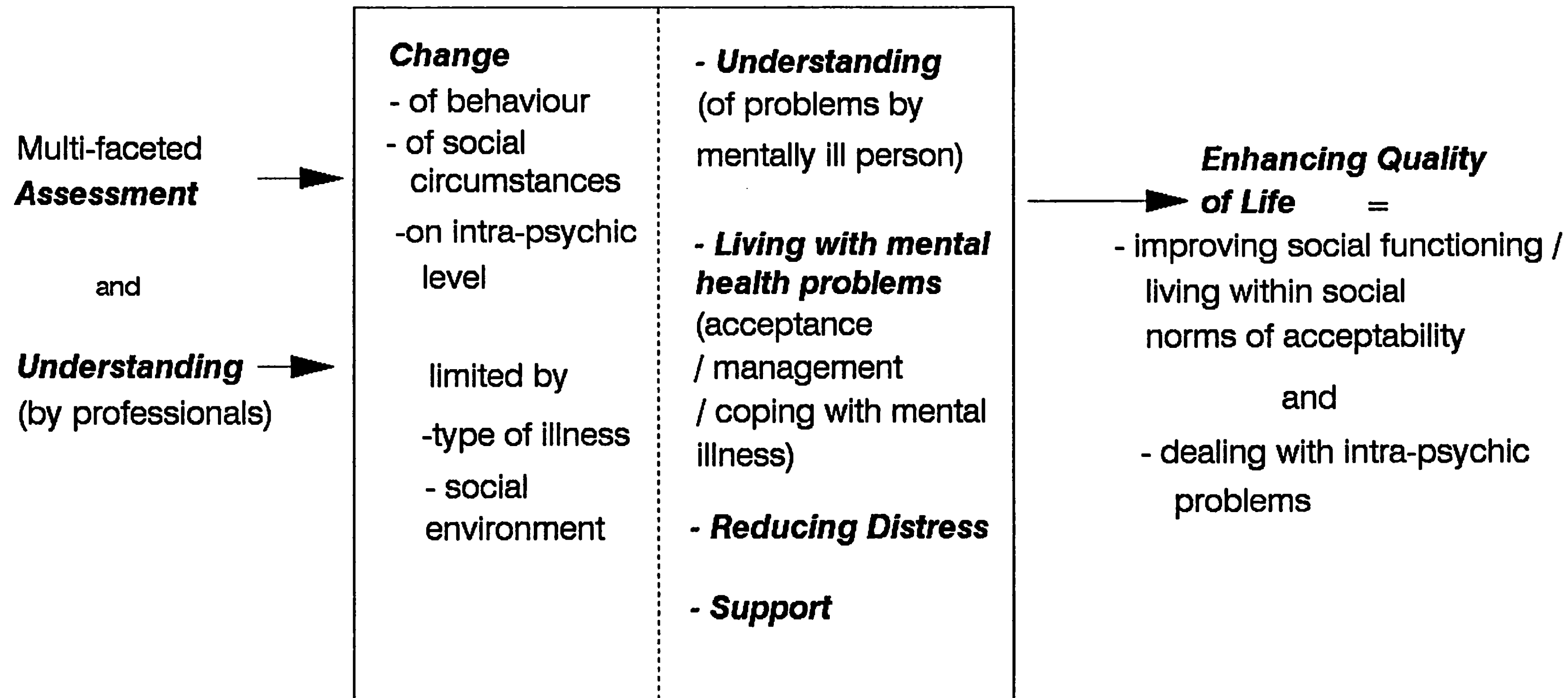
[1] Much of interview respondents' descriptions of their daily work mirrors the standard roles and working styles of the various professional groups described in Appendix 2. For example, occupational therapists see the assessment and improvement of clients' 'daily living skills' as central to their work, whereas social workers typically focus on issues relating to housing, employment and State benefits. Whilst this confirms that the practitioners studied in this research are 'typical' of British and French mental health professionals more generally, what is of more analytic interest is how the expectations and guidelines of the various professional bodies are drawn upon and interpreted in the development of collective working practices in specific mental health service settings.

Figure 6.1: The Work of Mental Health Professionals: Strategies and Aims



1.1 Assessment: Provisional anchoring and initial sense-making

Assessment and understanding emerge from interview narratives as an essential goal to be achieved in the daily work of all mental health practitioners, both as a way of judging the problems and needs of new clients, and to rate the effectiveness of on-going practical strategies. Professionals conceptualise assessment as a multi-faceted task which involves the collection of a whole gamut of information about the lives of their patients (for example, their family relationships, living conditions, and abilities to conduct basic tasks of daily living such as shopping and cooking).

If the mental health services studied in this research operated according to a straight forward medical model (the approach which has exerted the most normative influence historically), we would expect assessments of mental health status to be limited to diagnoses conducted by psychiatrists according to standardised medical and psychiatric nosological systems. Here, however, we find all professional groups involved in more holistic assessments, of which psychiatric 'diagnosis' is only one strategy which may or may not be included[2]. Although as the (formal or informal) heads of multi-disciplinary teams, psychiatrists are most concerned with assessment as a technique for planning and overseeing treatment strategies, assessment is generally described as a collective endeavour conducted from different perspectives by all professional groups. This centrality of assessment in the daily work of multi-disciplinary mental health teams can be accounted for in three ways. The first of these is structural, the second semantic and representational, and the third relates to the multi-faceted nature of professional practice.

Firstly, the importance of assessment relates to social structural aspects of the provision of mental health care. As the analysis in chapter 7 highlights, limited financial resources are a major shaper of contemporary professional practice, especially in Britain. Careful assessments of need are essential in deciding how to allocate scarce resources, which increasingly in Britain, are being targeted and limited to those with more serious and long

[2] For example, a French psychiatrist who is generally very critical of the use of standardised diagnostic criteria such as DSM-IV, nevertheless talks of diagnostic labels as something 'which I keep in reserve in case I need to use medication' (F20). In quantitative terms, references to assessment as an important part of daily work are equally prevalent in France and Britain, and are made in 53% of interviews. Respondents' use of the terms 'assessment' or 'evaluation' rather than 'diagnosis' (which is very rarely used in interview discourses) suggests that contemporary mental health professionals do not see themselves as medical practitioners.

term mental health problems. The social positioning of mental health practitioners as publicly accountable implementers of government policies whose work is funded by public monies also heightens the importance of assessment[3]. Society designates the task of assessing who is mentally ill and who is not to mental health professionals. Within the former category, professionals must further decide who is most 'dangerous', 'at risk' or 'in need' and worthy of the scarce resources of mental health services. Given the threat and uncertainty which characterise lay representations of mental illness, it is a social imperative that professionals make assessments which gain consensual acceptance both within the world of mental health and in the public sphere.

Secondly, as the preceding point suggests, the social representational status of mental illness places assessment and understanding high on the agenda. The polymorphic nature of professional representations highlighted in Chapter 5 has important implications for how a client is subsequently treated. If professionals' basic understandings are deeply permeated with a collective sense of uncertainty and with notions of fundamental difference and incomprehensibility (especially with respect to 'psychoses'), the problem of sense making may be made easier by the continual gathering a vast body of information. This aids two important representational processes: Firstly it allows professionals to anchor the problems of a particular client, at least provisionally, into a category of mental health problems, and in so doing, to give it a name which can be used in communication with other professionals. Secondly, evaluation serves to concretise and objectify these problems into a distinct set of needs which can then be addressed in practice. Understanding and assessment of clients and their problems addresses the tensions between representational uncertainty and societal expectations of professionals as possessing definitive expert knowledge. Bridging the representational gap between themselves and their mentally ill clients, whose behaviour and experiences may be construed as incompatible with socially consensual norms and understandings, is regarded by professionals as central to their work. For example:-

> I: What would you say your aims are generally in all the work you do?
> B15: I would certainly hope that when someone was interviewed by me, that I would have

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[3] The central role of assessment is enshrined in recent British policy legislation. For example, three of the six principle directives made in the Griffiths Report on Community Care (1988) (widely agreed to be the for-runner of major policies changes implemented in the early 1990s) focus on identification, needs assessment and prioritisation.

> understood as much as possible, why they are in the difficulty they are in, that has resulted in them either being referred or referring them self for help. That I would have understood that, that they would feel understood, and that I will provide the best, or the most appropriate help possible. Obviously in psychiatry there will be a group who will not feel understood, because my understanding is this person is mad. But even then, I would hope that over time, particularly if they are better, that we would come to some mutual dialogue about their problem, that would result in some help with the difficulties that they or their family or society, sometimes, are experiencing as a result of their behaviour.

The third reason why multi-faceted assessment forms such an important part of the daily practice of all professionals relates to how they construe their work as a social endeavour, aiming to implement a wide range of social-psychological changes in the lives of the mentally ill. It is to these goals of various and multiple changes that we now turn.

1.2 Practical Goals: 'Managing' not 'curing' mental health problems.

> 'I suppose the overall aim is to enable people to enhance the quality of their life, by improving their psychological health and enabling them and empowering them thereby to tackle other social problems that they might have.' (B17)

Generally speaking, mental health professionals see the ultimate goal of their work as enhancing the quality of people's lives. This is conceptualised as a two-pronged endeavour, involving the inter-related tasks of improving a person's social functioning and ability to live within social norms, and helping them cope with their intra-psychic experiences. If mental illness is manifested in distress, difference and disruption, then the role of mental health professionals is to reduce distress and suffering and restore some sort of 'normality' in the person's life. Consistent with the ethos of current community care policies which seek to minimise dependence on state welfare systems, a key criteria for this 'normality' is the ability to live in an independent and self sufficient way within the community and its implicit norms. These expectations both rest upon and perpetuate the themes of autonomy, self-regulation and responsibility which make up western notions of authentic person-hood, and have been linked to Judeo-Christianity, the Renaissance, the profit motive of modern capitalism, and post-war Thatcherite politics (Henriques et al 1984, Rorty 1987, Turner 1986).

However, whilst 'quality of life' and 'normality' may be goals to work towards, professionals remain sceptical about the possibilities of attaining these goals. Instead they aim for approximations. Just as the lodgers in Jodelet's (1991) study live 'as if' they are

members of this rural French community, so the professionals investigated in this research see themselves as involved in constructing this 'as if' status for their clients. As the interview extract below hints, mental health workers are tacit partners in constructing an illusion of normality with their mentally ill clients, and in finding strategies which minimise the impact and social visibility of mental illness.

> (referring to the aims of her work) 'when someone, even though they may still be in the system, manages to live an everyday life again which you could call "classic". I've been avoiding the word "normal" since the beginning, but that's what it is. It's normality, the norms of society. The point at which someone manages to conform to those norms, even if they come to see the doctor once a month for medication, or if they need to see the nurse or a social worker from time to time. (F27)

It is this struggle to establish a socially acceptable space for mental illness within the norms of society that renders the modern-day, integrationist work of mental health professionals intrinsically moral, and imbues it with tensions between conflicting agendas. (We will return to this issue in Chapter 8, which considers the role of professional social representations in aiding the reconciliation of various conflicting agendas.)

Across the board, professionals see their work as a long term endeavour which involves them in managing rather than solving problems associated with mental ill health[4]. They take the presence of mental health problems, in society and in the lives of specific people, as a given, as something which is unlikely to go away, and which sets limits on the work they do. We return here to the notion of mental illness as a permanent trait, which competes with, but generally carries more weight than views of mental illness as a temporary state (Chapter 5, section 2.1). For professionals, mental illness is something they work with, rather than work to get rid of. Mental illness is 'kept at bay' by their on-going work, but remains as a risk factor or vulnerability, which differentiates those with mental health problems from others. Across the disciplines in both Britain and France, professionals do not see themselves as involved in curative practices, and statements endorsing the general 'curability' of mental health problems are strikingly

[4] One of the most frequently cited personal qualities which professionals see as necessary to work in the field of mental health is patience. One British respondent (B10) talks of entering this world with 'too high expectations of what you can achieve' and of having to 'recalibrate' his scale of expectations.

absent from the interview narratives[5]. Much more typical are bold and unconditional rejections of the notion of cure applied to mental illnesses. In fact, the notion of cure even seems to hold a quasi-joke status within the professional community:

> I: Is concept of cure something which you use or that means anything to you?
> B17: No... it's a joke that you often find mental health professionals using here a lot in saying 'how are you getting on with so and so?' 'Cured him, cured him', and predictably, everyone will burst out laughing, because it is a joke the concept of cure. It's essentially redundant. ... I think it's also a joke because it implies that you're using a medical model you know, here's a disease, we've found a cure, we've done something, patched it up, cured him and the person can go now. Also I think because it implies a great sense of omnipotence - these wonderful professionals who can go around waving our magic wands, and popping pills and people are cured.[6]

The professionals in this study clearly do not see themselves as medical practitioners, and they reject an <u>exclusively</u> medical view of their work. Whilst medical factors figure within professionals' aetiological models of mental illness (Chapter 5, section 3), and there is widespread use of medical interventions (see section 2), these are positioned within more complex and multiple professional representations of mental illness and its treatment.

The representational distinction between neurosis and psychosis again acts as an important reference point for the goals of practice. Neurotic illnesses are judged to be more transient and, as such, open to the possibility of permanent eradication, whereas the more enduring and severe nature of 'psychotic' problems place limits on the types of changes professionals can hope to achieve. The experience of psychosis leaves scars and is seen as too fundamental to ever be fully eradicated or recovered from. This places the emphasis on goals of supporting people and helping them 'live with', 'manage' and 'accept' their mental health problems. The focus here is on reducing disruption and distress, whilst accepting the endurance of some kind of perceived fundamental difference. Even if psychotic problems are not manifestly obvious, they are often assumed to be 'in remission'.

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[5] Explicit interview questions about the notion of 'cure' aimed to investigate the current status of medical models in the professional community, given their historical dominance and the recent changes in the world of mental health.

[6] This extract illustrates a common tendency within the community of mental health workers to characterise medical perspectives as simplistic and superficial. Whilst medical practitioners might well see this is a mis-representation (and this is the position of several psychiatrists interviewed in this study), it can equally be argued that this constitutes a socially meaningful representation within a professional community whose 'scientific' and, hence, social status has always been inferior to that of the general medical profession.

I: In the work you do with patients, what would you say you are trying to achieve? What are your aims?
F24: If it's a neurosis, it's a question of modifying the personality so that the person feels better and, if the case arises, is even cured. In the case of psychotics and drug therapy, the aim is that they can live with their psychosis without too much trouble. But there are no pretensions there of a cure.

I: Would you say the concept of cure is something you use or think about?
B30: No, I suppose I don't actually feel that we cure anybody. I think we can help people to make life a bit easier, and understand it. And again I think that's because of working with people who have long term mental health problems, psychoses and things. I think people can go into remissions, but I don't think they are actually cured. (B30)

Given that the eradication of mental health problems is not on the agenda, professionals aim to institute a range of more modest changes. The following comments are typical:

'I think that if we can teach people to live with their illness, with our support, then that's pretty good. Help the person to recognise his illness when he doesn't feel well and if he manages to build up a good relationship with the doctor and the nurses, to come and ask for help.' (F18)

I: What would you say your aims are in the work you do with patients?
B12: Ideally it would be helping people towards either greater understanding of why they are like they are, or helping them actually change and move on. Or sometimes accepting the fact that they can't do anything about the circumstances and come to terms with their limits.

Professionals speak in interview of aiming to reduce their clients' distress (especially at times of crisis, when this is a prerequisite to other interventions), helping people to 'manage' their mental health problems, and aiming to help clients come to terms with, accept or understand their mental health problems[7]. This focus on clients 'making sense of' their mental health problems, and exploring how they fit into their subjective life history and sense of self, can be seen as another response to mental illness as strange and unfamiliar, not only to other people, but also to those who experience it. Again the aim is to find a connection with mental illness, to familiarise and make sense of extraordinary experiences. Another central aim of professional practice is to offer support in the tasks of daily living. If, as we have seen in Chapter 5, mental illness is construed as a diminished stock of 'resources for life', professionals conceptualise a role for themselves in 'making up for' this reduced stock of coping skills and emotional strength, by providing long-term social support which may be lacking in other areas of their clients'

[7] Although notions of 'understanding' are most closely aligned with psychotherapeutic perspectives (especially humanistic approaches), these aims are not limited to those professionals who practice psychotherapy formally. This is illustrative of the widespread diffusion and legitimacy within the practitioner community of the range of 'patient oriented' approaches which have developed principally since the 1960s.

lives, past and present.

This range of aimed for changes has undergone a paradigmatic shift away from individualistic medical approaches. Modern day mental health work extends far beyond the body or the mind of the mentally ill individual, into much wider aspects of the persons' life as a social entity and member of society. Tasks which were traditionally the remit of social workers, occupational therapists and community psychiatric nurses are now part of the daily work of all members of multi-disciplinary mental health teams. But this engagement with the mentally ill as social beings brings with it a second source of limitations to their work. If professionals see social factors such as unemployment and poverty as implicated in the aetiology of mental illness (Chapter 5, section 3), they also experience the inequalities of the social world as setting further parameters on the changes they can hope to implement. For example:

> '(I)t's often a matter of helping people understand their situation, relieving some of the bad symptoms or feelings they have. But they are still often lonely and isolated. And all those things - they're unemployed and they're in grotty housing and they are still unsatisfied. So there's a limit to what we can do.' (B15)

The following section explores what practical strategies professionals implement in their daily work in attempting to achieve these conditional changes in social, interactional and intra-psychic domains.

2 Eclectic Practice: Tackling Mental Illness from Multiple Perspectives

From a social representational perspective, professional practice constitutes the objectification of professional representations - the ways that implicit assumptions about the nature of mental illness are lived out and perpetuated in concrete terms. As a manifestation of the multiplicity of their representations, the practical work of the sample of British and French professionals investigated in this research is united by a common theme of eclecticism[8]. And as the enactment of representing of mental illness as a social phenomenon, contemporary care of the mentally ill constitutes the implementation of a

[8] Eclecticism amongst mental health practitioners is also reported in studies conducted in Italy (Zani, 1987, 1993).

range of practical strategies which involve professionals in the minutiae of their clients lives. Yet simultaneously, mental health care still involves the more traditional hospital-based treatments. The sections which follow chart the semantics of these multiple strategies, showing how they coexist and are practised variously by different professionals in France and Britain. Section 2.1 sets out the inter-relationships between three broad models of professional practice. This is followed in sections 2.2 to 2.4 by a more detailed exploration of each of these three care strategies in turn.

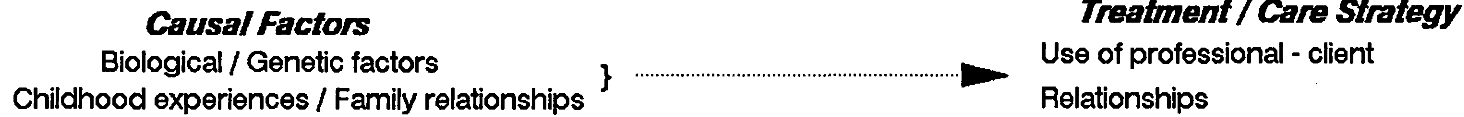
2.1 Complementary Strategies and Professional Uncertainty

Asked in interview about their daily practical work, professional cite a range of activities from administering medication to long-term psychoanalysis, discussion groups, visits to clients' homes and various other formal and informal activities in a range of settings. In order to conceptualise rather than simply describe these activities, an analytic strategy which allows some meaningful categorisation and comparison of these practices must be adopted. To this end, a quantitative cluster analysis on data analytic codes developed in QSR-NUDIST was employed. The details of the analytic procedure are presented in Appendix 7. This analysis produces three relatively distinct clusters of variables, which can be interpreted as three broad practical strategies implemented simultaneously in contemporary mental health care. These three strategies (whose validity is confirmed by their correspondence to descriptions in interview narratives) are presented graphically in Figure 6.2, which illustrates how the concepts associated with each model are inter-related. Table 6.1 shows the relative frequency of use of the various treatment interventions employed in these different styles of care.

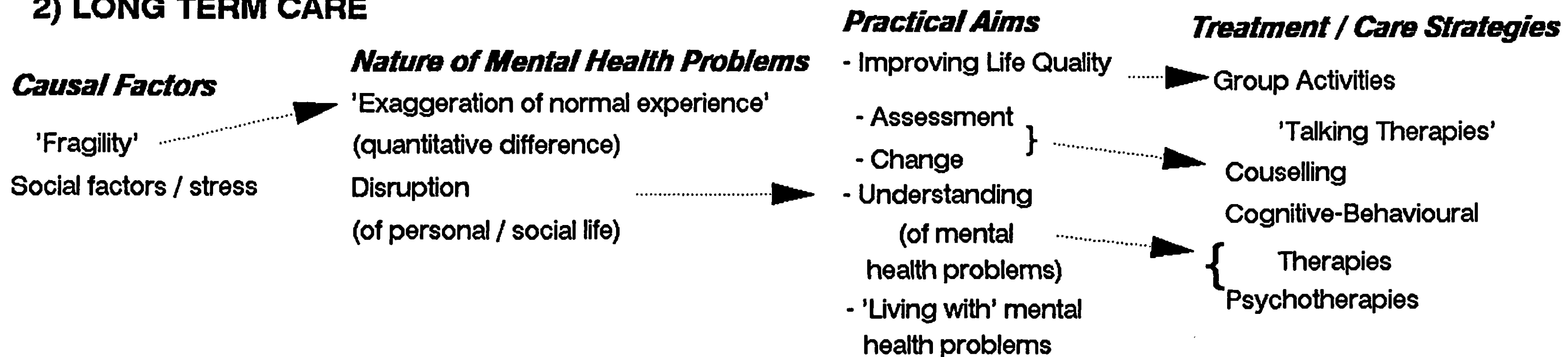
By far the most commonly cited practical strategy is the use of professional-client relationships. This is associated with a general understanding of mental illness as the product of the combined effects of biological and genetic factors and childhood experiences and relationships. Both quantitative and thematic analyses suggest this as a 'generic' model of practice which forms the basis of the other two more specific

Figure 6.2: Three Models of Professional Practice

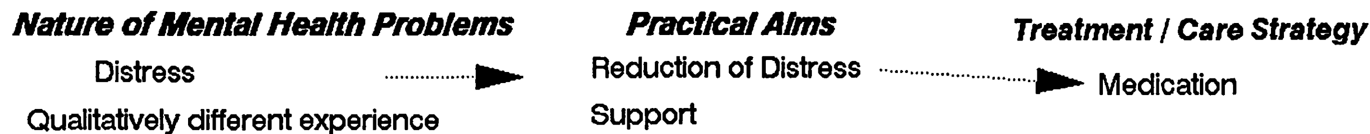
1) A GENERIC MODEL



2) LONG TERM CARE



3) CRISIS INTERVENTION



models[9]. The second and most complex model of practice constitutes long-term care strategies, centred around group activities and complemented by various one-to-one talking therapies. Thirdly, a 'crisis intervention' model is associated principally with the use of medication.

Table 6.1: Frequency of Use of Strategies associated with Three Models of Professional Practice[10]

MODEL OF PROFESSIONAL PRACTICE	Associated Activities	No. of British Respondents (n=30)	No. of French Respondents (n=30)
GENERIC MODEL	Development of Professional - Client Relationships	21	22
LONG-TERM CARE	Group Activities Psychotherapies Counselling Cognitive - Behavioural therapies[11]	14 3 10 8	9 7 5 0
CRISIS INTERVENTION	Medication	8	9

[9] The variables in this 'generic' model co-occur in the majority of interview transcripts, and there are significant correlations with the other two models of practice (see Appendix 7). Qualitative analysis presented in section 2.2 suggests that professional-client relationships are construed as the 'building blocks of care'.

10 This is not an exhaustive list all the activities cited by interview respondents. Other activities such as relaxation therapies used by movement therapists and art therapy are not included here because they are limited to a small number of specifically trained professionals. Given the importance of family relationships in professionals' aetiological models of mental ill health, it is notable that family therapy is not a regularly practised strategy. (Only two French psychiatrists report using family therapy, although referrals to family therapists are mentioned by a few British respondents). From this sample it appears that family therapy remains a marginalised and specialist approach which has not filtered into main-stream mental health services. However, another approach which involves the active use of families is family placements initiated recently for a small number of cases in two of the three secteurs investigated in France (sectuer 4 and secteur 15). There are many parallels between these placements and the rural family colony of Ainay-le-Chateau studied by Jodelet (1991), and it is probably the very existence of these colonies in France which prompts professionals in main-stream mental health services to experiment with this approach. (As far the author is aware, no such equivalents exist in Britain.)

[11] Results of a chi-squared test show that this difference between French and British respondents is statistically significant at $p<0.005$. (None of the other cross cultural differences in this table reach statistical significance).

It might be expected that long-term care and crisis intervention strategies would constitute relatively distinct areas of practice, enacted by different groups of practitioners working separately in different locations. Crisis intervention practices might be the realm of hospital-based professionals, whereas long-term strategies would be enacted by practitioners based in day centres and other community services. This pattern of practice is reported by Prior (1993) in a recent study in Northern Ireland, and in terms of the structural organisation of mental health services in the current study described in Appendix 1, there is certainly evidence for this. For example, service provision in Lewisham & North Southwark was being reorganised during the data collection period into two parallel teams devoted to 'continuing care' and 'acute response'. Statistically, it is certainly true (both in France and Britain) that periods of client contact are longer in community based services than hospital wards. However, examination of interview data suggests that, from the professional perspective, these activities are construed as much more overlapping and complementary than is apparent at first glance[12]. The three models of practice constitute the various perspectives, implemented simultaneously, through which multi-disciplinary mental health teams aim collectively to tackle the diverse range of problems which coalesce in their representations of mental ill health. Contemporary styles of mental health care break down traditional areas of specialism, and the activities of the various professional groups working in a range of service settings are now more similar than they are different[13]. Essentially, professionals perceive the various treatment strategies open to them as compatible approaches which build upon rather than contradict each other:

> 'I tend to think more in terms of the complementarity of theories and therapeutic practices - that's what I do in practice. I prescribe medication and I use an approach which takes its reference points from psychanalysis and a systemic approach to the family. (F20)

This perceived complementarity of multiple treatment strategies (used in tandem either by the same practitioner or by different practitioners working simultaneously with the same client) is striking if one considers the very different theoretical foundations of these

[12] As well as the thematic evidence below, this contention is supported in quantitative analysis which finds that long-term and crisis intervention strategies are practised by the same individuals, and that there are no clear-cut associations between the implementation of specific strategies and either professional status or location of work (see Appendix 7 for details).

[13] Analysis in Chapter 7 shows how this overlap is associated with difficulties in carving out new professional inter-relationships within multi-disciplinary mental health teams.

practices (see Appendix 3). Rather than seeing the approaches of, for example, psychotherapy and medical intervention as necessarily in conflict because of their differing views on the nature and aetiology of mental health problems, practitioners are more likely to see them as different, but potentially compatible perspectives, whose combination offers a more rounded and robust approach to mental health problems than the use of any single method. In fact, although professionals may express preferences for certain aetiological models of mental illness over others, the incompatibility of different practical approaches is a theme which is strikingly absent from the whole data corpus.

Eclecticism and the use of multiple treatment strategies are also associated with the sense of uncertainty which pervades professional representations of mental illness, and is manifested in practitioners' sense of limited mastery of the techniques they use, and their potential outcomes:

> 'Nothing is standardised - there are no fixed rules at all - it's all quite fuzzy round the edges. There's no set way of doing things - if one thing fails you try another and then another, or you try several things at once, or whatever.' (B4)
>
> 'When things start to go better for a patient he's no longer with us. So that leaves you always wondering if what you're doing is working, because you don't necessarily have any means of evaluation.' (F2)

Professionals recognise that there is no one 'right' way to treat mental health problems; that despite their best efforts mental illness endures; that any single treatment has both strengths and limitations; that their own ability to predict the outcome of any strategy is limited; and that under these circumstances the 'safest' approach is to implement several treatment strategies simultaneously. A very broad conception of 'treatment' is the norm across this professional community. The widening of the remit of mental health care beyond the bounds of the hospital and into the realm of daily life has brought with it the 'professionalisation of the mundane' (Prior, 1993). Virtually any activity can be considered 'therapeutic', and implementation of specific time-limited activities can be complemented by the benefits of a 'therapeutic environment' (the reassurance of the hospital structure, or the supportive, non-judgemental climate of a day centre, for

example)[14].

2.2 Professional-client Relationships: The 'Building Blocks' of Care

> B3: As I see my role, it's the relationship between myself and the client which is very much part of the therapeutic process. It's that that facilitates and decides whether the treatment is going to be successful or not - in a way I think it's based on a relationship very much. In that you can have a therapeutic relationship with a client - hopefully. If you don't have a therapeutic relationship which is supportive and trusting, it would be unrealistic to expect other treatment to be successful. I think that's the foundation for the treatment. ... The reason why I say that is because often a lot of the clients who come here, a lot of their problems are based in or stem from relationship difficulties, interpersonal problems, conflicts within their family, either currently or going back to childhood. And often for the first time in their lives, I think when they come here they're getting their first chance, in a way, to have an appropriate relationship with somebody. And not just with their key worker but with other clients around in the whole environment.

Professionals from all disciplines in both France and Britain are united by a common generic model of their practical work as resting upon the establishment and development of relationships with mentally ill clients. The use of professional-client relationships might be expected to be central to the work of a range of people-based professionals (teachers, GPs or social workers, for example). But the strong representational theme which emerges from this analysis of mental illness as a problem associated with relational difficulties in its genesis and nature, confers a special importance on relationship formation. Relationships with clients are seen simultaneously as 'compensation' for other relational difficulties and sources of support, and 'building blocks' for professional practice. Relational skills are the corner stones of practitioners' professional identities - they cite interpersonal skills such as empathy, listening and communication skills first and foremost as the personal qualities needed to work in the field of mental health. The forging of relationships with the mentally ill is crucial because it impacts upon all three of the central features of mental ill health: Firstly, it allows a connection across the gap of difference perceived between professionals (and consensual reality) and the mentally ill, with the possibility of overcoming or at least reducing these differences, by creating

[14] There are clear echoes here of the 'therapeutic community' concept developed by Maxwell Jones in Britain in the 1940s (Clark 1977). The principles espoused by Jones, that the treatment of mental health problems can be the product of normal interactions as part of healthy community life, are also lived out in the heavy use of group activities in contemporary practice. However, echoing Goffman, these themes coexist in the professional community with less positive views of the working environment, which, among other things, constrains or hinders the work of mental health professionals (see Chapter 8).

connections and understandings based on trust, support and continuity. Secondly, these relationships allow a space for the person to express and air their distress, with the potential to reduce the degree of suffering experienced. And finally, they act as important foundations from which professionals can encourage other changes which may serve to reduce the disruption of mental ill health in the lives of their clients and the social worlds they participate in.

At the very heart of these relationships, which form the basis of all professional practice, the essentially moral nature of mental health work, and the tensions and dilemmas which professionals face daily are revealed. Although professionals aim to understand their clients' points of view, and to involve them as willing participants in treatment strategies, as social agents, they are frequently faced with the need to reconcile this with quite different agendas emanating from the person's family or from society at large.

> 'My role is simply to have a relationship which is as real as possible with these people. As real as possible in the sense that I am part of an institution, so that the cards are dealt in advance. Which means that, at the same time, that relationship is impossible because we're within this framework.' (F4)

This paradox is an essential feature of professional practice which any socially oriented research must seek to understand. Chapter 8 offers a functional perspective on professional social representations as serving to aid the reconciliation of these conflicting agendas.

Listening or Coping?

It is also within the context of professional-client relationships that some subtle, but important cross-cultural differences between Britain and France are revealed. Interview accounts of the perceived purpose of relationships with the mentally ill highlight how divergences in psychodynamic thought which have developed over a number of decades on either side of the Channel filter into professional social representations. (These different versions of psychodynamic theory are detailed in Appendix 3). Broadly speaking, French professionals place more emphasis on the role of 'listening' (l'écoute),

whereas British practitioners talk more about 'coping'[15]. In France, where psychodynamic theorising is dominated by the ideas of Jacques Lacan, the linguistic nature of psychotherapy and its central aim of understanding the language of the unconscious is stressed. Listening is described as a way of making contact with the mentally ill, of bridging the gap which is perceived to exist not only between mental health and mental illness, but between existentially distinct beings. This connection is often perceived as only partially possible, which is why the effort, difficulty, but necessity of listening are emphasized.

> 'What he (Lacan) offers essentially, in my opinion, is his work on discourse that was begun by Freud. It was the linguists of the time that were Lacan's fundamental tool. So it's the field of speech and discourse in particular. ... Fundamentally, analytic practice involves listening to a discourse and trying to grasp what is in the language that can highlight the most important elements which explain the structure and organisation of the subject and the psychic organisation.' (F10)

> 'My goal is to listen first of all, and to help them get better - I can't put it any differently. ... That's not to say that I succeed or that one succeeds all the time, but the fact of listening is, in itself very important for them - you listen to what you can, that doesn't mean you understand. I'm of the opinion that listening is not comprehension, you can't understand certain things and we're not there to understand some things. But you can open up a space to talk for the person, give him something, a presence, nothing more than the fact of being listened to. Because these are people who, beyond the institution, are alone, nearly all of them. .... So it gives them the possibility to have someone to whom they can talk freely. It's the fact that it gives them the possibility to be themselves, without any sort of judgement.' (F5)

The greater emphasis amongst British professionals on relationships with clients as a vehicle to aid 'coping' can be traced to, among other things, the 'ego psychology' branch of English language psychodynamic theorising, which developed principally in the USA in the 1950s onwards. This version of psychodynamic ideas is often described as more optimistic than its French counterparts as it assumes the possibility of change through the exploration of ego defense mechanisms. The aim is to facilitate adaptation to 'reality'[16]. The client is encouraged to develop ways of managing emotions and psychic conflicts in ways that support and develop ego strength, and to develop ways of coping with everyday

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[15] Simple word searches in the data corpus indicate these imbalances: References to 'listening' are made by 19 French respondents compared to 9 British respondents; references to 'coping' are made by 18 British respondents, but only 6 French respondents. Thus, these are relative rather than absolute differences. It is certainly not the case that 'listening' is unimportant to British professionals and English language psychodynamic literature, nor that notions of 'coping' are not part of French thinking and practice.

[16] One of Jacques Lacan's objections to the American school of ego psychology, was its uncritical stance in failing to question the nature of this reality, or to recognise its socially constructed nature (Turkle, 1979).

life which conform to social norms.

> I: Generally, what would you say the aim of what you do is?
> B11: To get people who are not coping with their problems, not coping with their illness, not coping in society able to look at their difficulties and develop better coping strategies.
>
> 'I think of mental illness where systems try to come up with solutions and come up with bad ones. What we're doing is trying to help people to cope by coming up with a better one. Come up with a better way of dealing with this which isn't going to cripple your life, or interfere with your relationships or stop you getting a job.' (B20)

2.3 Long-term Care Strategies

The second model of professionals practice which emerges from interview narratives is a model of long-term care based principally on group activities and involving a range of one-to-one 'talking therapies'. As such, this model represents the translation of the ethos of modern community care policies into contemporary professional practice. Figure 6.2 shows how this model is based upon themes of mental illness as disruptive of personal and social life, and as an extreme version of other more 'normal' experiences. Associations with the 'similarity' face of mental ill health may legitimise this style of practice, much of which is implemented in public and community-based settings. Perhaps professionals see difference which is a matter of degree as having more potentially for integration into 'normal' community life, than more fundamental, qualitative difference.

Group Activities

Group activities form an integral part of all the mental health services sampled for the current research, conducted by a range of professionals and used with clients showing the full spectrum of mental health problems in both hospital and community settings. As well as providing a useful environment in which to make assessments of their clients as social beings, professionals see the activities and processes which occur in group work as essential to their broad aim of enhancing life quality. If, as section 1 highlights, improving quality of life involves simultaneously improving social functioning within the bounds of social acceptability, and dealing with intra-psychic problems, then group work fulfils both these aims by both teaching 'life skills' and, through the use of inter-personal

relationships within the group, helping people deal with their experiences of mental ill health.

The range of activities covered by group work betrays an implicit assumption that the work of mental health professions now constitutes a legitimate involvement in the details of people's lives. Groups are seen as a means of teaching people essential skills which they need to live an independent and 'normal' life within the community[17]. For example, how to plan, shop for and cook healthy food; how to relate to others in socially appropriate ways ('social skills training'); how to manage one's finances. Essentially the focus is on how to manage one's life within the parameters of social acceptability. Skills-based groups aim to equip the mentally ill with the minimum practical and social skills necessary to live (superficially, at least) as valid members of society. They focus on reducing, or at least managing, the disruption and difference associated with mental illness.

Professionals also conceptualise the group encounter as a tool which is central to the reduction of distress. The group experience *per se* is a vital treatment strategy in its own right, in helping participants deal with their intra-psychic experiences of mental illness. Through the formation of relationships within the group and opportunities for self-expression and increased 'insight', groups focused on creative writing, relaxation, anxiety or anger management, and formalised 'therapeutic' groups are all seen to offer something qualitatively different to professional-client dyads:

> F12: I think it (group work) is really just a mediator for interactions, whether you're doing modelling, painting or aerobics. It's a means of relating to the patient. It's also a period of time when you're with them, when you can discuss things with them. What it offers, at the end of the day, is a means of communication with the other person.'
>
> B20: Movement therapy ... is a non-verbal medium, or a form of group therapy which uses something in addition to words. And the aims are slightly different in each group, but broadly speaking it's an attempt to .... I suppose something to do with increasing awareness of what they are feeling, what they are experiencing, as represented by their body movement behaviour, and the way that can be symbolic of what's going on for them, or can express things that they are not saying verbally.'

Echoes of theories of group dynamic and 'therapeutic community' principles can be heard

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[17] The common term used by British mental health professionals for this type of group work is 'activities of daily living' (or ADL) groups.

in these interview narratives, although these links are rarely articulated explicitly. Whilst professionals may be unaware of their theoretical origins, assumptions about the link between group encounters and intra-psychic experiences have seeped into and become centrally integrated into professional representations of mental illness in both Britain and France.

'Talking Therapies'

The use of various one-to-one talking therapies is a second strand of attack in long-term care strategies. The figures in Table 6.1 illustrate differences between Britain and France which are summarised as the greater use of cognitive-behavioural techniques and counselling in Britain, compared to a greater reliance on psychodynamic psychotherapies in France. Beyond this, qualitative analysis of interview narratives highlights more substantial differences in the social signification of these practices. Far from representing fixed and unitary practices, each of these terms means different things in different social contexts, translated into various practical strategies depending on their historical development and status in each country.

Regardless of nationality, psychodynamic psychotherapy in the 'broadest' talking therapy in the sense that it constitutes, for many professionals, not only a way of working, but a more generic way of thinking. In professional sense-making, psychodynamic perspectives are important anchors. (Aims of understanding mental health problems - for both professionals and clients - are strongly associated with the use of psychotherapies.) Thus, although the numbers of interview respondents who term what they do 'psychotherapy' are relatively small, this masks the widespread use of a psychodynamic approach as an integrative 'meta-perspective' on the eclecticism of daily practice. For example:

> I: Can I ask you about theoretical models that you use in your practical work?
> B5: Very eclectic. The one that I use most is behavioural .... I also use cognitive work with people where it's appropriate. But I guess overlapping all of those is a more dynamic approach. I find it difficult to detach where the person is at now from their experiences in the past, and I think it's important to note that.

> 'Psychoanalysis provides some extremely important elements to situate a case a bit, and to know which directions to work in so as to not cause any damage or push the patient back into his defenses. .... Psychoanalysis can also help us to structure a hospital admission. In certain cases you might be able to say it would be better to suggest this or that activity rather than

> another. Or for example, not to use the imperative with certain psychotic patients. I think psychoanalysis can help us with those sorts of questions - questions about language and the weight of words. ... So it give us some reference points on what we ask of a patient, what we can say to the staff who are looking after that patient - the nurses and the other hospital staff' (F10)

The actual practice of psychotherapy is much more prevalent in the French mental health services studied than in their British counter-parts, and is utilised principally by clinical psychologists and psychiatrists. The later constitutes one of the most striking differences within a specific professional group: Of the six French psychiatrists interviewed, five claim to practice some kind of psychotherapy (and the sixth attends a psychotherapy discussion group). In contrast, none of the British psychiatrists interviewed practice psychotherapy. Long-term psychotherapy is taken in France as a valid and normal part of the work of public mental health services whose position goes unchallenged. In comparison, to practice psychotherapy within the context of British public mental health services is to take on a marginalised and contentious position in the face of widespread scepticism within the British professional community regarding the efficacy and 'value-for-money' of individual psychotherapy.

Not only are psychotherapies used more frequently in France, but the nature of these therapeutic strategies is also different. 'Lacanian' theories and practice and classic long-term psychoanalysis feature in France, whereas 'brief psychotherapy' is more the norm in Britain. The conceptual differences between 'listening' (in France) and 'coping' (in Britain) highlighted in section 2.2 constitute another significant cross-cultural variation. In comparison, psychotherapeutic perspectives are rarely put into practice in their pure form in Britain. These cross-national differences in practice are broadly in line with the causal models of mental ill health described in Chapter 5: The French place more weight on ideas aligned with psychodynamic perspectives (childhood experiences and family relationships), compared to the bio-psycho-social causal models prevalent in Britain.

The strength of these differences, derived from their historical and social rooted-ness, may be masked by the 'snap-shot' nature of this research, conducted at a time when the two countries are converging in their attitudes to psychodynamic ideas and practice: Whilst the practice of psychoanalysis in France has diminished substantially since its heyday in the 1970s, a more open approach to psychodynamic work has developed in

recent years in British mental health services, manifested in the rise of 'counselling'[18]. The weight of historical differences is evident in the differential development of other talking therapies, and in the way these various labels are used to refer to essentially the same practices on either side of The Channel. The term 'psychotherapy' is used in a much more general way in France, to refer to styles of interaction which involve listening to, supporting or interpreting what a mentally ill client says. A French psychiatrist makes the following comment:-

> 'There aren't any people who are not suitable for psychotherapy, although perhaps you need to make clear what you mean by psychotherapy ... Even if I'm prescribing medication - even when people come to have their prescription renewed or changed, I spend half an hour with them talking about things. That's a type of psychotherapy - it can be a supportive dialogue. I prefer to call that psychotherapy - it's not an ordinary type of conversation.' (F20)

In Britain, the term 'psychotherapy' is used in a much more constrained way to denote a very particular type of formal practice in which the in-depth exploration of past experiences and unconscious processes is the principle agenda. Supportive practices of the kind referred to above are seem more usually as 'counselling', although the possibilities of combining or slipping between these approaches in the course of daily practice are recognised:

> 'I think supportive counselling, it's for people who aren't perhaps terribly interested in understanding why they are experiencing the world as they are, why they are having difficulties in relationships, why they react as they do. That's not to say that doesn't come into it, but perhaps at a less deep level. It's very much working with the here and now, and what's actually going on in their lives, looking at that, and making some sense perhaps of difficulties, problems, issues, painful feelings. I think with analytic work it's much more using the relationship between you, and perhaps going more deeply into earlier causes, unconscious things that are going on. I mean it's difficult to draw a line between them. One can move into the other, and often does. (B27)[19]

In fact, there is no equivalent to the term 'counselling' in the French language, and although Table 6.1 indicates that counselling practices are used by five French

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[18] During the late 1980s and early 1990 counselling courses have sprung up across Britain, offering recognised qualifications for those wanting to practice 'talking therapies' without the rigours of psychotherapy or clinical psychology training. The number of counselling courses in the UK recognised by the British Association for Counselling has increased from 2 in 1989 to 32 in 1996.

[19] This view of counselling accords with the definition offered by The British Association for Counselling (1996): 'The task of counselling is to give the client an opportunity to explore, discover and clarify ways of living more resourcefully and towards greater well-being.'

respondents, these are referred to in interviews as 'psychotherapie de soutien' (supportive psychotherapy), supportive consultations, relational work, or simply talking[20]. This suggests that the greater general acceptability of psychodynamic ideas and practices in France translates into less need to construct a separate discipline of counselling, which, while borrowing many ideas from psychodynamic thought, defines itself as an explicitly different endeavour.

The third type of 'talking therapy' used by professionals in this study is limited entirely to the British sample. Like counselling, cognitive-behavioural therapy is a relatively new treatment strategy currently gaining popularity in the British world of mental health, where it has replaced the purely behavioural approaches of the 1960s and 70s (see Appendix 3). Although some French respondents are aware of the slow diffusion of these techniques into the world of French mental health (perceived as the influence of the English-speaking world), at the time of data collection none of the professionals interviewed in France actually practised cognitive-behavioural therapies. As the interview extracts below illustrate, the position of cognitive and behavioural perspectives in British professional representations is relatively circumscribed, taking the form of a useful practical tool for tackling certain mental health problems (specifically, anxiety, depression and phobias) within broader, more eclectic practical approaches and ways of thinking. On their own, cognitive-behavioural approaches are generally seen as insufficient ways of understanding mental health problems, which must be anchored into other spheres of knowledge simultaneously if their essence is to be captured more successfully.

> 'My thinking would always be broader than behavioural thinking, and would always be broader than cognitive thinking, but the therapeutic strategies I may recommend may well be because those models are useful in symptom relief. They have a theoretical model that underpins some human behaviour, but I don't think cognitive or behavioural models address meaning on the more deeper level that I'm interested in. They can be very useful, but they don't for me underpin my understanding of the person. (B15)
>
> I use the three approaches [cognitive, behavioural and psychodynamic] to give a more holistic approach, because the constraints of things like behavioural work are that it's just dealing with overt behaviour. There's no feeling for what's going on in people's heads, it's too reductionist. But because of the process that's involved, of breaking things down into very small steps, you can actually see some change quite easily, which is both rewarding for the client and for the therapist. It's very effective in certain problems. Things like anxiety it's very useful for. Things like phobias - simply phobias, not complex phobias. And very

[20] The fact that as a British researcher, I coded these activities under a category termed 'counselling' when analysing the data is a clear example of the impact of the researcher's perspective and social positioning in the research process.

satisfying when you feel you've done something really good.' (B5)

A final component of long-term community-based care strategies described in interviews is the use of long acting medication[21]. Although medication is primarily associated with crisis intervention, the administration of slow release 'depot' injections (primarily by community psychiatric nurses and case managers) allows mental health services to manage and contain the risk of violent, dangerous or socially unacceptable behaviour 'by proxy', ensuring the 'as if' status of the mentally ill living apparently independent lives in the community.

2.4 Crisis Intervention Work

In tandem with these long-term care strategies, the practical work of mental health professionals also involves them in crisis intervention work which addresses the less benign and more threatening face of mental illness. The use of medication (often within the 'containing' environment of the hospital ward) is perceived by professionals as important medium through which they can tackle the distress of mental illness. When a patient is intensely distressed, or in a state of apparent dissociation from consensual reality, displaying behaviour which is bizarre, dangerous or unpredictable according to rational-based theories of mind, medication is seen as a 'first resort'. It allows professionals to re-establish some sort of contact with intensely disturbed clients, contains the most dangerous and threatening facets of mental illness, and in so doing, reduces the distress and fear that extreme disturbance provokes in others.

> 'Someone who has voices in their head, or hears things, or feels like their body is falling apart, or has other strange bodily sensations, if medication can allow them to not have those agonies, then they should take it. Because that's what a lot of our patients tell us - I don't feel well, I feel this or that in my body - it's really dreadful. You have the impression of feeling their distress which transmits itself to us. It's there - it flows out of them, and you can feel how unwell they really are. So I think that at that point, you really need to use medication. Because it's not simply through talking that those voices are going to go away.' (F12)

Just as 'psychotic' forms of mental illness are generally attributed more to biological or

[21] Medication does not appear as part of the long-term care model in Figure 6.2 because cluster analysis does not allow a variable to appear in more than one cluster.

organic factors and are more likely to be constructed by professionals as dangerously 'other', so the use of medication is a strategy most commonly used with psychotic illnesses. But within the context of a practitioner community which rejects an exclusively medical view of its work, the use of medication is legitimized by its combination with other treatment strategies. Similar to cognitive-behavioural therapies, medication is seen as a practical tool, whose focus is relatively circumscribed and can be applied, with little recourse to related medical models, as a valid and useful component in an eclectic 'package' of care strategies. At the same time, the legacy of widespread reliance on medication in post-war mental health services, and the associated anti-psychiatry backlash are detectable in professionals' contemporary awareness of the potential for abuse and repression in the use of medication. As a point of controversy and debate, medical intervention encapsulates many of the paradoxes and tensions inherent in mental health work (for example, debilitating side-effects and denial of freedom versus the need for 'containment' and rapid symptom reduction). Even those professionals who reject or are extremely sceptical about medical approaches to mental illness may sanction the use of medical interventions in their practical work.

3 Theory in Professional Practice: Disjunctions and Insufficiencies

At several points in the analysis presented thus far there are indications of a split between theory and practice in professional social representations. We find, for example, that professionals in Britain and France subscribe to rather different causal models of mental illness (Chapter 5, section 3.2), yet when it comes to their practical work, they enact broadly similar combinations of treatment strategies[22]. For example, although medical perspectives hold more sway in Britain, the use of medical interventions is broadly equal in both countries. Weak links between theory and practice are also indicated by practical eclecticism based on a perceived complementarity of strategies derived from very different theoretical traditions. Professionals judge the value of the strategies they employ in practical terms. If a treatment strategy, or, more likely, several strategies in combination 'work' - if they help professionals achieve the aims they set for themselves -

[22] An important exception is the more dominant position of psychodynamic perspectives in France, a cross-cultural difference which is lived out in practice.

they are worth employing regardless of the theoretical models from which they derive. And in describing their collective models of practice, professionals offer intuitive rather than formal theoretical backing for the central role they allocate to relationships with clients.

The analysis in this section addresses the position of formal, theoretical knowledge systems as one of the key components of professional representations which differentiates them from lay representations or common sense. The role of theory in daily professional practice is explored in section 3.1, and in section 3.2 four functions of theory within the representations of mental health practitioners are identified.

3.1 Multiple agendas and the limits of theory

> I: Do you make use of any theoretical ideas in your day to day practice?
> F22: Personally I don't, no. I think my style of working is according to experience. It's not so much theoretical, it's more what I've picked up from experience or learned from other people about how to act in relation to a certain person.
>
> 'I think you can have all the models in the world and then decide to use something completely different. I think it depends very much on the individual client and it can be a very eclectic approach. And with some people I might use a bit of one and a bit of another. It depends on what difficulties they have and what else they've got. ... I think a model should only be a check list. It should be a reminder about what things you should be looking at so you don't miss anything. It shouldn't be used rigidly, I think it's uncreative to use it so rigidly.' (B19)

For practitioners in mental health, their daily practice is more of a skill based on intuition and experience than an exact science based on the application of principles and theories. Adaptability and openness to the nuances and uniqueness of a specific situation and the problems of a particular individual are prized ways of working in this community, where practical experience is valued more than familiarity with esoteric bodies of knowledge. In the day-to-day routines of mental health services, practitioners must take account of much more than the theories they learned about in professional training. The multiple faces of mental distress which manifests itself in myriad ways mean that theory is simply 'not enough' for competence as a mental health practitioner:

> I: How do you see the relationships between theory and practice?
> F13: It seems extremely difficult to me, because when I begun my hospital training, even though I'd learned that depression is like this, hysteria is like that, psychosis is like that,

> when I found myself faced with patients I was completely disarmed. During the next three years I participated in a supervision group. It was run by a psychoanalyst, and we worked as a group every week. ... That helped me make the link between what I was reading and practice. It requires a lot of experience. When you start out in psychiatry it's extremely difficult. There are things that you can see quite clearly - someone who is very unstable. But beyond that, all the nuances - it's really very difficult. There are so many infinite possibilities of expression of suffering and of each type of pathology - you need to be constantly adapting yourself.

Professional practice must be adaptable, not only to the polymorphous nature of mental ill health, but also to the convergence of the multiple agendas of clients, society, policy, and scarce resources:

> I: What practical considerations come into your decisions about how to deal with a particular person?
> B15: The first one is what does the patient want. I may want to give them medication, and they may say no. I may then consider sectioning them, in which case they get it. Or they may not be sectioned in which case I can do nothing. So there's those elements - what does the patient want. And then what's available. So for example I can quite readily get brief focal psychotherapy for someone, I can get behavioural treatments quite readily. If I want family therapy we're a bit short on that. Equally as at the moment, a number of people who come into hospital could be treated in the community - even people with severe mental illnesses, if we had adequate community support teams.

Deciding how to respond to a particular person with mental health problems involves professionals in complex multi-factorial decision making processes, characterised by uncertainty and compromises. Professionals cannot rely on theoretical 'recipes' - their practice is a fluid and negotiated endeavour in which theory is only one component whose role may be minimal in relation to other practical factors. Unlike in the world of academic research, where research programs and clinical trails can be designed with closer correspondence to theoretical ideas, and where theories can be considered as social representations *per se* (Moscovici, 1993), professionals are confronted more directly with the need to take account of many different perspectives on what is 'desirable', possible and socially acceptable. This highlights the role of professional social representations in achieving compromise and reconciliation between the agendas of various social spheres, an issue which will be taken up further in Chapter 8.

Having established that theory generally plays a limited role in the construction of professional practice, variations in this general principle can also be detected. Clinical psychologists stand out as the professional group whose interview narratives contain most theoretical references, suggesting a stronger role of theory in shaping their practice than

other professionals. The close links of clinical psychology to its parent academic discipline and the profession's recent struggles to enhance its status (Appendix 2), may account for this. Clinical psychologists in Britain adhere to a 'scientist practitioner' model of work (Pilgrim & Treacher, 1992), and professionalisation is currently a central concern. The other group of respondents for whom theory plays a greater than average role is psychotherapists. For French orthodox psychotherapists (whose professional origins are either psychiatry or clinical psychology), a clear link between psychodynamic theory and practice can be maintained, and theory is an essential reference point. But for other more eclectic practitioners, referring back to theoretical principles only serves to highlight incompatibilities or limitations in their daily practice. For example, social models of the aetiology of mental illness suggest that changes in large scale social inequalities, which are beyond the remit of mental health work, would do much to alleviate the mental health problems of individuals. Talking about the use of causal models in professional practice, a British psychiatrist makes the following comments:-

> 'It can be useful if things can be changed. But sometimes it's just frustrating when you know what could be done but it's out of your control. The person doesn't want it done, or the family doesn't want it done or you don't have the means of getting it done. Like somebody who's living in a dreadful flat, somebody who's living in bed and breakfast and can't get into permanent accommodation.' (B4)

Finally, some interesting cross cultural differences in the citation of theoretical ideas in interviews with British and French practitioners can be detected. British respondents cite a range of 'theories of practice' - formulations of practical strategies (often aligned with certain professions) which derive from abstract models of mental illness, but aim specifically to guide practice. Examples which are commonly cited include Beck's cognitive model, humanistic theories associated with Carl Rogers, Gestalt therapy, and Pepleau's nursing model (a relational model of nursing practice in which the nurse-client relationship is central)[23]. Specific 'theories of practice' are cited less frequently in France where more general and abstract psychodynamic principles are the most common theoretical reference points. Whilst this is again indicative of the greater role of psychodynamic perspectives in France, it also highlights a contemporary British concern

[23] For the purposes of this analysis, what is important is the role these theories and models play in professional practice, rather than their specific contents. Readers wishing to know more about these models are referred to Beck (1967) for cognitive therapy, Perls (1969) for Gestalt therapy, Rowan (1983) for humanistic approaches, and Pepleau (1988) for Pepleau's nursing model.

with the transparency and public accountability of professional practice. (This justificatory role of theory is explored more in the following section.) Speculations on deeper cultural differences which this may betray can also be made: Esoteric and abstract levels of thought and expression may be more acceptable in France than in Britain, where the social legitimacy of abstract ideas relies more on their links to the concrete and the practical.

3.2 Four Functions of Theory in Professional Representations

The preceding section highlights the limited role of theory in the construction of day-to-day professional practice. Nevertheless, theoretical knowledge systems do form a significant component of professional social representations, enabling several important representational processes. Data analysis confirms the proposals put forward in Chapter 3 regarding the anchoring and justification functions of theory, and suggests two further functions in aiding professional identity construction, and mediating the emotional impact of mental illness. Each of these aspects is elaborated in turn below.

i) Anchoring functions

A principle role of theoretical knowledge is in the anchoring processes which are central to the genesis and development of social representations. Given the uncertainty that infiltrates professionals' conceptualisations and reactions to mental illness, theories and 'expert' knowledge provide essential categories, names and spheres of understanding as ways of making sense of and responding to mental health problems. Theory is a tool which professionals use to cope with uncertainty, to aid communication within multi-disciplinary mental health teams, and to bridge the perceived gap of difference between themselves and the subjective experiences of their mentally ill clients:

> I: How would you describe what mental illness is?
> B3: That's quite difficult ... It would be very easy, I suppose, for me to say what it is looking at it from a medical view point and my training as a psychiatric nurse, with various illnesses and symptomatology that make up various classifiable diagnoses. But that's very much a medical view point. ... I think symptoms and diagnoses are all very handy for giving a name to a collection of problems that a client is suffering. So it's a name we can all agree on, therefore we know what we're talking about when we use it. That in a way is its main function. It's just to be able to classify a set of problems or behaviours of difficulties that the client is experiencing or showing.' (B3)

The point was made in Chapter 2 that anchoring is rarely achieved effortlessly, and that choice of anchors is always a controversial issue involving debate and negotiation (Billig, 1993). This is certainly the case for professional representations of mental illness, in which daily work rarely involves the straight forward translation of theory into practice, and the use of terms derived from psychiatric nosologies are a point of much controversy (Chapter 5, section 1). The perceived limitations of any single theoretical perspective lead professionals to construct complex representations of mental illness in which echoes of a range of theoretical perspectives are integrated. As such, the anchors which theoretical spheres of knowledge provide are only ever partial and provisional, and are complemented by sense-making processes derived from experience and common sense understandings.

ii) Theory as *post hoc* justification

> I: Do you use any particular models or theories in your practical work?
> B14: I suppose we base things on Pepleau's nursing model, but that's very much so that we can answer questions like this and we're able to quote a model.

While this respondent clearly has a particular 'theory of practice' at her finger tips, it serves in this case not as a guide to practice, but as a *post hoc* rhetorical resource to justify a particular course of action. The intuitive, informal and atheoretical nature of much of what professionals do in the name of mental health care conflicts with social expectations that, as 'experts', mental health professionals should enact specific competencies and forms of knowledge over and above those of lay people. The citation of theoretical bodies of knowledge serves to bolster the (often fragile) public legitimacy of mental health professionals by enhancing the apparent gap between professional and common sense understandings of mental ill health. This accords with Timms & Timms' (1977) analysis of the value of theory in the social work profession, and with the organisational analysis provided by Kirk & Kutchins (1992, see Chapter 3, section 3.2)[24].

[24] Kirk & Kutchins conceptualise mental health services as systems struggling to manage uncertainty, in which psychiatric diagnosis serves as the 'rationalisation of action'. They comment that '(i)f no precise goal is established, if there is incomplete understanding of how to achieve vague objectives, and if there are few systematic methods of monitoring organisational outcomes, then staff and managers have considerable leeway in explaining what they do.' Kirk & Kutchins (1992, p171).

At the time of this research project, public justification of mental health care is a particularly cogent issue in Britain. Much public attention is focused on the policies and practices of care in the community, and the treatment strategies employed by professionals (especially in relation to patients deemed 'dangerous') are under constant media scrutiny. The increasing focus on accountability, quality assurance, and value for money in the market-led National Health Service of the 1990s add to this imperative for professionals to justify their working practices, both publicly and to colleagues and managers. A British psychiatric nurse sums up the situation thus:-

> 'The thing is, the way that nursing in mental health is going, everything has to be documented. In any documentation, if you don't show there is some sort of theoretical or research base, they're going to come down awfully quickly on that.' (B6)

iii) Professional identity construction

For professionals whose field is characterised by a huge diversity of approaches and theoretical positions, and a history of power struggles between these, choosing one theoretical perspective over others is far from neutral. It is a value-laden stance, which some professional use to define themselves in relation to colleagues and to construct their professional identities. Whilst many interview respondents are relatively unconcerned by theories and esoteric knowledge, others (most commonly, clinical psychologists and psychiatrists) incorporate a particular theoretical perspective into their professional identity. Thus, for example, a British clinical psychologist defines herself as a 'systemic therapist', whilst a French psychiatrist defines herself as a 'Lacanian psychotherapist'. In a similar vein, professionals often describe themselves as 'non-medical', even if they do not align themselves with any other particular theoretical stance.

iv) Theories in mediating relationships with mental illness

> 'Often theory acts as a mediator, it gives you reference points so that you can understand an certain illness, by going through the theory to understand it. It's a mediator, it allows you to protect yourself a bit, and hopefully also to understand.' (F4)

While the preceding three functions of theory could apply equally to mental health professionals as to teachers, medical practitioners or other professional groups, a forth implicit aspect of theory identified in this research relates specifically to mental illness.

For professionals working in mental health, theory is more than simply a means of categorising mental health problems. It is something which helps them cope with the emotional responses that mental illness and its associated uncertainties typically inspires. 'Expert' knowledge systems may serve similar functions for professionals as dominant representations of mental illness as 'other', in offering a way of containing a source of psychosocial threat. Faced with the paradoxes inherent in the role of 'professional carer', (the simultaneous requirements to establish contact with a psycho-socially threatening social object, and to maintain 'professional boundaries'), reliance on principles and laws derived from bodies of 'expert' knowledge may help professionals maintain a sense of 'keeping the upper hand' over mental illness whose chaos, irrationality and lack of control might otherwise threaten to take over. Established theory and practice offer the reassurances of structure and distance to professionals who choose to work with mental illness, yet simultaneously betray the difficulties of this position in their frequent references to stress and the required qualities of strength and personal equilibrium (see Chapter 5, section 2.4). Recalling the psychodynamic perspective on organisations reviewed in Chapter 3 (for example, Jacques 1955, Menzies 1960), the use of theoretical understandings could be conceptualised as a collective defense mechanism to help those who work in mental health systems cope with the anxieties invoked by mental illness and its associated uncertainties.

In summary, this chapter has shown how mental health professionals represent their work as a multi-faceted social endeavour which involves them in many aspects of their clients' personal and social lives. Medical practices may be part of this, but professionals do not conceptualise themselves as medical practitioners. Nor do they see themselves as involved in curative practices. Within the context of community-based care and a sense of the enduring nature of mental health problems, professionals aim to enhance life quality by managing rather than eradicating mental illness.

Faced with uncertainties about how best to approach mental health problems, professionals collectively adopt strategies of eclecticism. Underpinned by a broad conceptualisation of the relational nature of their work, professional practice targets the multiple faces of mental illness, falling broadly into crisis interventions and long-term

care strategies. Whilst use of medication as a means of reducing intense distress is common in the first of these, long-term care is typically centred around various group activities (usually involving 'social skills training' and the management of mental illness experiences). These are complemented in Britain by counselling and cognitive-behavioural techniques, and in France by psychotherapies. Analysis highlights how the meanings of each of these techniques are not fixed, but vary subtly between Britain and France. Thus the term 'psychotherapy' refers to a broader and somewhat different set of practices in France compared to Britain, where many of these activities are understood as 'counselling'. This indicates an important cross cultural difference in the status and nature of psychodynamic perspectives, which have significantly more influence in professional representations of mental illness in France.

With the widening of the remit of mental health work into virtually any aspect of a client's personal and social life, professional practice has become increasingly informal, and only a small proportion of what professionals conceive as 'therapeutic' is the formal application of specific treatment techniques. The day-to-day activities of mental health professionals can be conceptualised as the enactment of informal eclecticism in the social management of mental illness. Analysis suggests a cleavage within professional social representations between theory and practice, although in the various functions it serves, formal theoretical knowledge is far from unimportant in professional representations.

Throughout this chapter, there have been indications of the value-laden and 'moral' nature of mental health work. Professionals are continually confronted with tensions between 'abnormality' and social acceptability, and with the conflicting agendas of various social spheres which coalesce in decisions about how to react to individual showing signs of mental distress. These are themes discussed in Chapter 8. Before that, the following chapter considers the impact of organisational factors. In particular, it addresses the radical changes associated with recently introduced community care policies, and the effects of these on the social representations of mental illness circulating amongst mental health workers.

CHAPTER 7

COMMUNITY CARE AND PROFESSIONAL DISORIENTATION

The focus of this chapter is on how recently introduced policies of community based mental health care impact upon and are experienced by the professional community. Against a history of marginalisation of the mentally ill, recent policy shifts aiming to replace hospital-based care with community-based styles of care represent the most radical change in societal reactions to mental distress since the beginnings of confinement in the sixteenth century. This momentous challenge to how mental illness is socially represented must necessarily have a dramatic effect in the world of mental health practitioners. How do the professionals charged with implementing these changes evaluate their current and future success? What specific problems and issues does this raise for professionals' daily work? What is the impact of contemporary mental health policies on the representation of mental illness which circulate in this professional community?

In answering these questions, this chapter highlights how, at this early stage in its development, 'community care' remains a loose and ill-defined umbrella term which practitioners are struggling to construct and implement. The disorienting effect of these changes on mental health practitioners in France and Britain is considerable. Despite this, section 1 shows how professionals' evaluations of these shifts are not wholly negative. Whilst they applaud the general principle of reintegrating the mentally ill, this sits uneasily with their current experiences of the realities of community care and their sceptical views of its future. The analytic focus of section 2 shifts from broad professional opinions to specific experiences in the day-to-day implementation of these policies. The ramifications of these changes are felt particularly by professionals in the domain of professional inter-relationships and the tensions which multi-disciplinary team working raises. For various structural and historical reasons, this transition is particularly difficult for social workers and clinical psychologists. Whilst the focus of the first two sections of this chapter is on the organisational component of professional social representations as it relates to daily practice and the construction of professional identities, section 3 provides a conceptualisation of the broad impact of community care on professional representations in their entirety. This effect is three-fold: community

care increases uncertainty within representations already characterised by agnosticism; it challenges several aspects of professional representations; and it highlights the conflicting agendas which converge in mental health work.

1 EVALUATING COMMUNITY CARE: DISCREPANCIES OF PRINCIPLES AND PRACTICE

1.1 Current Realities: British and French Perspectives

The brief historical overview of State reactions to mental illness in Chapter 1 describes how Britain and France share common histories of the social segregation of the mentally ill and have pursued broadly similar policies of de-institutionalisation in recent decades. The legacy of widespread institutionalisation of the mentally ill leaves a similar mark on professionals on both side of the Channel: The majority opinion amongst professionals in both Britain and France is that a shift from segregated to integrated care of the mentally ill is generally desirable. For today's practitioners, the justificatory principles behind this ideal derive from the concept of 'normalization'[1] and the anti-psychiatry movement of the late 1960s (professionals in both countries often cite the writing of Goffman, Laing and Szasz). There is consensus on the need to implement new societal reactions to mental ill health, to the extent that this is taken-for-granted as an implicit assumption behind much of professionals' talk about community care.

This is an important starting point from which to understand the professional perspective in this change process. It suggests that the relatively cynical explicit debate about community care which circulates amongst professionals must be understood within a more implicit taken-for-granted framework of general concordance with the endeavour of reintegrating the mentally ill. However, overlaid on this general backing of the principle of integrated care, a more complex picture of professional opinions about the reality of community care policies emerges from interviews. For professionals, there is a striking disparity between their constructions of the ideal of community care and their perceptions of its reality. Their specific preoccupations and concerns regarding the later reflect a

[1] 'Normalization' is a term associated with integrative strategies in the field of learning disabilities developed originally by Wolfensberger (1972).

historical snap-shot of the different styles of implementation of community based care in Britain and France in the early 1990s. It is therefore useful to divide the data along national lines.

The British Experience

Recent policy changes in Britain have been both more rapid and more extreme than their equivalents in France, with some of the most dramatic changes being implemented around the time that this study was conducted[2]. For professionals working through these changes, the biggest single issue associated with community care policies is concern over financial resources. In the world of mental health in Britain, community care policies have almost become synonymous with problems of resources. (When questioned about the current state of community care for the mentally ill, 77% of British respondents make reference to insufficient financial resources.) Typically, lack of funding is used to account for the perceived gap between the ideal of community care and its implementation in reality:

> 'I think theoretically it (community care) is very good. I think the basis of the theory behind it is very good and it should work. But at the end of the day, sadly, it all comes down to money. And if the money is not available to implement the services that are required then it's going to be very difficult for it to work.' (B16)

Lack of government funding for community care is judged to have effected mental health care in several ways. First, professionals feel it places limits on the style of work they do and narrows the range of mental health problems they work with. Professionals feel forced to target more long-term and serious problems at the expense of minor and short term mental health problems, and to work reactively at the expense of preventative work:

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[2] The final phase of implementation of the National Health Service and Community Care Act (1990) came into operation in April 1993. At this point, management (but not provision) of community care for the mentally ill was fully transferred to local authority control. (Interviews with British professionals were conducted just after this change in the period May to December 1993.) It should also be noted that changes in mental health care occurred within the context of much broader reforms of the National Health Service. Concurrent moves towards an 'internal market' engendered dramatic changes in funding structures and inter-agency relationships across the whole field of health care.

I: How would you say that community care policies have effected the work of mental health professionals in recent years?
B15: It's certainly made psychiatry target the seriously mentally ill. That's the first thing. Target and prioritise more than before.

'In an ideal world one should be able to do more preventative work and more early intervention which would help prevent some of the damage which does occur with these clients. I think by the time we do intervene now it's so late on with the problem, it's got so tangled up and twisted that we spend so much more time on untwisting it. If there could be more people in doctors' surgeries and things like that, who were mental health trained, we'd be able to do some proper prevention. But at the moment it's a joke, we're just picking up the pieces.' (B18)

Secondly, it has limited the development of comprehensive networks of community facilities. Professionals perceive a need for more sheltered housing, more 'half-way houses', and more 24 hour drop-in centres in the community. Third, professionals are concerned that cuts in hospital budgets have placed pressures on in-patient facilities, forcing professionals to discharge patients rapidly, often before they consider them to be well enough to leave hospital:

'Unfortunately the way things are going, as soon as someone appears to be well they're out of the door. Hopefully they've got adequate follow up and they shouldn't come back in, but it's not always so. Also, a big thing is the number of beds - we don't have enough beds to cater for everyone so we've got to get people out.' (B11)

Despite this pervading concern with insufficient financial resources, professionals in Britain do not see funding alone as the solution to narrowing the gap between reality and their ideal of community-based care. A second major concern is that the shift from segregated to integrated care for the mentally ill has been both too rapid and too extreme. Professionals feel that policy makers have not planned for or thought through the major social implications of such a rapid shift away from hospital based care (for example the need for public education to counter fearful and negative representations of mental illness). In particular, they see hospital based care as a necessary component of care, whose role has been overlooked by policy makers:

'I think there is always a need for acute beds. There will always be some people who need those acute admissions to hospital. They are shutting down all the old asylums, which is good, but there is nowhere for people to go for asylum. I'm not saying that the huge hospitals were great, they certainly weren't. But there now isn't that sort of place of asylum - it's either acute beds or you're out there. In an ideal world I think there should be some sort of safe place for people to be.' (B25)

The present mental health system is also seen as encouraging splits in the style and location of responses to different types of mental health problems. While many minor mental health problems are now effectively excluded from the remit of professional work, a minority suffering from serious and acute problems become 'ghetto-ized' in hospital wards:

> 'If you'd have visited the ward four years ago it would have been very different. When there was less pressure on beds we would have been admitting people with alcohol problems, drug problems, obsessional problems, neurotic problems. I think what community care has done is alter the character of admissions. The emphasis is to try to treat people in the community, so the impact is that people who come to the ward tend to be more severe or more dangerous or aggressive. It means that you are dealing fundamentally with psychosis.' (B10)

This situation of the marginalisation of 'psychotic' patients from mainstream community facilities may contribute to professional understandings of psychosis as a dangerous and fundamentally different 'other'.

A final concern amongst British mental health professionals is their experience of community care policies as producing increasing volumes of paperwork. The cost of integrating health and social services, and the growing concern with accountability mean increasing bureaucratization of daily work with inevitable trade-offs in the amount of time and energy professionals can devote to direct patient contact.

The French Experience

In France, where the recent transition towards community based mental health care has been less rapid, professionals' experiences and preoccupations are slightly different. They share concerns about lack of resources with their British counterparts, but the consensual strength of feeling associated with financial issues in Britain is not matched in France. In line with the more cautious approach to transforming mental health services in France, the effect of poor resourcing is judged primarily to effect the speed of application of community care policies:

> 'I think a certain orientation already exists at the political level, in the various government circulars. But it seems to be an orientation which at the moment isn't accompanied by facts or by resources. There is a need to reduce hospitalisations from the current level, but there are difficulties because we're not given the financial means to set up the facilities necessary in the secteur. There are really big difficulties in that respect. You can't push for policy change and at the same time not accompany that change with resources.' (F1)

Perhaps the most significant structural difference between Britain and France in the implementation of community care policies is the more decentralised system in France. As a consequence, the reality of community care in the early 1990s in France was much more variable than its counterpart in Britain. French government circulars regarding mental health services suggest targets and orientations, but control for implementing these policies lies much more at a local level than in Britain. And it is principally the 'chef de secteur[3]' (invariably a psychiatrist) who holds the power to decide how policies are implemented in any given area. As one respondent puts it 'each secteur is extremely influenced by the personality of the head psychiatrists' (F16). This means there is much more leeway than in Britain to retain hospital services until replacement community facilities have been properly established, but it also brings with it certain professional concerns. Unlike their British counterparts who bemoan enforced reductions of hospital facilities, French professionals are concerned with over-reliance on hospitalisation in the absence of community facilities:

> 'In my opinion, the flaw is that the hospital houses certain people - I think half our patients are here simply as somewhere to stay, in the absence of other accommodation elsewhere. They don't really need hospital care, but they don't receive care anywhere else.' (F24)

A second major concern amongst French professionals at the time of data collection centres around integration of services. Hospital and community services are described as poorly integrated, with little mutual understanding or coordination of staff working in different locations. One respondent comments 'sometimes we learn things about the other services through the patients!' (F2). This fragmentation is perpetuated by the fact that in many secteurs, in-patient facilities are located in hospitals which may be 20 or 30 kilometres away from the actual secteur.

> 'The principle difficulty at the moment is that we have problems communicating because the service is very compartmentalized. There's the drop-in centre, the community clinic, the hospital - each one makes its own interventions, and if we don't communicate we risk the person being seen differently by each one. And what worries me is that that induces even more fragmentation.' (F6)

The third area of preoccupation amongst French professionals centres around the boundaries between social services and mental health services. As mental health

[3] Head of mental health services in a geographical area corresponding to a population of 70,000.

professionals' work moves more towards concern with clients as social beings and involvement in their daily lives, questions are raised about the limits to psychiatric services and the respective roles of mental health professionals and social services:

> 'I don't think it is the responsibility of psychiatry to deal with problems of housing, or people's problems which are of a purely social nature. But at the moment, psychiatry is trying to do everything.' (F16)

As we will see in section 2, these unresolved questions about inter-relationships between mental health and social services raise particularly difficult issues for French psychiatric social workers.

1.2 (Problems of) Knowledge and power[4]

A collective sense of powerlessness, frustration and alienation pervades British professionals' accounts of the organisational changes they are experiencing. Professionals feel that control over many of the current changes is out of their hands, and that these changes have been forced upon them too rapidly, by policy makers who have little understanding of the complexities and realities of mental health care. The source of decisions regarding mental health policies is perceived to be located firmly within the world of politics, and whilst some practitioners call for increased politicisation of professionals, other become resigned or disillusioned by the system within which they work:

> 'I get very angry about what's happening in the NHS, very angry about the way things are managed. And really I feel completely powerless - I feel like I'd like to slap somebody and say "Look! What do you think you're playing at?" But we can't do it, and we're all just a very small cog.' (B1)
>
> 'It seems as though we can have answers as to how it should be, but we don't feed that back into the system - we're totally split from the people who make the policies and who have the power. And I think probably that as mental health professionals we should be feeding that

[4] As discussed in section 2.1 of Chapter 4, the interview schedule used in Britain included more specific questions on community care than the schedule used in France. Nevertheless, French interviews generated a considerable amount of data relating to recent mental health policies. The impact of this cross-cultural variation in data collection is thus relatively insignificant, and it is only on questions of knowledge of community care policies and their origins discussed in this section that no data for French respondents is available.

back up. Feeding up the stress, feeding up the lack of resources, feeding up the examples. ... It would empower us a bit more - we might feel a bit less oppressed if we stood up for ourselves.' (B23)

Marginalisation of practitioners from decision making during mental health service reorganisation, and associated feelings of helplessness have been reported in similar studies in Britain (Ramon, 1992) and America (Fourcher, 1975). However, in the current research, this general sense of powerlessness is not detected amongst French professionals, a finding which may be linked to both the slower pace of change and the decentralised organisation of mental health services in France. French professionals may feel psychologically closer to decision making about how community based care is put into practice, and thus more able to influence the changes to their work this will entail.

British professionals' sense of powerlessness and lack of control over recent changes is accompanied by relatively poor knowledge and understanding of the current policy changes and their origins. Many professionals feel inadequately informed about current policy changes, describing their sources as the media or informal conversations with colleagues. A few respondents, notably all the social workers in the British sample, refer to recent training programmes designed specifically to help them negotiate changes in working practices. Some professionals keep up to date by reading journals and specialized media, but many feel they don't have enough time to do this. Younger professionals may have learned about the shift to community care in their initial training, but many of the older generation give the impression of feeling lost amongst a mass of changes and policy directives which they only vaguely understand:

I: Where does your knowledge of community care policies come from, and what do you see as its historical and theoretical origins?
B20: I don't really know actually. My points of information are my colleagues and purely what affects me as I go along. ... But as far as the theory goes - I haven't got a clue - I don't know who first suggested it or anything.

For many respondents, questions about the historical and theoretical origins of community care proved the most difficult part of the interview. Over half the British sample (n=16) gave 'don't know' responses similar to the extract above. Of the others, the style of community care they are currently experiencing is understood in terms of various motivations, the most frequently cited being financial. This interview extract captures the pessimistic and cynical attitude to current changes which pervaded much of the world

of mental health in Britain at the time of data collection:

> I: What do you see as the origins of community care policies?
> B14: I suppose I don't think I can base my feelings about it on any sort of theory. I think again it comes down to money - my views are along those lines. I feel it's a lot to do with saving the government money. All the large hospitals that have closed down - these people are supposed to cope in the community, but nothing is provided, and these prime sites are sold off. ... As regards theory - for me there isn't anything to base it on. It's money - I feel it's all money.

1.3 Views of the Future: Professional Scepticism

Although professionals in both Britain and France generally judge community based care for the mentally ill to be 'the right way forward', they see its future as precariously dependent on three factors:- financial resources, socio-political factors and public will. They are highly aware of the ambiguities of the notion of 'community' in modern society, encapsulated in the paradox of attempting to integrate mentally ill people into a social environment which may be hostile or itself implicated in the development of mental health problems. As we saw in Chapter 6, along with the enduring nature of mental health problems, professionals see the social problems of 'the community' as a source of restriction to their work, and by definition, to the more general endeavour of community-based care[5]:

> 'The people we deal with have enormous social difficulties. We can respond to a certain extent, but housing and work - we can't help them with that. It's essentially psychological help that we can offer - moral support - it's quite a lot, but it's not enough, of course.' (F22)

> I: How do you see the future of community care?
> B23: I think a lot depends on resources. I also think if you want people to live in the community, the community has to be receptive to those people. Nobody wants it next door to them do they? And if that's going to be the attitude then I don't suppose we're going to get very far. ... I think we'll just muddle along as we do now really. It'll be a slow process of trying some improvements here, and suddenly noticing there's a huge hole there.

For British professionals, a common prediction is of a return in the future to more reliance on hospital based facilities:

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[5] It is worth noting that all the respondents in this research work in areas of Paris and London where social problems such as housing, unemployment, racism and poverty are relatively high, and they are therefore likely to be particularly aware of the limitations the social environment places on their work.

I: How do you see the future of community care in general?
B21: One of my worries is that it may take a complete U-turn, in the sense that with the enthusiasm at the moment to push more and more for clients in the community, I think a breaking point may be reached when everything will have gone too far and there will be some kind of immediate response to start looking at things backwards, and start bringing people back in again.

Many professionals consider that greater reliance on hospital based facilities would provide a more 'balanced' response to mental health problems than the radical shifts into the community currently being implemented. But others fear that this may be motivated by a public backlash against large numbers of mentally ill people in the community in a context of insufficient community-based facilities[6].

French professionals' views of mental health services in the future are more variable - some paint a bleak view of the future, others are more hopeful. Primarily, they anticipate that the move towards community care will gradually become more widespread in France, as the 'slower' secteurs catch up with those that have already implemented significant changes. They also anticipate greater integration with general medical services as psychiatric services are moved into general hospitals. How this integration will be managed in practice, given that mental health professionals define themselves and their work as distinctly different from medicine, remains to be seen.

2 Working Within Changing Systems

In their lived experiences of the changes that community care policies entail, a central concern within professional communities in both Britain and France is with the impact of these on professional inter-relationships. Although interviews were not designed specifically to investigate multi-disciplinary team working, changes in working relationships emerge from interview narratives as a universal challenge within worlds of mental health care, but one which affects the various professional groups in rather different ways.

[6] Interestingly, three years on, there are signs that this prediction is being lived out in the increasing pre-occupation of the British media with the failure of community care, typically objectified in stories of tragic and violent episodes involving mentally ill people living in the community. This is accompanied by growing public debate around the need for tighter community supervision of 'high risk' (ie dangerous) patients and public calls for more secure facilities for mentally ill offenders.

2.1 The Challenges of Multi-disciplinary Team Work

In both Britain and France, the provision of mental health care by an integrated multi-disciplinary team of professionals is central to recent community care legislation. This very fact of multi-disciplinarity reinforces many aspects of professional 'common sense' which have already been elaborated. For example, eclecticism and teamwork embody the assumed impossibility of any single 'right' way of understanding or reacting to mental illness, aiding professionals in their construction of multi-perspective understandings and reactions to mental ill health. Similarly, the inclusion in these teams of a wide range of non-medical 'caring professions' and practitioners who work in a range of welfare, educational and personal development arenas perpetuates a representation of mental health work as a broad and essentially social endeavour, of which medical interventions are only a part.

However, tensions between the powerful legacy of the past and the impetus for change raise several fundamental issues regarding the status and remit of various professional groups. Perhaps most significantly, multidisciplinary teamwork challenges the historically established dominance of medicine in the world of mental health. Although this century has seen the rise of many professionally autonomous mental health workers, psychiatry has generally retained its position of power[7]. This is most obvious in two contexts. Firstly, the power of psychiatry is evident in hospital teams on both sides of the Channel, where care strategies and daily routines have changed little with the implementation of community care policies, and there is more reliance on medical treatments than in community services. Secondly, across most services in France, power is retained in the managerial roles of psychiatrists in planning and running local services. It is primarily in community-based settings where more egalitarian multi-disciplinary teams can be found[8].

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[7] The fact that psychiatrists remain the only profession who can prescribe medication, and as such, carry much greater legal responsibility than other professional groups helps this situation to endure.

[8] For example, in Britain the day centre in West Lambeth is run by a team of nurses, social workers and occupational therapists, with only sessional input from a psychiatrist. In France, the 24 hour drop-in centre in Secteur 1, Paris represents a radical departure from traditionally organised services in that psychiatric nurses are entirely responsible for the evaluation and referral of all new cases.

Other difficulties in multi-disciplinary team working appear to revolve around two main issues. Firstly, tensions between diversity of opinion and a need for minimal levels of consensus, and secondly role ambiguities. The first of these is illustrated below:

> 'What is difficult at the day centre is that we are a team of practitioners who don't all have the same orientation. It can be very enriching, but sometimes it's difficult because you want things to be done in a certain way according to your own personal orientation, whereas other people may want something else, and it's not always easy to find a compromise.' (F30)

The different theoretical and practical perspectives on mental illness that diverse professionals bring to a multidisciplinary team can be a double-edged sword. Just as a lexicon of shared terminology allows professionals to collectively anchor a client's mental health problems (Chapter 6, section 3.2), so a minimal level of consensus between team members is required if they are to communicate and make practical decisions.

A second area of difficulty concerns role blurring. Having spent much of the twentieth century carving out distinct areas of specialism and professionally unique theories and bodies of knowledge (see Appendix 3), mental health practitioners are now required to pool their understandings and work much more closely with each other than ever before. Given this history, overlap is likely to provoke the defense of unique professional 'territories':

> 'I'm happy when each person sticks to their role. ... To a certain extent I find it difficult to work as a team. If several people are involved with one patient I find it easier when each person does his own thing, giving others the elements they need to do their own work, but without interfering. I can't tolerate things getting diluted very well.' (F16)

Similar areas of difficulty in multi-disciplinary team work have been identified by several other studies of mental health teams. For example, Ramon (1992 p94-5) notes that 'interdisciplinary work is often presented by workers as a major source of conflict and strife, of consistent discontent'. This author attributes the difficulties to unrealistic expectations, inter-disciplinary competition and collective myths about the incompatibility of other professions' models. In the context of services for people with learning difficulties, Dockrell, Gaskell & Rehman (1990) note that both horizontal integration (between team members) and vertical integration (between practitioners and managers) are crucial to the successful development of community services. And in a recent study

of community mental health teams in Britain, Onyett, Pillinger & Muijen (1995) report that role ambiguity is a particular problem of multi-disciplinary approaches to community care, associated with stress and job dissatisfaction. Practitioners are now members of two professional groups (their discipline and their team) and this research predicts that the ideal conditions for team working would be those in which each discipline has a clear and valued role within the team, allowing team membership to coexist with rather than challenge professional identities.

Faced with these various difficulties there is sometimes a tendency to fall back on more traditional professional relationships and established role definitions. Kirk & Kutchins (1992) conceptualise the standardised divisions of labour within mental health organisations as a way of dealing with the ambiguities and uncertainties which permeate this professional world. In times of rapid change, in which multi-disciplinary teams are the site of power struggles between professionals and redefinitions of professional identities, the clarity of historically established roles (even if these are unequal) may provide a valuable sense of stability and orientation. Traditional hierarchies may be implicitly retained as a way of providing the reassurance of clarity of leadership.

> 'There's still a very obvious hierarchy there. It's less rigid - people don't assume that the higher up the hierarchy you get, the righter you get. You certainly have more experience and you have more theoretical knowledge to go on, but ultimately I think a junior nurse and a consultant can often shed the same light on a problem. ... People have different things to offer and they're equally valuable, although ultimately somebody has to bear responsibility and make decisions and that is invariably going to be a hierarchical thing.' (B8)

2.2 Struggling with the Changes: Social Workers and Clinical Psychologists

Given the historical positionings of the various professional groups, it is evident that different practitioners come to this situation from very different perspectives. The current research identifies two professional groups whose perspectives on multidisciplinary teamwork are unique: The experiences of social workers and clinical psychologists are worthy of comment not only because they are described as particularly difficult, but because these difficulties are manifestations of more general shifts and contemporary dynamics in the world of mental health. In particular, the concerns of social workers reflect current questions regarding the boundaries of mental health work, and how it relates to other social agencies, whilst the difficulties experienced by clinical

psychologists reflect current challenges to the traditional dominance of a medical perspective.

Although differences between professional groups are generally minimal, the experiences of social workers in the implementation of community-based care are highly distinctive. On both sides of the Channel, social work respondents in particular talk about acute difficulties and dissatisfactions with the current nature of their work. Recent and on-going policy changes appear to be placing particularly heavy strains on mental health social workers, particularly in France, where unanimous feelings of discontent are expressed by all the social workers interviewed. French social workers feel undervalued by psychiatrists and other colleagues in the mental health team, scape-goated, marginalised and torn between the often conflicting agendas of mental health teams and social services:

> 'I'm ordered about by the patients, the doctors, and the social workers at the town council, and sometimes that makes me feel very uncomfortable. Sometimes the psychiatric team doesn't understand, or doesn't want to understand. They think it's important to have links with other services, but more in terms of just getting allowances or services for people than really working together. I find it quite disturbing - I think the psychiatric team is quite put out by the social services, which are also extremely powerful, and sometimes the social worker becomes everybody's scapegoat. Sometimes I'm the target of aggression and incomprehension from the psychiatric team about what is happening in the outside world, because I represent that outside world. I think it's also a form of self protection for psychiatrists in relation to the outside world. Psychiatry has its limits of course, and when it comes up against those limits it tries to see if another response can be found elsewhere. And because they are not specialists in social issues they'll say "I can't do that for this patient, so it's down to the social worker to do it". But sometimes reality means that we can't offer what the doctors would like us to offer. Sometimes there's a lot of misunderstanding, with each person stuck in their own world. (F18)

Social workers in France have become the victims of current debates highlighted in section 1.1 surrounding the boundaries between psychiatry and social services. As professionals involved in welfare and health services struggle to redefine new roles and relationships, and the remit of mental health widens and becomes less clearly defined than in the era of institutional care, tensions are felt most acutely by practitioners who work at the interface between health and social services. Mental health social workers are doubly marginalised, regarded as only token members of both mental health teams and social services. Their experiences reflect the challenges of community care for mental health services in reacting to the mentally ill as social beings, while nevertheless maintaining a distinctive mental health approach. Social workers become the messengers

in the continuous 'buck passing' which occurs between various social agencies faced with the enduring nature of mental health problems and social inequalities.

Whilst many of the experiences of British social workers parallel those of their French colleagues, their difficulties are slightly less acute, and reflect somewhat different structural issues. For British social workers, perhaps more than for any other profession, the implementation of community care policies is equated with significant increases in work-load, responsibilities, and a shift in the nature of work towards greater concern with finances and the targeting of scarce resources:

> 'What I think it (community care) has meant is that there is more work for us to do. Whereas before if someone needed a day centre with nothing else, a nurse could refer or the person could refer them self, now everybody who needs any service has to come via a social worker. So it increases our paperwork. It's also increased the amount and the categories of people we are supposed to see and assess on wards. With the turn over of the number of people on the ward, and all the other work we've got, you can't, with the best will in the world, keep up with that. You just can't do it unfortunately. So the general thing that I feel, and probably the rest of us feel, is that it has increased paperwork and increased the expectations of our work.' (B25)

Recent changes in the funding of British mental health services means that social workers are now implicated in all referrals of mentally ill clients to any community or social services facility. One respondent describes this shift as social work 'becoming simply a means tester' (B12). Social workers in Britain bear much of the brunt of the budgetary limitations imposed on the development of community care, as well as taking on increasing responsibilities in their legal role in compulsory hospital detentions on the grounds of serious mental illness. These findings parallel those of the recent Onyett, Pillinger & Muijen (1995) study, which reports that compared to other professional groups, social workers show the least overall job satisfaction, lowest levels of satisfaction with work relationships, high levels of emotional exhaustion and depersonalization, and a low sense of personal accomplishment. On a more positive note, all the British social workers in the current study report receiving professional support and training to help them negotiate these changes.

The second professional group whose common experiences of multidisciplinary teamwork mark them out from other professional groups are clinical psychologists. In both Britain and France, clinical psychologists in this study express difficulties establishing their position within multidisciplinary teams, and report a continual struggle to carve out a

valid and valued perspective against the dominance of psychiatry:

> 'The unique position of the clinical psychologist shouldn't be considered a superficial position, but as fundamental to the team. The problem is that at the moment we inhabit a rather marginal position, which is often seen as something rather superfluous. People don't quite know what the psychologist is doing there, whereas for me it's a fundamental role. (F25)

> 'I see psychology as being quite different from other mental health professions. I think traditionally mental health or mental ill health has been diagnosed by medical people. ... As psychologists we are less interested in diagnoses and names and labels and more interested in making psychological formulations - tying up all the information about that person with a view to trying to understand them. ... I think psychology's about making individual formulations for each person's problems, and the treatment very much depends on that formulation, rather than what label you've given their difficulty. ... I think there's a place for both medicine and psychology to work hand in hand. I think we should be working together. So I don't think one is better than the other, but I wouldn't be a psychologist if I didn't believe that was the preferred or more fruitful way to work with people's psychological difficulties. (B17)

Recent professionalisation of the discipline, together with the significant contribution of psychological theories and therapies to expert understandings and treatments of mental ill health (for example, social learning theories, and cognitive perspectives) mean that, of all the mental health professions, clinical psychology represents the most significant challenge to the dominance of psychiatry. Yet there is currently an imbalance between the influence of psychology on a theoretical level and the status accorded to psychology practitioners. Struggles with the implicit power of the medical profession, and difficulties of presenting other perspectives are amongst the most important current concerns of the clinical psychology profession in Britain (Johnstone, 1993). Together with psychotherapists, clinical psychologists are the profession who claim to make most use of theory in their practical work, a strategy which may well be related to the desire to enhance their professional status. What seems most likely is that the experiences of clinical psychologists represent not only the struggles of a single profession, but are indicative of current erosions of the medical power base in the world of mental health.

3 Community Care and Professional Social Representations

The themes presented in sections 1 and 2 of this chapter represent a snap-shot of professionals' opinions and experiences of the implementation of mental health policies taken at a particular historical moment within a longer and more general process of change in public mental health care strategies. But can a more general understanding of the impact of community-based care policies be developed? Extrapolating from this historically and geographically situated data, this section conceptualises the impact of these change processes on professional social representations, highlighting three overlapping aspects. Firstly, the novelties, ambiguities and lack of knowledge associated with community care policies augment the uncertainties which are already a defining feature of professional representations of mental illness. Secondly, current mental health policies constitute significant challenges to many aspects of these representations. And thirdly, community care policies highlight the conflicting agendas of various social worlds, bringing into sharp focus the position of professionals at the interface between these agendas and the consequent difficulties with which their daily work is imbued.

3.1 Augmenting Representational Uncertainties

> 'We're working in a structure where there isn't really any precedent. It's a new type of structure which has only been around in psychiatry for the last ten years. So we haven't really come to any conclusions regarding *savoir faire*. We're breaking new ground. Situations develop and we innovate. ... There are some general reference points, but they're less easy to pick out than at the hospital because the whole project and the type of responses are more personal. So it's more difficult to pass them on to other people because you're faced with a new situation every time. At the hospital you can fall back on a classification system - you know there are certain signs and a standard treatment, and you follow a protocol. Here we have certain lines of conduct, but no protocol.' (F2)

> 'I've been working here for a bit more than ten years, and I've seen psychiatry evolve from being very hospital based to wanting to get out of the hospital and pull down the walls of the asylum. From eighty hospital beds we went down to eighteen or twenty, and we've now gone up again to twenty five. ... I feel that at the moment we're going through a period of a kind of apprenticeship, and that we're not managing to move beyond this difficult period too well.' (F18)

It is clear from interview narratives that the implementation of community care policies equates with change and uncertainty in daily working practices. In disentangling the origins and semantics of this uncertainty, several sources can be identified. First and foremost, novelty is a prime cause of uncertainty. Professional communities are in the

midst of radically rethinking and reworking the established daily practices upon which their historically grounded representations of mental illness rest. Particularly for the older generation of mental health professionals, working with the mentally ill as social beings integrated (more or less) into society is a radical departure from the more institutional work they were trained for, and one which requires new styles of relating, new aims and goals. There are clear parallels here with Kuhn's (1963, 1970) notion of shifting 'paradigms', in which challenges to the basic assumptions and practices of an expert community initiate crisis and revolution. In this case however, old representational anchors may have been firmly rejected, but new ones are not yet in place. The professional community may be sure of what it has rejected, but it is still in the midst of deciding what to replace this with. Furthermore, this process is hindered by generally low levels of knowledge and understanding of current and recent policy changes within the professional community. Professionals regard themselves as uninvolved and under-informed about current policy changes (section 1.2), and there is currently a striking lack of consensual understandings of what the notion of 'community care' actually means. The 'top-down' ways in which policy changes have been introduced (especially in Britain) engender uncertainty in professionals regarding the political and organisational frameworks underpinning their practice.

Individualised care strategies, which are enshrined in contemporary mental health policies in both countries, are another source of professional uncertainty. The deliberate attempt to provide packages of treatment appropriate to the needs of specific individuals means that mental health work necessarily becomes less standardized. As analysis in Chapter 6 shows, the work of mental health professionals becomes an active, constructive process of integrating multiple strategies, characterised by high levels of uncertainty and minimal reliance on theory and standard protocols.

A final reason why community care augments representational uncertainty relates to the ambiguities inherent in the complex social semantics of the notion of 'community'. Whilst any organisational change or disruption of the *status quo* is liable to produce some degree of anxiety and concern in its replacement of what is known with what is unknown, ambiguities surrounding the relationships between mental illness and the social environment evoke many more questions and uncertainties than can be attributed to organisational change *per se*. The world of mental health is replete with assorted

understandings of how mental illness relates to notions of 'the community'. For example, while the community has been implicated in the aetiology of mental health problems (as a source of stress, or due to social deprivations and inequalities), it has also been construed as a potential source of support and therapeutic value. Similarly, in its journey towards becoming a social reality, the notion of 'community care' has been associated paradoxically with both left-wing and right-wing political ideologies (the former through the anti-psychiatry and human rights movements of the 1960s, the latter more recently, through promotion of the values of independence and individualism, and reductions in state welfare provision). These ambiguities map onto broader social concerns in which the concept of 'community' in post-modern society is an area of much current debate (Berger et al 1974; Giddens 1991).

Organisational change is simultaneously a chance for innovation, initiative and creativity, and a potential source of stress and tensions. In the case of professionals living through the introduction of community-based care for the mentally ill, the combination of novelty, semantic ambiguities, and lack of control render this primarily a source of struggles with uncertainty. As the analysis in preceding chapters highlights, uncertainty and agnosticism are already defining features of professional representations of mental illness. Current changes and instabilities at the level of policy may unsettle professional communities by adding yet more uncertainty to their practice-based representations of mental illness.

3.2 Community Care as a Social Representational Challenge

It was proposed at the beginning of this chapter that community care represents the most dramatic shift in societal reactions to mental illness since the beginnings of confinement. As such, it constitutes a dramatic challenge to how mental illness is socially represented in requiring that society integrates those it has traditionally defined as threatening, different and worthy of a marginalised or excluded social position. A significant part of the work of mental health practitioners becomes that of challenging these common sense understandings of mental illness, and suggesting to society that new ways of reacting mental ill health are possible and preferable. New practices enacted by professionals challenge the historically established anchor of 'otherness' which society has traditionally used to make sense of mental illness.

The theoretical implications of these representational ambiguities are discussed in more detail in Chapter 8 (section 2.1), which attempts to conceptualise the complexities of current societal understandings of mental illness. Keeping the focus on professional representations for the time being, there are several knock-on effects of community care which constitute specific challenges to professional representations. For example, as well as requiring professionals to challenge societal assumptions about mental illness, implementing community care may also challenge professionals' own tacit beliefs about mental illness (remembering that lay representations can be considered as integral elements of professional social representations). As Jacques (1955) and Menzies (1960) highlight, organisational change may be resisted because it undermines the use of established working structures and routines as collective defenses against anxiety. Community care also entails a challenge in the domain of professional identities requiring, as we have seen, radical changes in professional roles and relations such that previous areas of specialism, hierarchies and professional distinctions are broken down. It also challenges the world of mental health in provoking questions regarding the social role and positioning of mental health services. Where are the boundaries of mental health services' remit, and how do they interrelate with other social agents, namely social services and medicine? The representations emerging from this research suggest that the world of mental health is increasingly defining itself as distinct from medicine. But this shift away from general medicine, and the prevailing view of mental health work as a social endeavour brings with it challenges to the boundaries and respective roles of mental health workers and social services.

3.3 Highlighting Conflicting Agendas

In increasing uncertainties and provoking representational challenges, the recent policy changes highlight tensions and incompatibilities between the agendas of the various social worlds involved in the construction of social knowledge. As such, they bring into sharp focus the unique and difficult 'cross-roads' position of mental health professionals who act as translators, vectors and integrators of various belief systems and demands (Chapter 3, section 2.6). Professionals are faced with the task of developing strategies of care for the mentally ill which are simultaneously consonant with policy directives, legitimate in the eyes of the lay public, and acceptable to clients themselves. Awareness of these

multiple agendas forces professionals to recognise that the success of the strategies they implement is, to a large extent, out of their hands:

> I: How do you see the future of the mental health system in France?
> F2: It's complicated because I think essentially it's linked to two variables which we can't control. They are the economic situation, because nothing can be done without the financial resources, and also what society wants. Is society aware of mental health, and if it is what sort of solutions does it want to give? So we are at the conjunction of several elements.

In implementing community care, there is a confrontation of old and new, an antagonistic meeting of what is historically established as a given (the mentally ill as different and dangerous) with innovation and change. Research reviewed in Chapter 2 shows how members of the lay public prefers to distance and differentiate themselves individually and collectively from those defined as mentally ill. They may accept general arguments about tolerance, civil rights, and the horrors of large scale institutionalisation, but the 'not-in-my-back-yard' syndrome is alive and kicking. And as Jodelet's (1991) study so powerfully illustrates, there is a big difference between integration into the community in terms of shared physical space, and true psychosocial integration. Professionals are likely to face scepticism and resistance from the public in their attempts to support mentally ill people as equal and valid members of society.

As well as these substantial tensions with the desires and representations of the lay public, community care also enhances agenda conflict with the world of politics and policy making. As analysis in section 1 illustrates, professionals are deeply concerned about government funding of community care policies and suspect that policy makers may be primarily motivated to cut costs. This sits uneasily with professionals' representations of their work as a long term endeavour, requiring multiple interventions, and comprehensive networks of community based and hospital facilities. Especially in Britain, where change has been imposed rapidly with little consultation with practitioners, professionals feel they are being asked to enact political agendas which neither they, the public, or mental health 'experts' are entirely in agreement with. However, although professionals are highly critical of many aspects of current policy, they are generally in agreement with the broad principles of community based care. Thus, a more complex picture emerges of major conflicts between professional and political worlds in the area of mental health, but also of professional ambivalence. Relations between policy makers and professionals are clearly more complex than universal antagonism.

To conclude this chapter, the professionals in this study are vital actors in the on-going process of carving out how society makes sense of and constructs the notion of 'community care', and in shaping mental health strategies which will take us into the twenty-first century. Whilst the practitioners investigated in this study are united both nationally and internationally in their belief that community-based care for the mentally ill is generally a desirable ideal, the discrepancies between this and their perceptions of the realities of community care are striking. Cross national variations in concerns over implementation reflect structural and organisational differences between Britain and France: There is general concern in both countries over limited financial resources, but in France this is perceived primarily as hindering the <u>speed</u> of change, whereas in Britain financial constraints are judged to effect the <u>amount</u> of community facilities. The over-riding sense amongst British professionals of living through a period of rapid and dramatic change in working practices, over which they have little control, understanding or general knowledge, risks creating not only disorientation, but also disillusionment.

Current changes disrupt the fragile *status quo* in the social position of mental health professionals and the internal workings of their representations. Both within the mental health services and in interaction with other social agencies, practitioners are struggling to renegotiate new working relationships. The impact of these changes on professional social representations can be conceptualised as three interrelated effects: Community care adds further uncertainty to professional representations already characterised by much uncertainty; as a paradigmatic shift, it poses challenges to several aspects of these representations, such as professional identities and the remit of mental health services; and it highlights and enhances tensions between mental health professionals and other social spheres, particularly the lay public and the world of politics. Within this climate of change, professional representations of mental illness are currently the site of much debate, negotiation and power struggles. The result of this rhetorical and practical activity is the construction of practical strategies in the on-going endeavour of mental health care, which constitute insecure compromises rather than fixed solutions. This theme of professional social representations as compromise will be taken up and discussed in more detail in the following chapter.

CHAPTER 8

EMPIRICAL INTEGRATION, THEORETICAL REFLECTIONS AND IMPLICATIONS

This final chapter draws together the principle empirical findings of the thesis, and uses these as the basis for reflections on both theoretical and substantive issues. As a conclusion to the thesis it has four aims:

Firstly, (in section 1) it summarises what this research shows about the social representations of mental illness which circulate amongst mental health practitioners in France and Britain, contextualising these findings in relation to other domains of social knowledge. Whilst the uncertainty found in these representations is also a feature of professional knowledge in general medicine, it is argued that the area of mental health is characterised by particularly high levels of doubt and speculation. In comparison to common sense, professional representations of mental illness are more complex and less definitive, with otherness themes existing as one of several areas of debate rather than as an unquestioned defining feature. Similarities between British and French professional representations generally outweigh differences, and professionals of all disciplines are united by broadly similar representations. The most consistent cross cultural difference centres around the influence of psychodynamic ideas which hold more sway in professionals causal models and in daily working practice in France.

Secondly, the chapter aims to explore the functional aspects of professional social representations. Section 2 proposes that professional social representations serve important compromise functions helping practitioners to reconcile tensions and ambiguities which they confront in their daily work. Areas in which reconciliation and compromise are required are classified into those relating specifically to professional representations of mental illness, those which may occur in all professional social representations, and those pertaining to more generic social representational processes.

The third aim of the chapter is to use the empirical analysis of the thesis to address current lacunae in the theory of social representations. Accordingly, section 3 speculates

on the theoretical consequences of otherness, multiplicity, ambiguity, notions of unfamiliarity, and several other themes which have emerged from this research, suggesting ways in which the theory could be fruitfully modified and refined to account for these characteristics of our social world.

The forth and final aim of the chapter is to speculate on the implications of this research, both in respect of future social psychological research that this study suggests and in terms of the issues it raises for contemporary mental health care. Some suggestions for professional training and strategies which could facilitate the implementation of community based care are made. The thesis concludes with a reminder of the social relevance of this form of research.

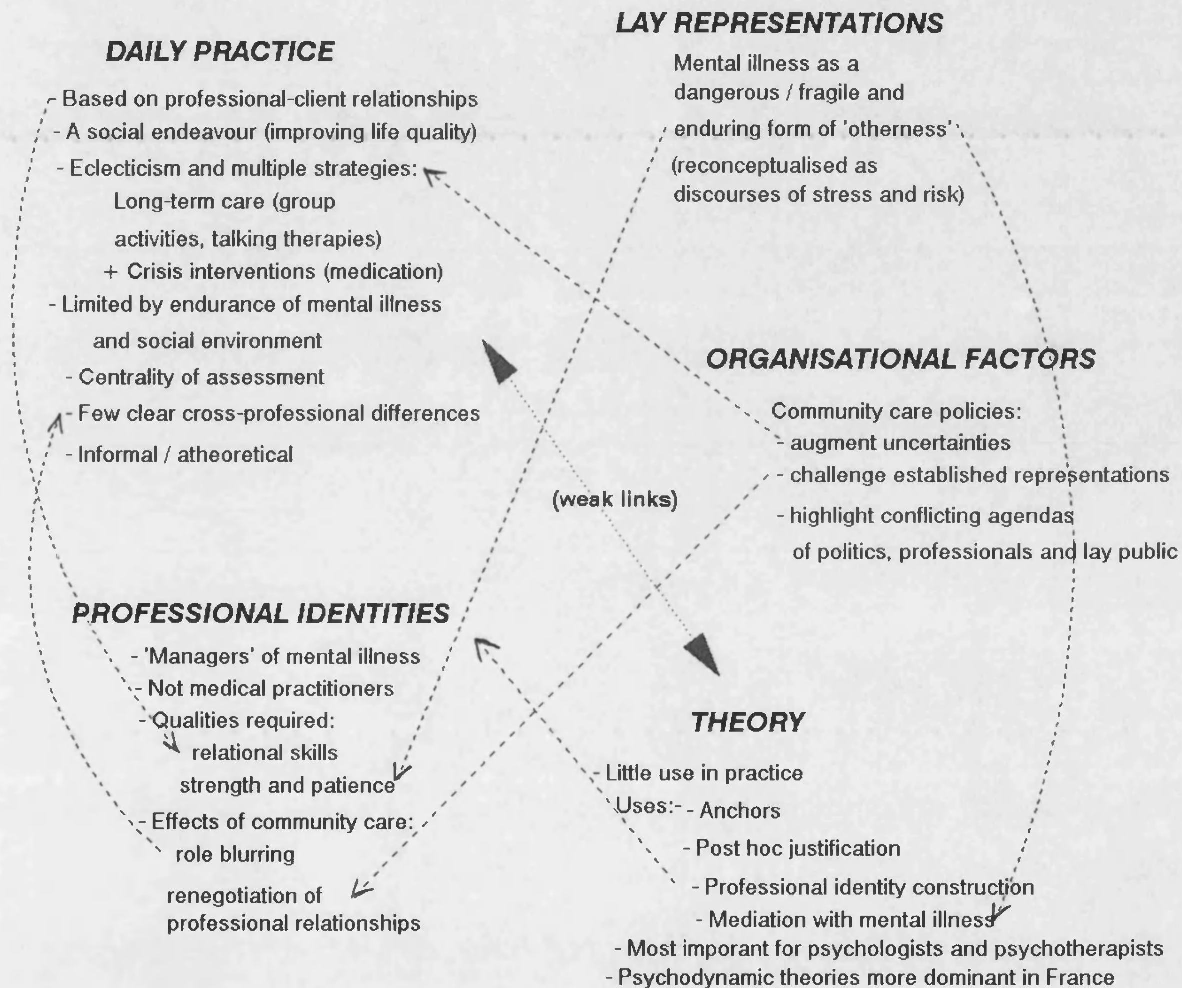
1 Revisiting 'Professional Social Representations'

1.1 Representing Mental Illness: Social understandings and professional uncertainties

Rather than attempting to summarise the findings of the previous three empirical chapters, Figure 8.1 presents a graphical illustration of the professional representations of mental illness which have emerged from this investigation. Building on the proposed structure of professional representations developed in Chapter 3 (and illustrated in Figure 3.3), the principle findings are grouped according to five components of professional representations: theory, practice, professional identities, organisational factors and lay representations. Some of the clearest inter-relationships between aspects of these knowledge spheres are illustrated using arrows (although doubtless other connections could also be added).

Following the detailed expositions in Chapters 5, 6 and 7, the contents of each of the five domains in the main section of Figure 8.1 should be self-evident. Rather than reiterating these details, this review aims to take a broader perspective, contextualising these empirical findings within the broader tapestry of social knowledge of which they form a part. Representations of mental illness must overlap with understandings of other forms of deviance such as physical illness, and rest upon implicit collective representations of life, human nature, and relationship of individuals and society. The delineation of a

Figure 8.1: Professional Social Representations of Mental Illness
A Graphical Summary



"BED-ROCK THEMES"

* Mental Illness as:- Polymorphous (neurosis - psychosis distinction)
  - A "social" phenomenon (difference, disruption and distress)
* Agnosticism / Uncertainty
* Multiplicity
* Tensions and Moral Dilemmas

specific area of social knowledge for the purpose of research is, to some extent, a false boundary, which carries with it risks of decontextualisation. In order to appreciate the full social meaning of any branch of knowledge, we must look beyond the limits of a single study, to position its findings within the broader web of inter-connecting social and collective representations. Accordingly, this section focuses on the 'bed-rock' themes in the lower part of the figure, which constitute the defining characteristics of these representations. The inter-related representational features of 'social' and relational understandings, multiplicity, and uncertainty, and their linkages to other spheres of social knowledge will be considered in turn. (A forth characteristic, namely internal tensions and inconsistencies, is the focus of section 2 which considers functional aspects of professional representations.)

First and foremost, the representations of mental illness which emerge from this research constitute an essentially 'social' model of mental illness. In other words, the mental health or illness of an individual is judged by professionals not in isolation, but relation to the norms of the social world in which they live. To be defined as mentally ill, an individual must be judged to be not only distressed, but also different from other people in a way that disrupts normative ways of being and relating. This concern with social functioning reflects a broad shift in the nature of professional practice, away from its historical roots of treating individuals in isolation from mainstream society. Not only in mental health, but in areas of general medicine, learning disabilities and so on, a concern with 'social functioning' rather than symptomatology is now central to the work of practitioners from doctors to social workers, nurses, educationalists and care assistants. Socially oriented care policies force society to question its consensual notions of normality, deviance and difference, and bring these issues to the forefront of contemporary social representations. Whilst understandings of physical and mental health and illness have always been bolted onto notions of normality and abnormality[1], professional concern surrounding the type of difference that mental ill health is (temporary or permanent, quantitative or qualitative) is indicative of how community-based care for social deviants forces society to contemplate the bounds of its tolerance and its criteria for acceptability.

[1] That health is the default status or background condition from which various states of illness deviate and are marked as 'abnormal' is illustrated simply, but powerfully, by the fact that people are referred to as 'unhealthy' (ie deviating from the norm), but never as 'un-ill'.

The implication of inter-personal relationships is central to professionals' 'social' understandings of mental illness are manifested. For example, interpersonal relationships (especially familial relationships in childhood) are seen as important causal factors in mental health problems, which may be manifested in ways that disrupt current relationships or make the establishment of relational links (empathy and understanding) more difficult. Relational aspects of the work of mental health professionals are seen as vital building blocks which underpin all treatment strategies, compensating for other relationship difficulties or deprivations, and enabling trust and knowledge to be established. Many of the treatment interventions enacted by professionals (especially those taking a psychodynamic perspective or involving group activities) aim to encourage change in current relationships and ways of relating, and enabling the mentally ill to form and continue 'normal' relationships in everyday life is one of the principle aims of contemporary mental health work. Although these relational themes can be traced in several spheres of expert knowledge (for example, psychodynamic, humanistic and social learning perspectives), their ubiquity, even amongst professionals who do not subscribe to these theoretical perspectives, betrays a more basic aspect of mental illness representation. Namely, it indicates that mental illness is not cast as an 'absolute other', detached completely from social participation, but more as a problem of otherness and difference which must be tackled within the course of daily social intercourse. (This theme is addressed in more detail in section 3.1).

Two other defining features of professional representations of mental illness are multiplicity and uncertainty. Professional representations are multiple both in terms of conceptualising mental ill health as a polymorphous phenomenon (split primarily into 'neuroses' and 'psychoses'), and in their integration of various expert schools of thought. Chapter 6 suggests that it is because of their agnostic stance and their uncertainties regarding treatment selection and outcome, that professional generally choose to adopt multiple and eclectic strategies in daily practice. This is confirmed by observations of ward rounds and team meetings (a secondary data source) in which it is not unusual for debate about a particular individual's mental health problems their treatment to last for thirty minutes or more[2]. A sense of 'going round in circles' and failing to reach any

[2] This is within the context of services which may have between fifty and one hundred clients on their books at any one time.

definitive understanding is common in these team discussions. In the face of this acknowledged collective uncertainty, mental health teams invariably resort to multiple treatment strategies in the hope that something they do might make a degree of difference to the person's quality of life. Perhaps the only relative certainty amongst these professionals is that they are not involved in the business of cure, but are practitioners who work within the parameters set by the enduring nature of most mental health problems.

Throughout the twentieth century and further back into the history of mental health care, 'expert opinion' has provided various ways of approaching mental distress (medically, behaviourally, psychodynamically and socially, for example). Although each of these has had its heyday and received its share of criticisms, none of them have been entirely discredited. Their contemporary coexistence offers mental health professionals, whose working remit is now extremely wide, a heterogenous pool of expert knowledge from which they can select and combine elements in their daily practice and their continual struggles to make sense of the elusive phenomenon of mental illness. Interestingly, although the basic principles of these various perspectives may be logically inconsistent, professionals rarely regard theoretical inconsistencies as a problem. The compatibility of their practical derivatives is assumed in eclectic daily practice. This situation highlights two important features of professional common sense in the world of mental health. Firstly, it suggests that links between theory and practice are tenuous. Secondly, such multiplicity debunks the myth perpetuated by simplistic research designs, that professionals can be categorised according to subscription to single models of mental illness (for example, Rabkin 1972, Strauss et al 1964, Thommen et al 1992). Instead, it is the relative weight or importance given to each perspective that is the differentiating factor between mental health workers.

As noted in Chapter 3, multiplicity and uncertainty are features of professional knowledge uncovered by other studies of the world of mental health (for example, Kirk & Kutchins 1992, Prior 1993, Strauss et al 1964, Zani 1987, 1993). However, research conducted in similar professional spheres suggests this is not unique to the mental health professions. The work of the medical sociologist Fox (1988) highlights how the professional world of physical illness is also imbued with high levels of uncertainty. Fox conceptualises medical training as 'training in uncertainty' which derives from medical

students' incomplete mastery of available knowledge, the limitations of medical knowledge, and the difficulties of distinguishing between these two. She suggests that medical students and doctors develop collective coping mechanisms to deal with this professional uncertainty, such as strong group identities, and attempts to achieve as much cognitive command of the situation as possible through acquisition of medical knowledge and technical skills ('learning to conjure possibilities and probabilities' as one of her medical student interviewees puts it). Compared to general medicine, expert understandings of mental distress are general regarded as 'less advanced'. For medically trained psychiatrists (as well as some nurses) who experience the transition between these two worlds, treatment decisions in mental health work are made harder and more uncertain by the current transition to community based care, and by the more ethically loaded nature of the work. More than in general medicine, there is a need to take account of patients' opinions and wishes, not only for moral reasons, but also because information about mental health problems can often only be obtained through self-report, rather than through independent, 'objective' measures such as blood tests, X-rays or urine samples.

Finally, how do professional representations of mental illness compare to their counterparts in the world of lay thinking and common sense? As argued in Chapter 3, professional representations should be regarded as emerging from, and forming part of a socio-historically specific web of constructed social knowledge, such that elements of common sense are contained within professional representations. Beyond the general structural features which differentiate professional representations from lay understandings (inclusion of 'expert knowledge', the enactment of professional competencies, and so on), this analysis suggests that professional understandings of mental illness depart from common sense in two inter-related ways. Firstly they are more differentiated and complex, and secondly, they are less definitively set in stone as unquestioned social realities.

Whilst polymorphism and the coexistence of multiple forms of knowledge have been identified as characteristics of lay understandings of both mental and physical illness in studies conducted across Europe and North America in the last two decades (for example, Bastounis 1996, De Rosa 1987, Herzlich 1973, Glasgow University Media Group 1994a, Räty 1990, Stainton-Rogers 1991, Zani 1995), this complexity seems to be particularly

exaggerated in professional knowledge systems. More than lay people, professionals understand mental ill health as a range of problems rather than a single entity. The most important distinction for professionals is between 'neuroses' and 'psychoses'. Their representations of 'psychotic' problems as permanent, fundamental and incomprehensible difference or 'otherness' shows the clearest parallels with common sensical notions of mental illness. But the coexistence of views of neurosis as a less permanent and fundamental form of difference, and their unanswered questions regarding the types difference, disruption and distress that can be attributed to mental illness, undermine any fixed, constant and definitive understanding within the professional community. Somewhat paradoxically, as society's 'practical experts', mental health professionals may be more agnostic about mental illness than lay people. Their daily interactions with the mentally ill alert them to the arbitrary and partial nature of their understandings (a challenge which may be less common amongst lay people), such that professionals are less willing than the lay public to accept their social representations as fixed and ontologically real (Markova 1992).

Compared to lay people, professionals represent mental illness less definitively as a fearful and dangerous 'other'. Whilst danger, violence and 'risky' behaviour are part of their representations, these are not such strongly defining and ubiquitous themes. 'Otherness' coexists with themes of the similarity of mental illness to more common or 'normal' experiences, and professionals recognise subjective distress as a key feature of mental ill health. They appear more willing to construct links through empathy and parallels between themselves and the mentally ill than lay people, who prefer to keep 'psycho-social clear water' between themselves and people defined as mentally ill. This suggests that professionals may be more at ease with integrationist policies than lay people, a relatively unremarkable finding, given that practitioners were at least partially responsible for this historical shift[3].

[3] Similar findings are reported by Zani (1987) who finds that in comparison to lay people, Italian mental health professionals tend to stress the diverse manifestations of mental health problems, and place more emphasis on social and environmental causes. Professionals in Italy have more complex views of treatment than lay people, emphasising the benefits of a range of strategies, and seeing the community as a more appropriate location for treatment than lay people do.

1.2 Representational Variations

The analytic strategy adopted in this thesis has been open to both variation and consensus in the data corpus, with *a priori* segmentations of interview data according to nationality, professional groupings and location of work (hospital or community based settings) built into the qualitative investigations conducted using QSR-NUDIST (see Chapter 4, section 3.3). However, in reviewing the empirical findings in Chapters 5, 6 and 7, commonalities between interview respondents generally outweigh divergences. This is not to say that complete consensus is found. The intersection of a diverse range of beliefs and knowledge systems in professional representations generates continuous debate and questioning. Whether this diversity ever did, or will in the future distil into distinct representational positions is a matter of debate, but at the time of flux and transformation when this research was conducted, no such neat divisions could be made. In other words it has not been possible to identify coherent groups of respondents, either aligned to professional groupings, nationality or place of work, or clustered in some other way, who subscribe to obviously distinct and different representations of mental illness. The variations which are detected are more a matter of subtle differences in weight or emphasis.

In an attempt to rule out the possibility that qualitative analysis may have over-looked patternings which might form the basis of several distinct representations, some multi-variate quantitative analyses were also conducted. The details of the cluster analysis of respondents using data from twenty three of the principle variables developed in analysis are reported in Appendix 7. The results of this analysis show that, essentially, no meaningful clusters of respondents can be detected, and support findings from the thematic qualitative approach which suggest that professional understandings of mental illness consist of one representational field containing diverse and debated themes rather than several different and distinct representational positions. Given this, the purpose of this section is to draw together what representational variations have been found, by summarising comparisons made according to the three *a priori* divisions of the data corpus.

i) Variations between France and Britain

The differences between British and French representations which emerge from this study illustrate the disjunctions between theory and practice which characterise professional representations. Essentially, whilst there are substantial differences in the types of expert theoretical knowledge which professionals in each country believe in and draw upon in making sense of mental illness, these differences diminish at the level of actual daily practice. It is as if French and British professionals anchor and make sense of their work with the mentally ill by drawing upon theories whose status has varied historically in the two countries, but they nevertheless do very similar things regardless of which country they work in and which theories they subscribe to. So, for example, accounts of essentially similar interactions with clients may be couched in terms of counselling (in Britain) or psychotherapy (in France).

Although cross-national differences are generally diminished by the eclecticism which is common in both countries, psychodynamic theories generally hold more sway in France, compared to a relatively greater influence of medical and social perspectives in Britain. This is clearly detected in professionals' accounts of the genesis of mental illness (Chapter 5, section 3.2) and, to a lesser extent, in their practice (Chapter 6, section 2.1) in which pure forms of long-term psychotherapy are more common in France. Although medical interventions are equally as common in both countries, the historical dominance of the medical paradigm is very much still a part of current professional representations in Britain. This has been challenged in France by the rise of psychodynamic perspectives as a major ideology which has shaped both common sense and spheres of expert knowledge in the post war decades.

Not only are psychodynamic perspectives generally more influential amongst French practitioners, but historical divergences in the development of psychodynamic thinking in France and the Anglo-American world are detectable. Section 2.2 of Chapter 6 details how professionals describe their work with clients in terms of 'listening' (in France) and 'coping' (in Britain). One could speculate that such divergences may rest in turn upon deeper cultural and religious differences between Britain and France. French styles of psychodynamic theorising centre around Jacques Lacan's reinterpretations of Freud's early work on dream interpretation, and focus on interpreting the language of the

unconscious. In comparison, Anglo-American versions of psychodynamic thought, based on Freud's later works and the conceptual development of ego defense mechanisms provided by Anna Freud, focus on the restoration of social and inter-personal functioning. It might be argued that 'coping' and 'functioning' are more congruent with the Protestant work ethic and a culture in which people are judged by their output and mechanical analogies are encouraged. To lead a 'normal' life within this cultural context is to 'function' socially and inter-personally, and deviations such as mental ill health are construed as failures to 'function' in a socially acceptable way. (In support of this speculation, references to 'coping', 'functioning' and 'managing' in relation to mental illness are detected in 57% of British interview narratives, compared to only 17% of French interviews.)

ii) Variations between different professional groups

Generally speaking, analysis highlights very few cross-profession differences, a situation which, arguably, reflects the nature of modern professional practice in mental health: With the move away from hospital based care, not only is there a wider array of professional groups involved in care of the mentally ill than ever before, but the boundaries between these groups in daily practice are becoming increasingly blurred. All professionals, regardless of their status are now involved in the type of social and supportive work traditionally associated with the roles of nurses, social workers and occupational therapists.

The difficulties of this role ambiguity in multi-disciplinary teams are currently one of the most important areas of concern amongst professionals. Faced with challenges to traditional professional roles and hierarchies, the various professional groups hold onto some degree of professional distinctiveness through their respective professional bodies, training processes, and roles in carrying out certain specific tasks. For example, psychiatrists have legal responsibility for the prescription of medication; nurses are trained to deal with general medical complaints; clinical psychologists retain a monopoly over psychometric testing; social workers have unique knowledge of and relations with social services; and (in Britain) there is a mandatory requirement for psychiatrists and social workers to sanction the enforcement of legal restrictions and compulsory treatment.

The two professional groups who stand out most in this research are clinical psychologists and social workers. However, this distinctiveness centres more around inter-professional issues than on general notions of mental illness and its treatment. Social workers are distinctive in their position on the inter-face between mental health and social services, and (particularly in France) experience difficulties in their working lives associated with this. Clinical psychologists stand out in three ways. Firstly, they occupy a distinctive position within multi-disciplinary mental health teams in which they are currently struggling to raise their status and define themselves in relation to psychiatry. Secondly they report a greater reliance on theory than other professions[4]. Third, the discipline of psychology is where differences between France and Britain are most clearly manifested. British clinical psychologists typically use eclectic practices, integrating cognitive-behavioural therapy, counselling and psychodynamic practices and ways of thinking. In comparison, their French counter-parts are more likely to conduct purer forms of long-term psychotherapy.

iii) Variations between professionals working in different services

Given the diversity of working locations from which interview respondents were selected, surprisingly few representational differences between professionals working in acute hospital wards, inner city drop-in centres or suburban day centres emerge. This suggests that a common basic understanding of mental illness and the general endeavour of mental health work over-rides the very different daily tasks with which individual practitioners engage. However, the possibility can not be ruled out that the semantically based analysis conducted in this research may mask more other practice-based variations. Compared to research conducted recently by Prior (1993), which finds that in Northern Ireland representations amongst psychiatric hospital staff are dominated by a medical ideology, the current research suggests that the more social and relational understandings of mental illness which Prior detects amongst community based staff are a feature of all professionals' social representations, regardless of where they work.

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[4] These two features may well be related, in that the citation of theory and the appropriation of bodies of 'expert' psychological knowledge may serve to raise the status of clinical psychologists against the historical dominance of medicine.

2 Functional Considerations: Professional Social Representations as Psycho-social Compromise

Chapter 3 describes 'professional social representations' as spheres of collective knowledge held by practitioners such as teachers, doctors, psychiatrists and social workers through which these professional groups put their competencies into practice, and make sense of the aspects of human social life with which they are charged. Section 2.6 of Chapter 3 conceptualises professionals as 'integrators, translators and vectors' between the various agendas and sources of social knowledge derived from common sense, politics and 'experts' which converge in their practical work. Following the empirical analysis of this thesis, this section returns to these functional considerations, elaborating a conceptualisation of professional social representations as practice-based belief systems which serve to reconcile several areas of tension and ambiguity that arise in professional practice. Many of these tensions are associated specifically with the work of caring for the mentally ill (section 2.1), but there are also paradoxes which apply more generally to the social position of a wide number of professionals (section 2.2), as well as tensions to be reconciled in the broader process of social representation *per se* (section 2.3). Table 8.1 summarises the specific tensions which arise within these three overlapping areas. It is argued in section 2.4 that whilst all representation necessarily involves some degree of compromise, the social position of professionals and the moral, social and inter-personal issues which are raised in contemporary mental health care imbue professional social representations of mental illness with a central purpose in helping practitioners to manage these dynamics, such that they are able to practice and retain a sense of professional competence and legitimacy in daily working life.

Table 8.1: Tensions and Paradoxes within
Professional Social Representations of Mental Illness

Areas of Ambiguity	Specific Paradoxes
MENTAL HEALTH WORK	- Respect of individuals and their wishes versus social norms of acceptability - Requirements to react practically to mental illness versus professional uncertainty, inability to predict treatment outcome, and potential negative side effects - Mental illness as incomprehensible and dangerous versus goals of understanding and proximity
THE SOCIAL POSITION OF PROFESSIONAL PRACTITIONERS	- Paradoxes inherent in the notion of 'professional carer' - Professionals as self regulating, autonomous 'experts' versus the constraints of social institutional structures - Professionals as implementors of change:- the power of established practices versus the impetus for innovation - Convergence of the agendas of various social actors in professional practice (politicians, 'experts', the public, service users)
SOCIAL REPRESENTATIONAL PROCESSES	- Tensions between familiarity and unfamiliarity; between pre-existence and novelty; between individual / collective fantasies and needs, and the interactive demands of social life

2.1 The social ethics of mental health work

The work of mental health professionals is an essentially moral endeavour in its focus on people and attempts to change aspects of their lives and experiences. The analysis in Chapter 6 highlights how contemporary mental health work involves practitioners in an ever widening gamut of medical, intra-psychic, inter-personal and social aspects of their clients' lives. Clients' eating and sleeping habits, their family and marital relationships, the state of their home, their dreams, their use of public transport, even the clothes they

wear are all potentially open to the scrutiny and evaluation of mental health professionals[5]. Under the broad remit of 'enhancing life quality', mental health work may involve encouraging change in virtually any area of the minutiae of daily life. Such decisions cannot be made without recourse to socially constructed norms which dictate what is considered 'normal', 'desirable' and 'appropriate'. Located within the community, mental health work is imbued with social ethics revolving around tolerance, difference and diversity. If mental ill health is understood socially as some form of relatively enduring difference, distress and social psychological disruption, then the work of mental health professionals is essentially to find a mutually acceptable space for difference in society, and to contain and manage distress and disruption within the bounds of society's collective norms.

So, whilst interview discourses focus on how mental health work benefits mentally ill individuals, we cannot escape from the fact that much of the remit of these practices is to satisfy broader social agendas. If the mentally ill are to be cared for within the community, professionals must reassure the public and society at large that they are able to adequately contain and manage this fearful aspect of humanity, that the mentally ill can, with their help, live in society and behave in ways that are acceptable, that conform to social norms, and that are not disturbing to individuals, communities and the broader social *status quo*. Thus, the first tension which arises in mental health work is between the demands and needs of the mentally ill client and those of society in general, which may not necessarily be in accord. Evidence of this tension is detectable in several aspects of the empirical findings. For example, Chapter 5 highlights the unresolved issue of whether the mentally ill are people who are themselves distressed, or whether the key criteria is the evocation of distress in others (in other words the tension between distress<u>ed</u> or distress<u>ing</u> individuals). Although professionals define themselves as practitioners who possess specialist skills in listening, forming relationships and trying to understand the experiences of mental ill health (Chapter 6), they must also listen to the concerns of friends or family who may consider their behaviour to be intolerable,

[5] Even within the confines of the psychiatric hospital, Goffman (1961, p 358) makes a similar point: 'All of the patient's actions, feelings, and thoughts - past, present and predicted - are officially usable by the therapist in diagnosis and prescription. ... None of a patient's business, then, is none of the psychiatrist's business; nothing ought to be held back from the psychiatrist as irrelevant to his job. ... Almost any of the living arrangements through which the patient is strapped into his daily round can be modified at will by the psychiatrist, provided a psychiatric explanation is given.'

inappropriate or unsafe. Tolerance, openness and respect are frequently cited as personal qualities required to work in mental health, but professionals also have a social duty to respect the norms and expectations of society.

Invariably, when the wishes of an individual conflict with the demands and expectations of society at large, the later carry more weight. In such cases, it becomes untenable to include 'clients' as willing partners in treatment, and professionals may find themselves dealing with people who regard themselves to be mentally healthy, calling upon legal statutes to curtail their freedom, or administering medicating against their will. Mental health practitioners grapple with these power inequalities daily in their work, and must ultimately decide upon 'the best' course of action, whilst recognising that this may involve going against the wishes of some parties. (Similar ambivalences are reported amongst professionals charged with occupational of the mentally ill in France (Jodelet, 1996).)

A second area of tension revolves around the fact that 'ideal' solutions and treatment strategies are impossible to achieve in the world of mental health. Professionals' agnostic stance means that they can never be more than tentative about the potential outcomes of any strategy. Their daily work is set against a background of assumed limitations in what they can hope to achieve, and collective knowledge that many mental health problems endure or reoccur, and that treatment strategies may produce unpleasant side effects[6]. Professionals must somehow reconcile their sense of uncertainty and limited understanding regarding mental ill health, its causes and its treatment with the expectations of clients and of society in general, that they will be able to offer some sort of definitive solution to the problems associated with mental illness.

Finally, tensions abound between mental health practice as aiming to understand and recognise the experiences of mentally ill clients, and collective professional understandings of some mental health problems (especially 'psychoses') as fundamentally different forms of experience or being which renders full understanding or empathy

[6] For example, asked about how satisfied he is with the outcomes of his work, a British psychiatrist makes the following comment: 'It's very mixed. There are no panaceas. ... It's always a compromise. And sometimes it's horrific to realise that to get someone well, to keep them well, we are giving them medication that may be harmful, and they know it. I see plenty of people in out-patients who say the medication is awful, but they know that if they stop it they get unwell. But that's the best we can offer.' (B15)

impossible. Working with the mentally ill requires physical proximity, and a degree of psychological closeness with phenomena to which common reactions are fear and the maintenance of clear psycho-social distance[7]. The establishment of professional identities, the use of theories as mediators, and the maintenance of symbolic differences in the organisation of most mental health services are illustrative of how professional representations help mental health practitioners overcome these ambiguities, allowing them to work with the mentally ill whilst positioning themselves as psycho-socially different and distant from them. The high levels of stress that professionals report are a testament to the difficulties of achieving this balance.

2.2 Paradoxes of 'the professional'

Whilst mental health professionals clearly face ambiguities and conflicts of interest in their daily work, many of these are not confined to the world of mental health, but are features which also characterise other people-based professions, and relate to the social role and positioning of expert practitioners[8]. Mental health professionals, medical practitioners, nurses and those who work with the elderly, the disabled or the socially disadvantaged are often referred to collectively as 'caring professions'. The notion of being a 'professional carer' is deeply imbued with paradoxes and contradictions. To be a professional is to behave in a balanced and neutral way, according to collectively agreed standards of practice based on 'expert' knowledge and theories, to make rational and unprejudiced decisions, to keep personal involvement to a minimum, and to establish clear and unambiguous relationships with clients. In contrast, the notion of 'care' implies a degree of personal involvement sufficient for inter-personal empathy, support and the development of a unique and genuine relationship. The modern notion of 'professional carer' renders 'care' a technical and expert enterprise in which economic considerations

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[7] Rosenhan (1973, p 254) comments that 'most mental health professionals would insist that they are sympathetic towards the mentally ill, that they are neither avoidant nor hostile. But it is more likely that an exquisite ambivalence characterises their relations with psychiatric patients, such that their avowed impulses are only part of their entire attitude.' This observation highlights the difficulties of detecting taken-for-granted or taboo collective semantics, an issue which is discussed in section 4 in relation to the use of individual interviews.

[8] The reader is reminded that the model of 'professional social representations' proposed in Chapter 3 limits itself to 'people-based' professions, such as teaching, medicine, and occupational groups associated with social welfare and 'caring'.

meet existential needs. These challenges have been highlighted by several authors. For example, Menzies (1960) describes various aspects of ward practice as institutional defenses against the anxieties which the intimate nature of nursing work evokes. The requirements for medical students to attain a balance between empathy and objectivity are described by Fox (1988) as learning to develop 'detached concern', and Goffman (1961, p 339) describes professionals' 'cultivation of trustworthy disinterestedness'. There is recognition of similar paradoxes amongst the professionals in this research. For example, one respondent, talking of the centrality of the professional-client relationship, comments that 'that's not pretending to be best mates or friends - it means being quite clear that as a professional, you are there to help and support.' (B29)

Another set of paradoxes which unite professionals across a range of spheres concerns their membership of organisational structures. Larson (1977) describes the privilege of self regulation and the power to practice according to distinctive 'expert' theories, knowledge and self generated ideologies as defining features of what it means to be 'a professional'. Yet professionals are also part of organisational structures such as schools, hospitals and the broader education and health systems these form part of, which are shaped invariably by economic and political agendas. As such, professionals' freedom to act autonomously is curtailed by these structures, and they maintain an uneasy and ambiguous relationship with the social institutions they work within. The organisation is often experienced as having agendas which conflict with the interests of patients and the goals that professionals aim to achieve (Hasenfeld, 1992)[9]. Simultaneously, however, practitioners are also fundamentally reliant on these structures for their very existence and social integrity. Paradoxically, institutions both constrain and enable the professional groups who work within them.

Within the modern social context in which economic considerations are high on the social and political agendas and paramount in debates about the provision of health and social services, financial limitations are one of the most frequently cited ways that professionals experience organisational constraints. As health services are increasingly required to

[9] For example, a British clinical psychologist comments, '(my work) involves juggling the needs of the client with the needs of the system, the needs of the organisation. And although the organisation's main aims would be to meet clients' needs, often in my therapeutic work, I'm faced with questions of who am I doing this for. Is this to reduce waiting time and to make my numbers up, or make it look as if I'm seeing people, or is it actually for the need of my client?' (B17)

justify their effectiveness on the basis of the economic logic of 'clinical audit', this issue is likely to become increasingly significant in the future. It is detectable in the current study in professionals' perceptions of financial constraints as one of the most important factors in the current shape of community-based care. Similarly, practitioners who work psychodynamically often report being forced by financial constraints to reduce the number of sessions they offer a client, compared to the more long term work they would ideally like to do.

Professionals working in the field of mental health are faced with particular ambiguities which surround collective understandings of mental health institutions. Historically, various aspects of psychiatric systems have received attention by researchers, social theorists and practitioners alike, who have charted both the positive, 'therapeutic' potential of these systems (for example, Rapoport 1960), as well as the negative aspects of mental health organisations (Goffman 1961, Rosenhan 1973 and many others). The coexistence of diverse and sometimes oppositional themes in interviewee's accounts of the systems they work within reflects these paradoxes. Accounts of organisational structures as factors which limit or conflict with the work of caring for the mentally ill coexist with views of these organisations as therapeutic to the mentally ill and beneficial to the work of professionals. In order to be able to practice on a daily basis, professionals must be able to reconcile negative representations of psychiatric institutions with their own position as agents of these organisations. Professionals' representations facilitate this process such that, three decades after the publication of Goffman's 'Asylums' and the development of anti-psychiatry, and with increasing experience of care in the community, they recognise both the dangers and the positive aspects of hospital based care. They argue, typically, that hospitals can provide genuine asylum from the outside world, reassurance for intensely distressed people, and structures which helps 'contain' the disruption of mental illness.

A third area of potential difficulty and need for compromise concerns the role of professionals as implementors of change. As social and political thinking changes regarding the 'best' ways to maintain the population's health, to educate children, and to deal with society's deviants, professionals are the social agents charged with introducing new policies and practices. As integrative, community based policies become the norm in many areas of health care and social provision, many different professional groups are

currently facing the task of challenging established social representations and introducing new ways of reacting to social problems which may seem alien or bizarre. The current generation of mental health professionals, for example, are the first to grapple with implementing community-based care for the mentally ill and, as such, must reconcile the power of established and familiar working practices with the political and professional impetus for change. Chapter 7 illustrates how this water-shed in the history of mental health care engenders uncertainty and collective anxieties within the professional community.

Finally, the social position of professionals as integrators, translators and vectors between the various social spheres involved in the production of social knowledge brings with it the need to reconcile potentially incompatible demands and agendas. Professional practice involves the construction of compromise solutions between the demands of service users (people with mental or physical health problems, those in need of various forms of social care, and so on), the expectations of the general public, the political and ideological agendas of policy makers, and the current thinking and recommendations of experts in the field. The diversity of these social worlds is reflected in the internal components of professional representations (theory, practice, lay representations and so on), and it is through the convergence of these knowledge spheres that professional representations help practitioners steer a path through the thicket of various individual and collective demands which they face in their daily work.

2.3 Tensions in processes of social representation

The third area in which tensions and paradoxes can be identified concerns more general and fundamental dynamics of social representation formation. The process of representing a social object in a collectively meaningful way requires individuals and groups to confront tensions between what is known and familiar and what is novel, unfamiliar or strange. Anchoring processes, for example, constitute finding a balance between adapting an unfamiliar concept to pre-existent representational systems and recognising its unique or novel characteristics. (The vicissitudes of 'unfamiliarity' and the difficulties of anchoring processes are addressed in sections 3.2 and 3.3 below.) The involvement of social representations in innovation and social change necessarily means

that they are characterised by these dynamic tensions.

Further, when the object to be represented is one which inspires fear and suspicion, tensions also arise between social representation as a reflection of collective fear, desires and fantasies, and the requirements of everyday social interaction. For example, while it may be possible in art or the media to represent the mentally ill, gays or people from other cultures as radically different, inhuman or totally 'other', processes of social representation which occur during the course of everyday social interaction are more complicated. Collective fears of insanity, contagion or loss of identity must be reconciled with cultural assumptions of some degree of commonality, respect and equality between human beings. Building on ideas proposed by Gilman (1988) and Kaes (1984), which highlight the emotionally loaded nature of representation, social representation can be understood as the reconciliation of collective motivations, imagination and defenses against anxiety (for example, maintenance of the social *status quo*, defense of positive social identities, guarding against loss of control or order), and the more ambiguous and less absolute nature of social interaction. As Giami (1987, p 178, my translation) puts it '(social) representation is not a construction according to the wishes of the subject, but a solution of compromise with the demands of reality which is transferred to different levels of social organisation.'

2.4 Reconciling Tensions and Ambivalences

The preceding three sections have detailed several areas of social representation in which tensions and inconsistencies arise. Beyond the compromises which characterise generic social representational processes, many of these pertain to features of professional representations and the practical work of mental health professionals in particular. Faced with this list of psycho-social and moral dilemmas, mental health professionals nevertheless manage to conduct their daily work. If social representations mediate and construct collective interactions with and understandings of aspects of the social world, then a central function of professional social representations is to construct compromises which enable practitioners to conduct their daily work. Specific strategies such as the use of multiple treatment strategies in the face of uncertainty illustrate how professional representations aid reconciliation and facilitate the management of paradoxes through

which a collective sense of professional competence and legitimacy can be maintained. Professional social representations help practitioners to take one course of action rather than another, and to develop a position within this web of dilemmas and unresolved questions which can provide personal and social justification for their daily work[10].

Often, smooth and complete reconciliation of the dilemmas of mental health work is simply not possible. This is evidenced by the various disjunctions detected in the research, between for example, theory and practice, and the principles and realities of community-based care. Faced with the impossibility of harmonising various incompatible agendas, professional representations allow collective recognition of these difficulties, and airing of unresolved points of contention through the on-going debate and uncertainty which permeate even the most basic aspects of professional representations of mental ill health.

3 THE THEORY OF SOCIAL REPRESENTATIONS: ADDRESSING LACUNAE

A case was made in the initial stages of this thesis that the theory of social representations provides a valuable theoretical framework from which to embark on a study of how mental health practitioners are involved in the construction of contemporary societal understandings of mental ill health. To reiterate briefly, Chapter 2 presented the theory as a truly social form of social psychology which allows the researcher to conceptualise both the agency of individuals and the power of society, culture and history in shaping and constructing social knowledge in its broadest sense. Perhaps most importantly, the theory has proved itself through this research, as a perspective able to handle complexity. As such, it serves to debunk the myth - perpetuated by research whose theoretical starting point assumes that belief systems are homogenous, unitary and

[10] There are parallels between this argument and those proposed by discursive psychology which highlight how individuals and groups draw upon collective discourses to construct 'positions' in relation to context specific combinations of arguments, counter-arguments and ideologies (Billig 1987, Edwards & Potter 1992). As an illustration, a French interview respondent justifies her work in the following way: 'I think to be a carer is basically to try and do some good. ... it's to give back a sense of relating to other people. But you see some patients who are happy with their solitude, and for them, that intrusion is absolutely unbearable. So you're a sort of intrusion which must have a purpose - the term intrusion is quite pejorative - but the goal of that intrusion must be to try to establish a relationship, try to make sure the person isn't entirely alone in his illness.' (F17)

individual-based - that individuals or social practices can be categorised as expressing single models of mental illness (for example, 'psychodynamic', 'medical' or 'social' models of mental illness). Instead, it enables conceptualisation of the tensions, consistencies and negotiations of diverse spheres of knowledge and social practices which coalesce in the field of mental ill health.

Beyond this, however, the researcher has an intellectual obligation to go further than theoretical self-congratulation. By taking a more constructively critical stance, empirical findings can be used to actively engage in debate at a theoretical level[11]. Furthermore, the contribution of a specific empirical study is enhanced by the value social representational theory places on content as well as process. The choice of mental illness as a topic of in-depth empirical investigation provides rich investigative ground, tapping directly into a range of social and cultural belief systems surrounding themes of deviance, abnormality, person-hood, and the nature of society.

Perhaps the theoretical premise most central to this study is the distinction made by social representations theory between the reified and the consensual universes. The arguments presented in Chapter 3 highlight how, on several accounts, this conceptualisation is problematic. As an initial exploration of a social world which incorporates aspects of both the reified and the consensual universes, this thesis shows the utility of developing a more complex model of the social circulation of knowledge which recognises the interactions of various social spheres (politics, the media, professional practitioners and so on). Beyond this, several other aspects of the theory of social representations have been called into question by the empirical research conducted within this thesis. The sections which follow capitalise on the current openness of the social representational approach to address some of these lacunae. Firstly, section 2.1 asks how mental illness as otherness can be reconciled with the multiplicity of representation detected in this research. It considers how uncertainty and fear are exacerbated by the ambiguous and insecure nature of these multiple representations of mental illness. Extrapolating from this debate, section 2.2 considers implications for the notion of unfamiliarity within the social representations theory. It speculates that different forms of unfamiliarity could be

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[11] This is encouraged by the openness and resistance of clear definitions which characterise the theory of social representations (although this very versatility has also led to problems of misuse of the theory (Allansdottir et al 1993) and accusations of vagueness (Jahoda 1988)).

used to develop a typology with which to compare representations of various social objects. Finally, section 2.3 addresses some other conceptual issues raised by this research, which whilst they have not been taken up as topics of detailed consideration by this thesis, are nevertheless worthy of comment.

3.1 Otherness and Multiplicity: Conceptualising the ambiguous representation of mental illness

The literature review in Chapter 2 suggests that the concept of otherness provides a useful way of integrating a disparate range of sociological, historical and psychological research on mental illness. Themes of difference, abnormality, strangeness and danger are the defining features of common sense knowledge about mental illness which is invariably associated with strong emotional reactions of suspicion, fear and rejection. In the current research there is ample evidence for similar constructions of mental illness as 'other' within the professional community. Particularly in relation to mental health problems termed 'psychotic', mental illness is represented as other in two ways: Firstly, in the sense of being a radically or qualitatively different type of experience, and secondly, as a fundamental and enduring trait-like difference compared to 'normal' people.

Yet this is not a definitive and un-problematic understanding of mental illness: the uncertainty which pervades professionals' representations and the multiplicity of their understandings and practices are common threads through-out the analysis. Chapter 5, for example, highlights how otherness competes within professional representations with notions of similarity and sameness. 'Expert' literature provides professionals with a diversity of models of mental ill health, each of which is no more than provisional and partial. Given that no single theory appears, on its own, to account adequately for the complexities and diversities of mental illness, professionals develop multi-factorial causal models and eclectic strategies of care which are matched by multiple but indefinite understandings of mental health problems in the lay community.

This raises two conceptual problems in our struggle to theorise both professional and public understandings and reactions to mental illness. Firstly, how can we account for the coexistence of otherness themes and multiplicity within a social representational

framework? And secondly, what are the social psychological correlates and consequences of this complex combination of otherness, multiplicity and ambiguity which converge in representations of mental illness?

The first of these issues can be addressed in a relatively straight forward way by conceptualising otherness as one element in the multiple representation of mental illness in contemporary society. Historical analyses suggest that mental illness as otherness may be the most historically rooted representation, but in today's world of integrationist policies, understandings of mental illness have diversified. If mental illness is multiply represented, then one of these coexistent representations (whose historical dominance may confer power and status which less well established representations cannot match) is of the mentally ill person as a dangerous and / or fragile other[12].

The second issue of the semantic and representational consequences of multiple representation is more complex, and requires more detailed elaboration, especially when we consider the ambiguous, insecure and speculative nature of this representation. The initial model of the social representation of mental illness presented in section 2.5 of Chapter 2 proposes that representing mental illness as other allows individuals and collectivities to making sense of a phenomenon which is socially and individually challenging. Construing mental illness as otherness serves to localise, contain, distance and marginalise a social object which threatens both person-hood and society. From this perspective, the other is a familiar social category which unites various social groups such as Jews, blacks, homosexuals and the mentally ill who for various reasons have challenged the basic values of society, arousing mixed and intense emotional responses of fear, fascination and anxiety (Gilman, 1988).

But what happens when the category of other cannot be un-problematically brought into play to make sense of mental illness? Take the person living apparently successfully in the community, but with a past history of psychiatric hospital admissions; the colleague whose life-long existential doubts are defined by a clinical psychologist as 'clinical

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[12] Although this is the conceptualisation favoured by the author, it is not the only way of relating the notion of otherness with the representational features of multiplicity and ambiguity. An alternative conceptualisation would be to see otherness as something which fundamentally disrupts the representational process and <u>produces</u> a surfeit of multiple and uncertain meanings (see Morant & Rose, 1996).

depression'; the stranger whose erratic and bizarre public behaviour could be interpreted as drunkenness or signs of mental illness. All of these illustrate the overlaps between behaviours defined as 'sane' and those taken to be signs of mental ill health. 'However much we may be personally convinced that we can tell the normal from the abnormal, the evidence is simply not compelling' (Rosenhan, 1973, p 250). Representations of the mentally ill as definitively other are almost always open to question, and community-based care which seeks to reduce the physical and social dislocation and marginalisation of the mentally ill serves to exacerbate this questioning and uncertainty.

For each of the examples above, the world of mental health 'experts' cannot provide clear, definitive understandings and predictions. Despite the best efforts of the professional community to make sense of mental illness unequivocally (for example through the use of theories as anchors, or through detailed and multi-faceted assessment procedures), they are unable to reach clear, consensual understandings of why a person is showing signs of mental distress at a particular point in time, when this distress becomes acute enough to be called a mental illness, or whether a person's mental health problems are likely to reoccur later in life. This unsuccessful search for clear ways of identifying the mentally ill has been pursued throughout history. Changing with developments in medical science, its manifestation has shifted from a focus on facial expression and craniology in the eighteenth century, through interest in physiology and behaviour, to current research on the genetics of mental illness (Gilman, 1988). But compared to medical science, which can increasingly provide clear, unambiguous indicators of the presence or future manifestation of various physical health problems, mental health experts are still unable to furnish the public with definitive knowledge and predictions.

If the category of other cannot be un-problematically applied, because its nature is ambiguous, because mental illness cannot be clearly identified or tied down to something we can definitively explain and understand, because those defined as mentally ill now live within the community, then we must accept the potential and unidentifiable presence of this fear-provoking phenomenon within the social world in which we participate. The definitive separation between self and madness is challenged by this competition between 'otherness' and other ways of representing mental illness. If mental illness can be understood as an exaggeration of 'normal' experiences, as a state rather than a trait, or

as something which is not limited to certain 'different' people but can affect any one of us, and can appear (or disappear) at any stage of a person's life, the reassuring assumption of our own immunity to mental health problems which 'otherness' representations provide, is shattered.

The combination of 'otherness' themes with the multiple and ambiguous nature of mental illness representations produces a potent combination of formal and substantive uncertainties[13]. Mental illness is unpredictable and fear-provoking both because, as a socially constructed other, it represents chaos, loss of control and the inapplicability of 'normal', rational folk theories of mind or notions of the 'generalised other', and because it simultaneously resists this, or any other single classification. Such ambiguities of people and their status are socially dangerous and threatening in their challenge to the underlying structures and consensual orderings of society (Douglas 1966, Kelvin 1969)[14]. Despite societal expectations of their ability to disambiguating sanity and madness, professionals' representational uncertainties do little to reduce these ambiguities. Douglas (1966) describes how traditional societies often define ambiguous people or practices which transgress established social categories as unclean or polluting. Slippage from established social groupings, especially when it constitutes a challenge or break-down of categories containing deviants or socially feared groups, may arouse collective fears of contagion[15].

Modern integrationist care policies arouse such fears by exacerbating the ambiguities surrounding mental illness. Mental illness is a psycho-socially feared phenomenon, but one which may now be part of daily life, and can no longer be definitively identified as separate and marginalised from 'normal' mainstream society. It invades the social grouping in which we participate and with which we identify. In the contemporary world, the social practices of removing and permanently marginalising the mentally ill

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[13] While the theory of social representations seeks to avoid such splits between form and content, this artificial separation is nevertheless useful for the purposes of the current argument.

[14] The cognitive equivalent of this ambiguity would be the disruption of established systems of categorisation and understanding, which social cognition research suggests is a fundamental basis for our ability to make sense of the diversity of our social world (eg Rosch & Lloyd 1978).

[15] This may take the form of pre-medical beliefs in magical contagion such as those detected by Jodelet (1991, see section 2.1 of Chapter 2).

in psychiatric institutions no longer exist as ways of 'containing' mental illness and the anxieties it evokes. Collective fears of this seepage are expressed in the growth of a discourse of risk surrounding mental health care: 'Risk assessment' and 'risk management' are increasingly part of the social definition of 'community care' (for example, McGovern 1996, Monahan & Steadman 1994). In short, psycho-social correlates of the convergence of otherness, multiplicity and ambiguity in the contemporary social representation of mental illness are the exacerbation of collective anxieties, uncertainties and fearful responses.

3.2 Reflections on Unfamiliarity: Towards a Typology of Representations

Moving beyond the substantive topic of mental illness, this conceptualisation of how mental illness is represented in contemporary society has broader implications for the theory of social representations. Specifically, it challenges the theory to recognise firstly, that representation does not banish unfamiliarity, and secondly, that the notion of unfamiliarity is complex and merits more serious consideration than it has so far received by social representations researchers.

Returning to the basic premises of social representations theory, we can recall the assumption that social representations function to familiarise the unfamiliar. It is stated that:

> 'the act of re-presentation transfers what is disturbing and threatening in our universe from the outside to the inside, from a remote to a nearby space.' (Moscovici 1981, p 189).

The implication here is that representational processes necessarily involve drawing unfamiliar objects psychically and socially closer, and reducing their threat. From the evidence of this and other research, neither of these assumptions appear to hold true in the representation of mental illness. While it is undisputed that representation involves the construction of social meaning, in some cases it is through this very construction process that unfamiliarity is perpetuated. If, as is argued above, the Other is a familiar social category, then one of the most common ways of making sense of mental ill health is to familiarise it as unfamiliar. Through its very representation as other, mental illness is constructed as unfamiliar, as something which constitutes fundamentally different

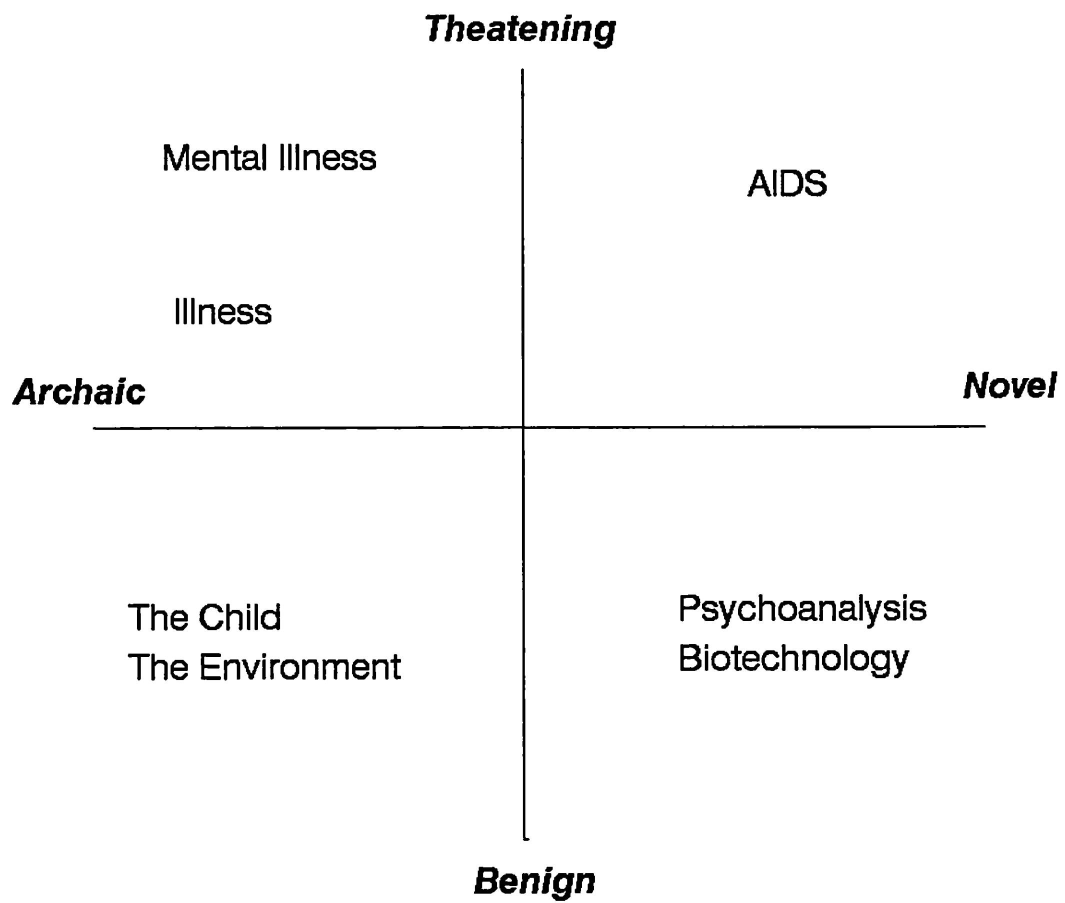
experiences and falls beyond the bounds of consensual rationality-based theories of mind. This perceived gap of experience (which for professionals is most commonly applied to 'psychosis') perpetuates an assumption that some forms of mental distress remain fundamentally unknowable. The sense of threat and fear that mental illness commonly inspires; the associated tendency to keep contact with the mentally ill to a minimum; the historical social marginalisation and taboo of mental illness; and the provisional and speculative nature of mental illness representations all combine to perpetuate this sense of strangeness and unfamiliarity which remain at the heart of contemporary mental illness representations.

It is clear that there is space for unfamiliarity and threat within a social representation, and that neither of these are simply banished when a social representation is created as the theory implies[16]. Throughout history, social representations have functioned to give mental distress some sort of tangible social meaning, but one which is centred around unfamiliarity. Comparing this situation with other social objects whose unfamiliarity derives from their novelty (for example, biotechnology, AIDS, psychoanalysis), we begin to see how different sources of unfamiliarity, associated with either novelty or the capacity to arouse collective and individual fears and anxieties might be distinguished. Novelty and 'threat' could be conceived as two independent sources of unfamiliarity within a representation. Novel social objects are unfamiliar in the sense of being 'not known about', and although there will always be some level of resistance and scepticism towards what is new, those objects which are relatively benign will eventually come to be more-or-less un-problematic features of our everyday social world (science or information technology would be illustrations). Other more enduring social objects are continually constructed as unfamiliar and their retention of unfamiliarity highlights their capacity to arouse collective and individual fears and anxieties. Still others (for example, AIDS) combine novelty and profound social anxiety evoked by associations with historical illnesses and social taboos (Joffe 1996, Sontag 1990)

Figure 8.2 shows how a speculative typology of representations could be developed on the basis on two independent variables: a time dimension and a threatening - benign

[16] A similar argument is put forward by Purkhardt (1993 p 114) who comments that 'the theory must embrace the unfamiliar within its historical and evolutionary framework such that it incorporates the social construction of the unfamiliar as well as the perpetuation of the familiar'.

Figure 8.2: A Typology of Social Representations based on two sources of unfamiliarity



continuum[17]. The positioning of social objects within this schema is necessarily linked to the social context in which representations develop[18], but consideration of both a time dimension and an object's link to social semantics of fear and threat may prove a useful way to conduct comparative explorations between various social objects. Embarking on a meta-analysis of this kind counter-balances the tendency within social representations research to focus on single objects, and tackles the associated dangers of fragmentation without sacrificing the rich and in-depth understanding generated by individual studies.

3.3 Other Theoretical Considerations

Power

The problem of power was initially raised in Chapter 3 which suggests that social representations theory has not provided an adequate conceptualisation of the workings of power in modern society. Moscovici's (1988) categorisation of hegemonic, polemic and emancipatory representations fails to adequately account for how any single representation develops through social processes made up of complex power relations involving persuasion, imposition and resistance. Within the social sciences, the notion of power is complex, and there is not space in the confines of this thesis to enter into this debate. However, as a step towards reiterating the role of ideological power struggles in the development and negotiation of common sense and social practices, several aspects of the professional social representations investigated in this research can be highlighted. The social role of professionals as integrators of the agendas of politics, 'experts', 'patients' and the lay public, and the associated compromise functions which section 2 proposes as a key feature of professional social representations constitutes the most immediate example of power struggles. From a Foucauldian perspective, for example, the work of

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[17] Against this two dimensional conceptualisation, Joffe (1996) argues that there are no social representations which are benign or non-threatening, since it is the very novelty of a concept which renders it threatening. However, Joffe's argument fails to take account of the varying history of different social objects.

[18] For example, in Moscovici's (1976) study of psychoanalysis as a novel social object, social representations in the world of French Catholicism might be located in the top right hand quadrant due to controversial associations between psychoanalysis and sexuality. In comparison, representations which developed in the world of Marxism, where psychoanalysis was more readily accepted, might be better placed in the lower right hand quadrant.

professionals in 'managing' mental health problems within the remit of community care policies represents social processes through which ideological power and implicit forms of social control over what is 'normal' and acceptable in contemporary society are perpetuated (Foucault, 1980). In daily decisions about treatment and care, the voices of the patient, the professional and the policy maker are far from equal, and professionals are not blind to the value-laden nature of their work[19].

A key determinant of power balances in contemporary society is money. Economic considerations are an increasingly important factor in shaping societal reactions to mental illness, and the recent shifts towards community care for the mentally ill which are being implemented across Europe are intertwined with public and political debates about the changing role of The State and the financing of health and social services. As financial considerations move into the foreground of practical care strategies, 'cost-effectiveness' becomes an increasingly powerful bench-mark for assessing social value and legitimacy.

Another area of professional social representations in which power imbalances can be detected is in the historical dominance of medicine and the models of mental distress which emanate from this. Especially in Britain, the historical dominance of the medical perspective over-shadows the world of mental health, existing as a constant reference point which cannot be ignored, even by those who reject it. This sets the scene for the unequal influence of the various professions in shaping professional representations (for example, the struggles of clinical psychologists to position themselves against the dominance of psychiatry). The dominance of medicine as one of the most influential social institutions in western society, whose power infiltrates common sense, public life and many of the most profound aspects of human existence is highlighted by medical sociology (Foucault 1967, 1973; Zola 1972 for example). It is against this background, in which mental distress has traditionally been dealt with as a medical phenomenon, that

[19] For example, a British interview respondents makes the following comment: 'A lot of social workers would say what you are trying to do is to help people develop insight. Obviously there is such a thing, but it's not a term I use a lot, because it's been my experience that when people say a client has insight, what they actually mean is that the client accepts their definition of their problems. Obviously a lot of mental health work, because of the power relationship and the access to services, is about renegotiating people's reality.' (B29). This professional awareness of the moral and ideological nature of their work adds weight to criticisms of the anti-psychiatry and labelling approaches made in Chapter 2 (section 2.2). These perspectives tend to offer an over-simplified gloss on social psychological processes, and to assume, incorrectly, that professionals are either willing agents of social control or simply oblivious to their role in perpetuating societal power relations.

the enactment of changing professional representations is played out.

Whether it is manifested in the dominance of medical interventions, in the determining role of financial resources, or in the value-laden decisions professionals face every day in their practical work, there is ample evidence in this research for the existence of power struggles and inequalities in social representational processes. The theory of social representations could only be enriched by attempts to integrate notions of power into its understandings of social knowledge construction.

Anchoring as an active and problematic process

Another theoretical issue raised by this research relates to the fundamental process of anchoring. It is clear that in the case of mental illness, the process of collective sense-making is far from smooth and un-problematic. This can be interpreted theoretically as problems of anchoring - mental illness resists classification and definitive anchoring through its imperfect fit into any single belief system. Neither experts or lay people can decide what is the most appropriate system of beliefs for mental illness to be anchored into, and as a consequence, they 'buy into' several different models simultaneously. These findings add weight to the argument put forward by Billig (1988, 1993) (discussed initially in Chapter 2) that anchoring is not as smooth a process as the theory of social representations implies. Rather, it is one which always involves controversy and debate surrounding choices between several possible but imperfect spheres of knowledge into which a concept could be anchored. The consequences of problematic and ambiguous anchoring are the simultaneous circulation of multiple representational themes, often (as we saw in Chapter 5) organised in terms of binary oppositions which are debated rather than fixed. The coexistence of these oppositional themes (difference - similarity, temporary - permanent, distressed - distressing, for example) enhances a sense of unpredictability and ambivalence, and guarantees that, despite its enduring nature, mental illness remains an object of controversy.

Levels of consensus and representational fields

This leads directly to a final theoretical issue surrounding how the structure of a representation is conceptualised. Rather than the highly structured, two dimensional

model of representations consisting of core and periphery elements adopted by the 'Aix School' of social representational researchers (Abric, 1984), the argument proposed in Chapter 5 for a three-dimensional conceptualisation of a social representation is reiterated. This allows us to differentiate between the implicit representational themes which form the 'bed-rock' of a representation, and the on-going daily debate and dissension which occurs within the 'representational field' whose parameters are defined by more fundamental levels of consensus (Rose et al, 1995). (This distinction is illustrated in Figure 8.1.) Again, this conceptualisation shows parallels with the rhetorical perspective of Billig who argues that:

> '(c)ommon sense would appear to possess two contrary aspects in its relations with argumentation. On the one hand, common sense seems to close off arguments: certain matters will appear to be commonly sensible within a community, and consequently these matters will be accepted without argument. .... On the other hand, common sense seems to open up arguments: the common-places, which constitute important components of common sense, provide the seeds of rhetorical arguments.' (Billig, 1987, p 208)

The notion of a 'representational field' allows us to capture the dynamic and fluid relationships between diverse and contradictory themes which characterise representations of mental illness. The term 'mental illness' is used to account for experiences and behaviours as diverse as hallucinations, social withdrawal, eating or sleeping problems, intense grief, and anxiety. Subsumed within the same broad social category, these diverse aspects of human experience are defined in relation to each other and become ambiguously related. 'Representational fields' also allow us to recognise the possibility of both consistencies and inconsistencies between different components of the representation (for example, the weak links between theory and practice identified in Chapter 6). If, as has been argued, professional social representations function as psycho-social compromises, then inconsistencies between their elements can be expected. This view is supported by Horenczyk & Bekerman (1995), who argue that inconsistency and internal conflict are common features of all social representations, and point out that common assumptions amongst psychologists of cognitive consistency may have misleading consequences for social psychological research. The notion of representational fields also acknowledges that the boundaries of any representation are fuzzy, that they overlap with other representational areas (for example, deviance, illness and other 'disability' states in the case of mental illness), and that these may rest upon common culturally shared belief systems about person-hood, 'normality' and society.

4 Concluding Comments: Future Directions and Implications

4.1 Avenues for Future Research

The theoretical issues raised by this research which are discussed in section 3 point to several conceptual areas which could feasibly be investigated empirically in the future. But what specific areas of further inquiry does this initial attempt to apply a social representational approach to the world of professional knowledge point to? A critical evaluation of the focus and methodology of this research highlights some fruitful strategies of future inquiry and methodological modifications which would build upon and extend the investigations conducted in this thesis.

The model of 'professional social representations' as 'professional common sense' or practitioners' collective understandings of the object of their work has proved a useful theoretical tool to guide the research. This is a clear demonstration that the theory of social representations can be fruitfully applied to spheres of social knowledge beyond common sense. The validity of this model has been up-held and at least initially supported by the empirical findings, but many unanswered questions remain. Specifically, I would identify the need for investigations of other professional groups, for research which explores the interaction of professional representations with other spheres of social knowledge, and for studies designed to address processes of change as particularly pertinent avenues of future inquiry.

The first of these - the need to apply this model to other professional groups - arises inevitably from research focusing specifically on one particular professional world. Whilst the strengths of this 'case study' approach lie in its ability to provide in-depth understandings of substantive content, these are countered by associated difficulties of disentangling unique aspects of mental health work from more generic features of all people-based professionals. Although the comparisons made in section 1.1 highlight several parallels with professionals in general medicine, studies applying the same theoretical model to other professional worlds (teaching, for example), or to more than one professional sphere simultaneously, would provide a clearer mechanism for identifying areas of similarity and points of difference.

Secondly, the theoretical model on which this research is based proposes that several inter-related but relatively distinct social spheres are involved in the contemporary development and circulation of social knowledge (see Figure 3.2). Research which compares the representations of a particular social object circulating in the media, amongst lay people, and in 'expert', professional and political worlds, uncovering how interactions between these social spheres serve to modify, perpetuate or diffuse collective understandings, would extend our understandings of interactive, transformative and power-imbued processes in the development of social knowledge. This relates to a third recommendation, namely that future research should be process-oriented. Like much social representational research, the current study constitutes a snap-shot taken at a particular historical moment. Because this moment is one of rapid change in societal reactions to mental illness, it points implicitly to many dynamic process, but is unable to tap into these change and diffusion processes directly. Although the theory of social representations places much weight on the dynamic nature of social knowledge and the processes involved in its genesis and development, empirical research rarely employs longitudinal methods which are explicitly designed to investigate process[20]. Process-oriented methods would allow researchers to address issues such as how lay notions of 'community care' have changed in the years since its introduction, and how cycles of policy proposals, media and public reactions, and governmental and professional responses develop.

Methodologically, probably the most significant weakness of this study is its over-reliance on verbal methods, with concomitant risks of obtaining data shaped by self-presentation and rationalisation processes. Although methodological triangulation has been partially adopted (using secondary sources of documentary evidence, observations and 'key informant' interviews to inform the analysis of primary interview data), a more full-scale

[20] Some notable exceptions are work conducted recently by Bangerter (1996) attempting to model processes of knowledge diffusion between individuals, and research in Sweden on interactions between macro-social policy changes and the shared beliefs of communities cohering around young people with mild learning disabilities living in the community (Gustavsson, 1996). This research shows how, within this sub-community, consensuality and consistency with the integration ideology of policies contribute to a gradual solidification of representations of these people as legitimate members of society. However, these processes are set against a broader background of more widely held socially representations of people with learning disabilities as stupid, dangerous and sinful.

triangulation of methods involving non-language based techniques would be preferable[21]. For example, individual interviews could be fruitfully complemented with group discussions, observations of practice, or analysis of professional training procedures (in which the implicit values of professional practice may be more explicitly communicated). The difficulties of cross-cultural investigations, in which the researcher's relationships with the area of study, the research participants, and the semantics of linguistic data are not functionally equivalent in foreign and native countries, could be overcome by the collaboration of researchers based in different counties (what Banister et al (1994) term 'investigator triangulation').

Finally, the analytic strategy of this research has been fruitfully shaped by the use of QSR-NUDIST, which not only allows the practical management of a large data set, but also encourages transparency and innovation in interacting with, linking and conceptualising data. The principle technical weakness of this computer package, in its current form, is its inability to capture narrative structure and temporal relationships between text segments. However, the sophistication of 'CAQDAS' (Computer-aided qualitative analysis) programmes is increasing rapidly, and substantial developments are to be expected in the next few years. The latest version of Atlas-ti already provides ways of specifying the nature of relationships between text segments and researcher-generated concepts which have the potential to capture temporality and narrative structure. It is hoped that this demonstration of how the credibility and analytic power of qualitative research can be enhanced by CAQDAS packages whose epistemological foundations are compatible with the theory of social representations will encourage other social representations researchers to explore their use in the future, and contribute to on-going methodological innovation.

4.2 Drawing Practical Implications

A potential danger of research conducted from a social constructionist perspective is that in focusing on how social reality is historically and culturally constructed and

[21] As discussed in Chapter 4 (section 2.1), the current study was limited by issues of client confidentiality which precluded the observation of many specific professional-client interactions.

deconstructing our common currency of value judgements, it may fail to offer any value judgements of its own. Unless such research takes a critical stand on what social psychological states of affairs it rates as more or less preferable, relativist nihilism or apathy may result. The aims of this concluding section, therefore, are to consider what the 'real world' implications of this research are, and how it could be used practically to 'make a difference'. To do this, it is necessary to re-state the value judgements on which this research is based, namely that care of the mentally ill is currently an important but problematic social issue, and that research which strives to understand the prejudices and social psychological difficulties which it raises may ultimately contribute to improving the lot of people suffering from mental health problems.

Much of the previous research reviewed in Chapters 2 and 3 presents negative and pessimistic messages of pervasive prejudice and social intolerance of mental illness. It both explains and anticipates problems in the successful implementation of community-based care in terms of the deeply-rooted and powerful nature of social representations. Mental ill health is collectively understood as a dangerous pollutant whose re-entry into the community is an invasion that threatens established identities and boundaries between normality and abnormality. How can a community accept into its ranks people who are assumed to be unpredictable and un-understandable in terms of its conventional folk theories of mind? Research cautions that we should not underestimate the power of historically established belief systems to generate substantial public resistance to this endeavour, and points to an urgent need for public education programs to ease the burden on mental health professionals faced with the task of implementing integrationist policies. Rather than focusing exclusively on setting up community-based support structures and preparing long-term hospital residents for life in the community, more energy (and resources) should be invested in the other side of the equation, namely social changes which will facilitate the success of community care. Public education and mental health awareness campaigns in schools, the media, local community centres and so on may not reverse public prejudice over-night, but done well, they may at least contribute to creating a social climate in which mental ill health is less stigmatized and feared than in the past[22].

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[22] A recent good example of campaigns to raise public awareness of mental ill health in Britain was the 'States of Mind' series of programmes on BBC 2 television and BBC Radio 4 in 1995.

Turning more specifically to the role of professionals in this process, the contribution of the current research is two-fold: Firstly, it furthers understanding of the practical and semantic vicissitudes of contemporary mental health work in two European countries, and secondly, in highlighting problematic areas, it is suggestive of several practical strategies which could ease the implementation of community-based care into the twenty-first century.

The thesis' contribution to knowledge and understanding lies in its in-depth description and conceptualisation of the work of mental health professionals in France and Britain. As a snap-shot of these worlds taken in the early 1990s, it is hoped that this analysis enriches the understandings of the social scientific community and other interested outsiders of modern mental health work and its relationship to broader aspects of society. For readers who are already acquainted with the contemporary world of mental health care, or are mental health practitioners themselves, the thesis serves to conceptualise their own lived experiences from a social psychological perspective, contextualising them within a broader historical, cultural and social psychological tapestry. This may help practitioners to reflect upon and make sense of their current practice in new and informative ways, providing a 'tool to think with' or suggestions for change.

In terms of its practical implications for practitioners, perhaps the most concerning aspect of this study's findings, in terms of the potential for professional prejudgments which may be detrimental to the care and life chances of particular clients, lies in the semantics of the term 'psychosis' which is primarily represented as fundamental and permanent difference at the level of the person (and possibly, their genetic make-up). Construing psychotic experiences as entirely distinct from 'normal' experiences renders professionals less likely to believe that empathy and understanding are achievable goals with this client group[23]. The result may be that people who are already stigmatized and alienated from mainstream society (typically people with diagnoses of schizophrenia, manic-depression or other non-specific 'psychotic' problems, who constitute approximately 4 per 1,000 people in the British population (OPCS, 1994)) remain marginalised and misunderstood

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[23] As R D Laing (1982, p 38) puts it, '(t)he way we construe a difference may serve to narrow or widen it. Both what you say and how I listen contribute to how close or far apart we are. A psychiatrist has been trained to believe that, if he were to think that he thought and felt much the same as those people he diagnoses as psychotic, this would not mean that they would not be psychotic, it would mean that he was psychotic.'

within the very services which are set up to care for them.

This issue is currently being tackled by mental health service users' and campaign groups, whose recent growth across Europe is described by Rogers & Pilgrim (1991) and Van Hoorn (1992). In Britain, for example, groups such as MIND, Survivors Speak Out and Hearing Voices work to promote a message of 'meaning in madness'[24]. Essentially, these campaign strategies encourage understandings of mental illness in terms of consensual models of behaviour based on rational intentionality. In other words, they aim to anchor social representations of mental illness into folk theories of mind, or more general social representations of person-hood. Although these notions are not incompatible with professional social representations (whose openness and uncertainty leaves space for debate surrounding issues of difference), they are currently a minority position. By suggesting new ways of making sense of 'bizarre' behaviour, these and similar awareness campaigns targeted at both professionals and lay people could help break the cycle of perpetuation of 'otherness' representations which hinders tolerance and empathy.

A second area in which suggestions for practice can be extrapolated concerns strategies for the implementation of community-based care. If community care constitutes a paradigmatic shift in the Kuhnian sense, this research has captured the struggles and uncertainties which are aroused by the process of change. While many aspects of contemporary professional representations are congruent with the integration ideology of community care policies (for example, involvement with the mentally ill as social beings, encouraging and supporting independent living), other features (for example, notions of irreconcilable difference) sit less easily with this new ethos. Although professionals' consensual desire to reject 'the old' (institutionalisation) is taken for granted, as yet there is little consensus about what 'the new' could or should be. The cultural revolution in mental health care is under way, but community care is still in the process of becoming, and the current cost of its implementation is measurable in professional uncertainty and

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[24] For example, at a recent conference for mental health practitioners and service users ('Meanings and Madness: Psychotherapy and Psychosis' organised by The Psychotherapy Section of The British Psychological Society, Bristol, 29-30 June 1995), members of 'Hearing Voices' ran practical workshops demonstrating how many of the secondary symptoms of schizophrenia (delusions, mood swings, paranoia and so on) can be attributed to the experience of hearing voices. By reconceptualising what are traditionally seen as 'symptoms' as 'coping strategies', the aim is to promote empathy and understanding of these experiences.

scepticism about the future, a sense of collective powerlessness, and tensions between professional disciplines.

Although many of these dynamics are features of any organisational change process, some specific issues highlighted in Chapter 7 suggest strategies of introducing change which may be more manageable for professionals and could harness the innovative energies of mental health teams more effectively. For example, the endemic sense of powerlessness and frustration amongst many practitioners (especially in Britain) indicates a need to involve professionals in the organisational decisions now in the hands of 'managers' (who often have little or no direct experience of mental health practice). It suggests a need for greater recognition of the toll that rapid and multi-level change accompanied by resource restrictions takes on practitioners struggling to understand and adapt to new demands and expectations. Whilst new generations of mental health practitioners may benefit from training which responds to recent policy changes, older generations, many of whom were trained in institutional working styles, struggle to get to grips with new integrationist policies. Professional development and training could usefully address this mis-match, as well as tackling the difficulties of role ambiguities, shifting relationships between professions, and renegotiations of boundaries between health and social service agencies. Spaces for debate regarding the ambiguities contained in notions of 'community', 'care in the community' and 'professional carers' should be encouraged both within the world of mental health and in the broader public sphere. Although this is unlikely to generate neat solutions, and may do little to reduce the basic uncertainties which professionals experience regarding the concept of mental illness *per se*, it may allow greater public recognition of the social ethics of mental health work in late twentieth century society. And as community care unfolds into its second decade and gradually solidifies into a social reality, new codes of practice, reference points and representational anchors may emerge, diminishing the uncertainties which currently characterise these professional representations.

This progress of mental health care into the twenty-first century must be accompanied by continual study of the spheres of practice-based knowledge which circulate in professional communities. For it is the powerful social reality of these professional social representations in shaping social practices as diverse as legal decisions, childrens' understandings of states of deviance, and the lives of thousands of people who pass

through the mental health services that imbues them with such significance in the on-going production of social knowledge and construction of society.

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[1] The references on this page are cited on pages 14 i - 14 v of the Introduction.

APPENDIX 1

DESCRIPTIONS OF THE MENTAL HEALTH SERVICES STUDIED IN BRITAIN AND FRANCE[1]

The current research is based on data collected in mental health services in urban and suburban areas of Paris and London. While there was a deliberate attempt to research 'typical' services, their location in capital cities implies several unique features: Services located close to academic institutions and teaching hospitals tend to be at the forefront of innovation and change, and may implement policy changes more quickly than provincial counterparts. Difficulties of staffing and recruitment (a chronic problem in mental health) are less acute than in rural areas. And the social environment of large cities implies social problems and issues which differ from rural areas.

1 France

Research was conducted in three psychiatric 'secteurs' in the Paris area. One of these is located in the centre of Paris, the other two in the north east suburbs of Paris, in the département of Seine-St-Denis. This is a relatively deprived area of suburban Paris, similar in social terms to the localities in London where research was conducted. It is characterised by high rise architecture dating from the 1960s, and has a reputation for serious social problems including unemployment, racial tensions, drug abuse, and youth alienation.

[1] This review describes mental health services in the study areas as they were during the data collection period of this research (1992 in France, 1993 in Britain). As well as the sources listed, this is based on information obtained from interview respondents and discussions with several 'key informants' (service managers, mental health researchers and professionals involved in service planning - see Chapter 4, section 2.2 for details.)

1.1 Secteur 15, Seine-St-Denis[2]

The fifteenth secteur of Seine-St-Denis provides mental health services in the areas north of Neuilly-sur-Marne including Clichy-sous-Bois, Gagny, Montfermeil and Coubron (an area containing a population of 100,000). The network of mental health services in this secteur consists of one psychiatric hospital ward, a 'centre medico-psychologique', a day centre, a team of social workers, a team working with AIDS victims, and a small amount of sheltered accommodation. Overall, the secteur employs around 80 mental health professionals, around half of whom are psychiatric nurses. Over the last fifteen years the secteur has lived through a period of radical change, implemented by a 'chef de service' determined to develop a community based network of services. The time when research was conducted was described as a period of 'letting the dust settle' and of gradual stability following these shake ups. Amongst the professionals and key respondents I talked to, the fifteenth secteur is regarded as slightly 'above average' in that it has succeeded in reducing numbers of in-patient beds, developed an adequate network of extra-hospital services, and is run by a dynamic and reasonably satisfied team. However it is far from being a model secteur, perceived problems being centred around the functioning of the hospital service. Research was conducted in three services in this secteur:- the in-patient ward at Ville-Evrard Hospital, the Day Centre at Clichy-sous-Bois, and the 'Centre Medico-Psychologique' (CMP) at Montfermeil. These are described in turn below:

Champagne Ward, Ville-Evrard Hospital

Ville-Evrard psychiatric hospital is a large hospital situated 15km to the east of central Paris, in the suburban district of Neuilly-sur-Marne. Its history can be traced back to the fourteenth century although its current architecture bears witness to the nineteenth century institution. It is set in large walled grounds, and is organised around a tree lined avenue leading to the central administration block, containing administrative departments, a shop, a chapel and a cafeteria. Spreading out into the grounds are the various wards, housed

[2] During my time in France, this was the secteur in which I spent most time, and which I came to know the best, using it to familiarise myself with the French mental health system. The detailed descriptions of this secteur provided here serve to illustrate how mental health services are generally organised in France.

mainly in the renovated nineteenth century 'pavillons', built in the style of large stone houses, with three floors and large shuttered windows. The hospital provides in-patient psychiatric facilities for adults and children in the fifteen 'secteurs' of Seine-St-Denis département, and contains a total of about 1,000 patients.

Champagne ward is typical of most wards in the hospital, and its general ambience is very similar to wards studied in Britain. Day rooms, a kitchen and dining room and staff offices are located on the ground floor, communal bathrooms and bedrooms with two or three beds on the first floor, and large meeting rooms used for group activities and staff meetings on the second floor. It has an institutional feel and there has been little attempt to soften the environment with pictures, plants or other decoration. The ward's 25 beds tend to be fully occupied most of the time. Most patients pass through in a number of days or weeks, but there are a few elderly and physically disabled patients whose stays are longer term and are well known by all staff. Despite many references by informants to improvements in recent years, there are few signs of attempts to animate hospital life. Patients can often be seen hanging around in the corridors or day rooms, while staff busy themselves with practical tasks or chat to each other in the staff office. In line with the majority of nursing staff in the hospital, most nurses on the ward wear white medical coats (In my experience, this is highly unusual in British psychiatric wards.) The team of ward staff consists entirely of psychiatrists and psychiatric nurses (social workers attend the ward for some sessions, but other professionals are located full-time at the various community centres). Thus, there is a clear sense of a working environment modeled on general medicine.

<u>Clichy-sous-Bois Day Centre</u>

The 'Centre de Jour' at Clichy aims to provide flexible daytime support specifically for people with long-term mental health problems living in the local community, most of whom also attend the CMP for formal psychotherapy or administration of medication. The centre has been created in an apartment in one of the rather run down 1960s tower-blocks which characterise the local area (a deliberate attempt to shift mental health services into the heart of an extremely deprived area). It consists of three large communal rooms, a kitchen and a staff office and is open three days a week for four to six hours. There is a generally relaxed atmosphere, and activities are not fixed, but

decided between by staff and clients. They may include cooking a midday meal together, having a picnic in the nearby woods (an activity in which I participated), visiting museums, parks, and other places of interest, or evening outings to the cinema or theatre. The team of professionals (all of whom appear to be highly motivated) consists of three psychiatrist and a clinical psychologist who work at the centre part time, and three full-time psychiatric nurses. During opening hours four or five staff are in attendance, with patient numbers varying from less than five to around fifteen.

Montfermeil 'Centre Medico-Psychologique' (CMP)

The CMP is located in a large three storey house just off the main street of Monfermeil. A central reception room staffed by two secretaries, a small medical room used for injections, a kitchen and a waiting room are housed on the ground floor. Rooms in the upper two floors are used for formal one-to-one consultations. The centre is open from nine to six on weekdays and on Saturday mornings. Typical of most CMPs, which exist now in the majority of psychiatric secteurs in France, its aims are to provide support for people with mental health problems living in the community, to prevent hospital admissions, and to reintegrate and support patients following discharge from hospital. Patients are referred to the CMP mainly by general practitioners, mental health practitioners at Ville-Evrard, or by the local general hospital. It is also open to the public to 'drop-in' informally to receive advice about mental health issues (although this service remains relatively under-used). Formal one-to-one consultations and domiciliary visits form the bulk of the daily work of a multi-disciplinary team of consisting of nurses, psychiatrists, a clinical psychologist, and a movement therapist. Psychotherapy is conducted by the psychologist and the psychiatrists (several of whom work part time), while nurses are involved in a variety of tasks including administering long-acting medication and monitoring clients' mental states and living conditions.

1.2 Secteur 4, Seine-St-Denis

The forth psychiatric secteur of Seine-St-Denis covers an area of the northern suburbs of Paris including Dugny, La Courneuve and Stains. In-patient facilities are provided at Ville-Evrard hospital (located about 25km away from the secteur), and there are two

CMPs and two day centres in the secteur. These operate along similar lines to those described above, although with more emphasis on group activities at the CMPs. The secteur has a small amount of sheltered accommodation, and also makes use of a family placement scheme in which local families house clients for a period of months following discharge from hospital. Secteur 4 has generally been more conservative than many others in moves to reduce its hospital capacity. Until recently it made use of three hospital wards, each with a capacity of 25 beds, although one of these was closed during the data collection period. Interviews were conducted with professionals working at the CMP in Stains and in the hospital ward (which was broadly similar to the ward describe in section 2.1).

1.3 Secteur 1, Paris

The first psychiatric secteur of Paris is responsible for the population of the first and second arrondissements of Paris, a central area north of the river. This location brings with it specific considerations - an extremely heterogenous and unstable population, and problems of homelessness associated with city centres. Hospital facilities (about 130 beds) are provided at a large psychiatric hospital in Perray-Vaucluse, 30km south of Paris. Interviews were conducted with staff working in a community centre in central Paris, housed within a large modern building, and containing a CMP / day centre and a 24 hour drop in centre as well as child / adolescent mental health services. The drop in centre aims to be the first port of call for new or existing clients, aiming to assess mental health and refer to other services if necessary. It is staffed by a team of 16 psychiatric nurses, who have unusually high levels of autonomy and responsibility. The CMP / day centre occupies two floors of the centre and aims to provide daily support for chronic patients living in the secteur as well as those recently discharged from hospital. A canteen provides a mid-day meal and various group activities are organised for long term clients by a multi-disciplinary team. More formal one-to-one consultations also take place, including various types of psychotherapy and prescription of medication.

2 Britain

Research was conducted in two District Health Authorities in south east London[3]. These areas are racially mixed and fairly deprived, with high levels of unemployment and large proportions of council owned housing. Literature produced by the regional health authority (SETRHA) suggests that mental health services in this region are generally typical of national service provision, and have followed trends similar to those occurring throughout the country. In both the districts studied, the data collection period (May to December 1993) coincided with major organisational changes involving new managerial structures and changing relationships with social service providers.

2.1 West Lambeth

The West Lambeth district covers areas of Brixton, Stockwell and Streatham, and its mental health services are under the control of the West Lambeth Community Care NHS Trust. The district contains St Thomas' Hospital, although most of its psychiatric in-patient beds are located at the South Western Hospital and Tooting Bec psychiatric hospital (a large Victorian institution which is being gradually closed down). Several key informants regarded the network of community mental health services in West Lambeth as poorly developed and failing to meet the specific needs of the local ethnic population.

Interviews in West Lambeth were conducted with staff working at a psychiatric day centre located in the grounds of the South Western Hospital in Stockwell. This is a small, Victorian hospital containing four adult psychiatric in-patient wards. The Day Unit represents a good example of the implementation of community care as envisaged by government policies. It is situated in single storey building and consists of a large day room containing easy chairs and table-tennis tables, other large rooms used for specific group activities, a woodwork and pottery workshop, several smaller rooms for one-to-one work, and staff offices. The walls and corridors are decorated with paintings done by clients and displays of woodwork and pottery. The overall aims of the Day Unit are to

[3] DHAs usually serve a population of between 250,00 and 330,000, an area significantly larger than the equivalent 'secteurs' in France (which cover a population of around 70,000).

provide day support and treatment-oriented activities to a variety of mentally ill clients (staff here always use the term 'client' rather than 'patient', and seem generally very aware of power issues associated with terminology). A proportion of the clients are long term service users, but the majority are relatively short term cases, many of whom are referred from the hospital's acute wards both prior to and following discharge. The average length of stay is around six months, following which clients may be referred to other community based support services such as community psychiatric nurse teams (CPNs) or sheltered workshops. There is an emphasis on helping clients to manage real world issue in preparation for more independent life, and there are close links with local social services involved in housing and benefits, and with sheltered work agencies. Around 60 clients are registered at the Day Unit at any one time. Most clients attend two or three days a week, so that around 20 people are present each day.

The daily activities of the Day Unit are very much group based. One-to-one work is limited to meetings between clients and key workers, and consultations with the psychiatrist to review medication. All the activities are designed to have a therapeutic focus rather than being simply time-filing exercises. They include 'work skills groups' using activities such as pottery and woodwork to develop skills needed in a work setting (time management, organisation, self discipline etc), informal discussion groups aiming to improve social and interactive skills and build self confidence, and psychodynamic groups focusing on trust building, self expression and disclosure through discussion and creative writing. At the time of interviewing the Day Unit was staffed by a team consisting of five full time professionals (three psychiatric nurses and two occupational therapists) plus sessional input from a psychiatrist at senior house officer level, a registrar, a consultant psychiatrist and a social worker.

2.2 Lewisham and North Southwark

The district of Lewisham and North Southwark covers some of the most deprived areas of south London, encompassing an area from Lewisham and New Cross north to the river, and as far east as Rotherhithe. Mental health services are provided by Guy's and Lewisham NHS Trust and The Optimum Health Services NHS Trust. Psychiatric in-patient facilities are located at Guy's, Hither Green and Bexley hospitals. At the time

of research, this was complemented by a network of services consisting of social work, psychology, psychotherapy and out-patients departments at Guy's Hospital, several day centres, teams of CPNs and case managers, teams focusing on problems of homelessness, and alcohol and drug abuse, and a small amount of sheltered accommodation provided in conjunction with housing associations. A major reorganisation of community services was being planned for the following year (causing much concern amongst staff members). Interviews were conducted with professionals working in three locations in this area:- an acute admissions ward at the York Clinic at Guy's Hospital, the Chaucer Day Hospital in Rotherhithe, and the Blackfriars Road Resource Centre.

The York Clinic

The York Clinic, a four storey building situated in the grounds of Guy's Hospital, contains two acute adult psychiatric in-patient wards and a ward run according to therapeutic community principles. The ward selected for study (one of the two acute admissions wards) has 11 beds, in single, two or three bed rooms. The lay out of the ward is reminiscent of a medical ward - a nurses station, a day room with easy chairs and a television, several rooms for one-to-one work and staff meetings, a treatment room and a laundry room. Meals cooked in the main hospital kitchen are eaten in one of the larger rooms. Although it is not particularly run down, neither is it a particularly friendly or inspiring environment. The ward caters for people suffering from acute episodes of confusion or instability, and frequently institutes sections of the Mental Health Act to detain people considered to be dangerous to themselves or others. Many patients are long-term service users who periodically have short stays in hospital at times of crisis. The average length of stay is a few weeks, although this can vary from a few hours (when a person is brought in against their will and immediately discharges them self) to several months. The catchment area is such that a large proportion of people seen in the ward have problems associated with alcohol or drug abuse, homelessness and unemployment. This means that staff work closely with local shelters for the homeless, social services and the police.

Typical of many psychiatric hospital wards, patients spend much of their time sitting in the day room and there is constant close surveillance by staff. Staff try to encourage patients to attend occupational therapy work-shops in the main hospital, but there are very

few group activities organised on the ward. There is relatively high use of medication in this context, although attendance at weekly ward rounds confirmed an eclectic approach amongst ward staff. At the time of interviewing, the staff team on the ward consisted of two psychiatrists and eight nurses. An occupational therapist, a psychotherapist, a CPN and a social worker are attached to the team part time while working in other community services. My impressions gained from observations of ward rounds and time spent on the ward suggest that the staff team is relatively cohesive. Weekly meetings to review patients had a relaxed, open and discursive atmosphere, informally led by the consultant psychiatrist but with input from all team members and much discussion regarding possible formulations of patients' problems.

Chaucer Day Hospital

The Chaucer Day Hospital is located in an old single storey building on the site of the former St Olave's Hospital in Rotherhithe, south-east London. It caters for acute and long term mental health service users, many of whom have moved on from in-patient wards at the York Clinic. Around 90 to 100 clients are on the books at any one time, although around 20 usually attend on any one day. Lengths of contact range from a few months to several years. The lay out and aims of Chaucer day hospital are similar to the Day Centre studied in West Lambeth. The centre is open weekdays 9am to 5pm and provides a variety of services with a hot midday meal provided. The main focus is on group work, with three or four groups running each day. At the time of interviews the groups being run included a small psychotherapy group, art therapy, a creative / drama group, anger management, anxiety management, gardening, pottery, media and discussion groups and a movement group. Clients are also seen for individual work. For some clients, medication is administered by nurses in the form of long-acting 'depot' injections. The staff team is multidisciplinary, including four psychiatric nurses, four occupational therapists, a clinical psychologist, an administrator and a secretary. Two psychiatrists are attached to the team. Integration with other services is high - most of the staff spend at least one day a week working at other services, and clients may be referred to social workers at Guy's hospital, CPNs or case management teams either during or following their time at Chaucer.

Blackfriars Road Resource Centre

This is the base for two teams of mental health professionals working with clients living in the community. A team of CPNs and a 'Case Management Team[4]' provide support and monitoring of clients whose mental health problems are mainly long term. The centre differs from others studied in that very little direct mental health work occurs at the centre. Professionals spend the majority of their time conducting home visits and use the centre primarily for team meeting and administration. Domiciliary visits may be conducted daily, weekly or less frequently, and involve a range of activities from administering long acting psychotropic medication, to checking on state of a person's flat or helping them with benefit claims.

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[4] For descriptions of the work of case managers and the other professionals referred to in this review, see Appendix 2. The case management team is probably the least 'typical' of all the services studied in Britain, being regarded as something of a 'flag ship' for new styles of community based mental health services in Britain. Its functioning is reported by Morgan (1993) Community Mental Health: Practical approaches to long-term problems. Chapman & Hall: London.

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APPENDIX 2

THE MENTAL HEALTH PROFESSIONS

Psychiatry

Psychiatry is the oldest of the mental health professions and the one that has had the most impact on public mental health systems throughout the world. From the earliest 'mad doctors' or 'alienists' of the seventeenth century to the present day, the medical profession has shaped the treatment of the mentally ill, and placed mental distress firmly within the domain of 'illness' and medicine. It is only in the second part of the twentieth century, with the professionalisation of other mental health practitioners, that the dominance of psychiatry in mental health care has been seriously questioned. Despite this, psychiatry still remains the most powerful of all the mental health professions, its alliance with medicine giving it considerable social status.

Against a background of significant developments in medical knowledge and conceptualisations of the psyche, the history of psychiatry has seen several shifts of focus, from a relatively limited view of the body and observable behaviour in the early nineteenth century, to a wider focus on the neurological system, the mind and social relations during the twentieth century (Prior 1993). Contemporary psychiatry takes the principles and practices of general medicine as its starting point (ie a focus on diagnosis and classification of specific mental illnesses, and an assumption of distinct and universal disease entities which can be treated using interventions impacting on the person's physiology or biochemical systems). However, while a medical model of mental ill health has dominated psychiatry historically and remains its closest conceptual ally, contemporary psychiatric training schools practitioners in a range of other perspectives in which the mentally ill person is seen as a bio-psycho-social entity.

In both France and Britain, psychiatric training can only be begun once a full medical training is completed. Psychiatrists are therefore first and foremost doctors whose medical training has socialised them as medical practitioners responsible for the prescription of medication. This medical responsibility places psychiatrists in a different

position from all other mental health professionals both legally and socially. Although psychiatric nurses are qualified to administer medication, psychiatrists are the only professional group who have the power to prescribe medication or other medical interventions such as ECT or psychosurgery. Psychiatry in Britain and France is broadly similar, the most notable difference being the greater up-take of psychodynamic ideas and practices amongst French psychiatrists. Although classic medical approaches to psychiatry still dominate, since the late 1960s a significant proportion of French psychiatrists have incorporated psychoanalysis into their daily work, either in private practice or within the public mental health system.

Clinical Psychology

Clinical psychology developed originally in the first part of the twentieth century to provide psychometric support for psychiatry (Prior, 1993). The discipline has traditionally been concerned with measurement, observable behaviour and tests of intelligence and personality. It is probably the most theoretically oriented profession in mental health, attempting to apply psychological theories and principles to the evaluation and treatment of mental ill health, and adopting a 'scientific practitioner' model of work. In so doing, clinical psychology has undergone several transformations in recent decades. Pilgrim & Treacher (1992) describe these shifts in British clinical psychology as constituting four stages:- a concern with psychometrics in the 1950s, a shift towards behaviour therapy during the 1960s, therapeutic eclecticism in the 1970s and 'managerialism' in the 1980s. These shifts have been accompanied by an increasing professionalisation of clinical psychology over the last two decades. Psychologists in both France and Britain have fought hard to enhance their status and to institute state-endorsed registration and chartered status for the profession. (In both countries, training to become a clinical psychologist must be preceded by a degree in psychology and involves a minimum of three years further training.)

Although the theoretical contributions of clinical psychology represent a significant challenge to the dominance of medical conceptualisations of mental ill health, there has always been an imbalance between the conceptual contributions of psychology to expert understandings and treatment strategies, and the relatively limited role of clinical

psychologists in mental health services. In both countries clinical psychology is a relatively 'small' profession and there is usually only one psychologist in a multi-disciplinary mental health team of between ten and thirty other professionals. While the status of clinical psychologists in the world of mental health is similar in Britain and France, divergences exist in the theoretical approaches adopted on each side of The Channel. Contemporary British psychology is dominated by cognitive-behavioural interventions. These strategies are virtually unknown in France where clinical psychologists usually adopt a psychodynamic approach. Like psychiatrists, the contact that clinical psychologists have with mentally clients tends to be time-limited and structured around pre-arranged consultations or activities.

Psychiatric Nursing

Historically, the position of psychiatric nurses in institutional mental health settings was been as 'guardians' responsible for the administration of medication and the basic physical needs of inmates, and employed essentially in a surveillance role. In the 1950s a more therapeutic role for psychiatric nurses was first envisaged, but it has only been in the last two decades, aided by the gradual shift of mental health services beyond the confines of the hospital, that significant professionalisation and changes in the role of psychiatric nurses have actually occurred. In France the shift towards a more social and therapeutic role for nurses was aided by the socio-political changes of the late 1960s. Training in both countries now takes a minimum of three years, with increasing numbers of nurses entering the profession at post-graduate level. The last two decades have seen the development of a large body of psychiatric nursing theory and literature which has borrowed from psychological, psychodynamic and humanist perspectives to develop eclectic models of nursing care. Psychiatric nurses have increasingly attempted to dissociate themselves from the medical paradigm and to emphasise a psychosocial approach to their work (Reynolds & Cormack 1990). Although they share a proportion of their training with nurses in general medicine, psychiatric nurses in both France and Britain generally consider themselves as a distinct discipline.

Psychiatric nursing constitutes the largest single profession in mental health, although the existence of specialisms and professional hierarchies makes for a relatively heterogenous

professional group. More senior charge nurses or 'infirmiers surveillants' often have considerable managerial responsibilities and power over the day-to-day running of services, especially those based in the community. Although psychiatric nurses are qualified to administer medication, they rely on psychiatrists for decisions about dosage. Compared to other professionals, nurses are the practitioners who spend most time in direct contact with mentally ill clients, especially in hospital ward settings.

Psychiatric Social Work

Psychiatric social work first appeared in the first half of the twentieth century as a profession concerned with aftercare following hospital admission. The gradual integration of social work into mental health services during the 1930s, 40s and 50s is accounted for by Prior (1993) in terms of growing beliefs in social factors in the aetiology of mental illness, a recognition that mental health problems were widespread in the community, and an expansion of the number and types of symptoms that were considered within the remit of psychiatry. The development of psychiatric social work theory and practice in Britain and France over the last few decades owes much to the theoretical perspectives of psychoanalysis, psychology and sociology. The profession has not developed its own distinct body of theory, but claims distinctiveness from both general social work and other mental health professions on the basis of its knowledge of the social welfare system and its specialised practice focused on the social situation of mentally ill clients. However, with the growing importance of community based professions such as case management and community psychiatric nursing these distinctions are becoming increasingly blurred.

The social position of social workers in both France and Britain has traditionally been as a profession which is undervalued and frequently the focus of public scrutiny and scepticism. Recent shifts towards community based care for the elderly, the mentally ill and the disabled have added to this, and have entailed significant increases in social workers' responsibilities for long-term social welfare. Since 1983 in Britain psychiatric social work involvement in mental illness has been enshrined in law, with both a psychiatrist and a registered social worker being required to agree to compulsory detention on the grounds of mental ill health. Social workers in both countries are now

principally involved in the coordination of services between health and social services departments. Their work is diverse and may include, for example, helping mentally clients claim sickness benefits, liaising with housing departments, or participating in group or therapeutic activities in community services.

Community Psychiatric Nursing

Community psychiatric nurses (CPNs) are psychiatric nurses who have undergone further training which qualifies them to take primary responsibility for the long-term monitoring of mentally ill people living in the community. CPNs may be responsible for a large number of clients in a local area, and typically arrange meetings on a weekly or less frequent basis, either in clients' homes or at a community or hospital based psychiatric centre. CPNs work mainly with people with long-term mental illnesses, and the profession defines itself as involved in four areas:- assessment and therapeutic input to clients and relatives; consultation with other professionals; monitoring the effects of psychotropic drugs; and (most definitively) administration of long-acting psychoactive injections (White 1993).

Recent shifts towards community based care have meant that superficially at least, the roles of CPNs and social workers have appeared to converge. Overlaps in the work of social workers and community psychiatric nurses in Britain have been noted by Wooff et al (1988) and Sheppard (1990), but both these authors also highlight differences between the two professions. Sheppard (1990) notes differences in the knowledge bases associated with the two professions: Social workers are more influenced by the social sciences, whereas CPNs have a stronger focus on mental illness, with a background tied more to medical knowledge. In their daily practice, social workers are more concerned with clients' social relations and work closely with other mental health staff. In comparison CPNs focus on symptoms and medication, and work more independently of the mental health team, liaising more frequently with general practitioners (Wooff et al, 1988).

Occupational Therapy

Since its beginnings in the 1930s, occupational therapy (OT) has always been a periphery component of the mental health team. Prior (1993) notes the moral undertones that have always been associated with OT, suggesting an implicit belief in the value of work, personal discipline and structured, goal-oriented activity, and the dangers of idleness. In asylum based mental health services, occupational therapy initially took the form of large workshops in which patients were put work on repetitive, unskilled tasks. From this shared historical base, OT has moved in different directions in France and Britain. In France, occupational therapy never really progressed beyond this non-therapeutic production basis. Despite the existence in some psychiatric hospitals of creative OT workshops (providing opportunities for pottery, woodwork or painting for example), OT in France has never recovered from its negative image as a component of coercive institutionalisation (Machto 1989), and has effectively died out as an integral component of multi-disciplinary mental health teams. In contrast, OT in Britain has moved through several transformations, shifting from a focus on work to the provision of time-filling, creative or expressive activities, and in recent years, to a more pragmatic social skills orientation. However, in the absence of theoretical specialisation, OT has been unable to assert a truly autonomous identity, and has borrowed theoretical principles from psychology, in particular behavioural and social skills training models. In contemporary mental health services in Britain, occupational therapists work in both hospital and community settings. They are typically concerned with two types of activity: Practical assessments and improvement of daily living activities (cooking skills, self-care, work and social skills for example); and creative / expressive activities. In its focus on social and practical skills, occupational therapy is concerned ultimately with individual 'functioning' and conforming to social norms.

Case Management

The idea of case management originates in the United States, where it was developed in the 1970s as an attempt to overcome the fragmentation of services that accompanied community based care. In Britain case management has only become a widely recognised profession in the last few years, identified in government policy literature as central to

community care policies[1]. In France the profession of case management does not exist.

Case management can be conceived either as a set of tasks performed by practitioners from various professional origins, or as an independent profession. In the services in Britain used for the current research the second approach is taken. Thus the case managers interviewed define themselves as specific professional discipline, although they originate from backgrounds in occupational therapy and social work. Case managers are principally concerned with the co-ordination of services rather than with their actual implementation. Onyett (1992) defines case management as 'a way of tailoring help to meet individual need through placing the responsibility for assessment and service coordination with one individual worker or team' (p 3). He identifies five parallel tasks of case management:- assessment of an individuals need and strengths; planning; implementation of a care strategy by a range of agencies; monitoring; and reviewing the outcomes of planned interventions. Case managers typically work with people with long-term mental health problems living in the community and fulfil the important role of ensuring that long-term service users do not 'disappear', but remain supported and in contact with mental health services. Although liaising with mental health teams, social services and medical practitioners, case managers tend to work in a relatively autonomous fashion. Given the novelty of this profession in the rapidly changing context of community care policy implementation, the overlaps and relative roles of case managers, CPNs and social workers are variable and unclear, and have yet to be established definitively.

Other Professions

Although the seven professional groupings described above form the core of multi-disciplinary mental health teams in France and Britain, these teams may also include a range of other professionals who offer specific individual or group therapies and activities. Movement therapists, art therapists, music therapists, and various other types of psychotherapists and adult education specialists may be linked to mental health services

1 Department of Health (1990) Caring for People: Community Care in the Next Decade and Beyond. HMSO: London.

(often on a part-time basis), providing specialised interventions in both hospital and community locations.

APPENDIX 3

THEORIES OF MENTAL ILLNESS

1) Medical Perspectives

Medical models draw parallels between mental health problems and somatic illness. Mental illness is seen as a consequence of physical or chemical changes in the brain or of genetic make up. This perspective makes sense of mental distress by anchoring it firmly into medical models developed to understand physical ill health. It suggests an approach to mental illness similar to that in general medicine; mental illnesses are diagnosed according to established systems of symptomatology, and treated with physical interventions, most commonly drugs, but also psychosurgery and electro-convulsive therapy (ECT). Medical models have traditionally dominated the psychiatric profession internationally, and general acceptance of the term 'mental illness' betrays the dominance of this approach historically in western societies. The discovery of pharmacological treatments in the 1950s provided strong support for a medical view of mental illness. Although this declined in the 60s and 70s, recent developments in bio-technology have rekindled interest in the search for genetic components of mental illnesses.

The traditional medical or psychiatric approach to mental ill health relies heavily on the process of differential diagnosis in which manifest signs and symptoms are used as the basis for categorising mental distress into specific mental illnesses. Since the 1950s the American Psychiatric Association and The World Health Organisation have been publishing successively updated versions of diagnostic manuals which are used internationally by the psychiatric profession[1]. DSM-IV (Diagnostic and Statistical Manual of Mental Disorders) and ICD-10 (International Classification of Diseases) published in 1994 and 1992 respectively are the most recent editions of these manuals. These psychiatric systems provide the basis for psychiatric training and the terminology of a common language between professionals in the world of mental health. They offer

1 Despite attempts to standardise these diagnostic systems internationally, some of the diagnostic categories used in French psychiatry are significantly different from their counterparts in Anglo-American psychiatry (Pichot, 1982).

psychiatrists clear guiding principles in their daily dealings with the mentally ill in suggesting, for example, the administration of specific types of medication for specific problems). In their contemporary forms, they conceptualise mental illness as a set of distinct disorders or abnormalities associated with a theme of loss of self control, and offer an essentially individualistic and biological model of the origins and treatment of mental distress (Gaines 1992, Light 1982).

Medical approaches to mental illness have come under attack from a variety of perspectives, most vigorously from the anti-psychiatry movement, and others critical of the dominance of medicine and the social *status quo* (see Chapter 2, section 2.2). Sedgwick (1982a), for example, notes that medical models are based on the assumption that illness constitutes abnormality in the sense of statistical deviation from the norm, and that this deviation is undesirable and worthy of treatment. He goes on to argue that neither of these assumptions stand up to scrutiny. Many commentators (eg Boyle, 1990; Gilman, 1988) criticise the lack of attention to cultural and contextual factors in medical perspectives, with the consequence that mental health problems are represented as bizarre and incomprehensible. They also suggest that medical models are attractive to the public and professionals alike, as a way of coping with the threat and fear implicit in representations of mental illness. In postulating the origins of mental health problems in biology and genetic make-up, they serve to absolve the victim, their family and society in general from responsibility; they suggest clear differences between the mentally ill and other people, thus serving to enhance a sense of distance from the threat of mental illness; and they suggest that the source of this threat can be specifically located and contained.

2) Psychodynamic[2] Perspectives

The writings and theories of Freud provide the basis for this approach. However, the multitude of theoretical and therapeutic developments since the appearance of Freud's original work at the beginning of the century, mean that it is more correct to refer to a

2 Although the terms 'psychodynamic' and 'psychoanalytic' tend to be used interchangeably, I choose to use the term 'psychodynamic' as it has broader connotations associated with a school of thought rather than a specific therapeutic technique.

'family' of psychodynamic perspectives. What unites these approaches is an understanding of mental illness as a phenomenon involving psychic and unconscious processes resulting from emotional traumas or experiences during early development, particularly in family or parental relationships. Psychodynamic practice aims to help the person become aware of and come to terms with their past experiences and the impact these have had on later relationships and experiences, through the reliving of childhood emotions during therapy. This can take a variety of forms within an ever expanding gamut of techniques which includes long term one-to-one psychoanalysis, short and medium term 'talking therapies', group therapy, therapeutic communities, art therapy, drama therapy, movement therapy and so on.

In the context of the current research, it is important to note that there have been significant divergences in psychodynamic developments in the English speaking world and in France (see for example, Laplanche & Pontalis 1973, Stevens 1983, Turkle 1979). The British 'object relations' school of thought developed through the work of Melanie Klein and, later, Winnicot. Essentially, this perspective focuses on the impact of emotional experiences infancy, in particular anxiety, aggression and frustration in the new-born child. American neo-Freudians including Erich Fromm, Karen Horney and Erik Erikson developed perspectives which stressed the impact of cultural context and down-played the role of biological determinants. Focusing on the ego and conscious experience more than the id and the unconscious, American psychoanalysts developed 'ego psychology', a more optimistic and individualistic perspective than European approaches, emphasizing the possibilities for individual change and adaptation to social reality.

In France psychodynamic developments followed a rather different line, which has tended to remain independent of developments in the English speaking world. The core of this approach is Jacques Lacan's significant reinterpretation of Freudian theory in the light of structuralist linguistics and semiotics, and as a critique of individualistic American approaches. Language is central to Lacanian theory, and it is through language and the spoken word of the patient that Lacanian psychotherapists aim to understand non-rational aspects of the unconscious, of humanity and of society. Lacan's suggestions that psychoanalysis could be used as a tool to understand not only individual problems, but wider societal issues, together with his anti-establishment approach mean that since the

late 1960s psychodynamic thinking in France has been closely associated with left-wing politics and social criticism. As a consequence, there has been a huge proliferation of psychodynamic ideas in France, compared to their relatively marginal position in Britain.

3) Social Theories of Mental Illness

Social models of mental illness see the social environment as a crucial aetiological factor in mental health problems. Research such as Brown & Harris' (1978) study into the epidemiology of depression among women living in the community suggests that factors including unemployment, poverty and lack of social support may act as stressors, increasing a person's vulnerability to mental illness. Attempts to improve a person's social situation, development of strategies to help people cope with social stressors, and the provision of a supportive environment are seen as crucial care strategies. Social models of mental illness developed in association with left-wing sociological perspectives in the 1960s. The theories of the anti-psychiatry movement which fall broadly within this perspective, conceptualising mental illness as labelling of deviance or a myth and criticising asylum based care, can also be categorised as social theories of mental illness. These have been discussed in more detail in Chapter 2.

4) Cognitive-Behavioural Perspectives

Cognitive and behavioural theories of mental illness developed out of psychological theories of the 1950s and 1960s. Generally they see mental illness as ways of behaving or thinking which have been learned through experiences and relationships in childhood and later life. Following this argument, mental illness can be treated by therapy which involves modification of behaviour and / or thoughts. Behavioural theories and therapy preceded cognitive approaches, drawing on learning theories and behaviourism which were dominant in 1950s psychology (eg Eysenck & Rachman, 1964). Shifts toward cognitivism in psychology in the 1960s and 1970s produced more cognitive perspectives on mental illness. Cognitive therapy (eg Beck, 1967), which attempts to modify thought processes and beliefs is a technique commonly used by clinical psychologists in Britain in the treatment of depression, phobias and anxiety. The impact of cognitive-behavioural

perspectives on mental illness has been much more marginal in France, although there are currently signs that this approach is gaining in popularity.

5) Systemic Perspectives

Systemic perspectives on mental health and illness have developed in the last three decades and are the youngest of the perspectives presented in this review. Although they draw on psychodynamic and psychological approaches, they represent a significant departure from the four previous models in their shift of emphasis to an inter-personal rather than individual level of explanation. Mental illness is seen as a consequence of dysfunctional patterns of communication, especially among family members. Gregory Bateson (eg 1972) is usually credited for the original ideas on which this perspective is based. Treatment is similarly inter-personal, using family therapy to change dynamics between family members (eg Haley, 1967). Although systemic ideas carry increasing weight in the field of mental health in both Britain and France, their application to family therapy, is a relatively new, but expanding treatment strategy.

APPENDIX 4

LIST OF INTERVIEW RESPONDENTS

For each respondent their profession and the location of their work are shown. B denotes British respondents, F denotes French respondents.

Interviewee number	Profession	Location of work	Geographical district
B1	psychiatric nurse	day centre	West Lambeth
B2	occupational therapist	day centre	West Lambeth
B3	psychiatric charge nurse	day centre	West Lambeth
B4	psychiatrist	hospital & community	West Lambeth
B5	clinical psychologist	community	West Lambeth
B6	psychiatric nurse	in-patient ward	Lewisham & N Southwark
B7	program worker	community	West Lambeth
B8	psychiatrist	in-patient ward	Lewisham & N Southwark
B9	occupational therapist	hospital & day centre	Lewisham & N Southwark
B10	psychotherapist	in-patient ward	Lewisham & N Southwark
B11	psychiatric nurse	in-patient ward	Lewisham & N Southwark
B12	social worker	hospital & community	Lewisham & N Southwark
B13	social worker	hospital & community	West Lambeth
B14	psychiatric charge nurse	in-patient ward	Lewisham & N Southwark
B15	consultant psychiatrist	hospital & community	Lewisham & N Southwark
B16	community psychiatric nurse	community	Lewisham & N Southwark
B17	clinical psychologist	day centre	Lewisham & N Southwark
B18	psychiatric nurse	day centre	West Lambeth
B19	occupational therapist	hospital & day centre	Lewisham & N Southwark
B20	movement therapist	day centre	Lewisham & N Southwark
B21	psychiatrist	hospital & community	Lewisham & N Southwark
B22	community psychiatric nurse	community resource centre	Lewisham & N Southwark
B23	clinical psychologist	day centre	Lewisham & N Southwark
B24	psychiatrist	hospital & community	West Lambeth
B25	social worker	hospital & community	Lewisham & Southwark
B26	psychiatric nurse	day centre	Lewisham & N Southwark
B27	art therapist	hospital & day centre	Lewisham & N Southwark
B28	psychiatric charge nurse	day centre	Lewisham & N Southwark

B29	case manager	community resource centre	Lewisham & N Southwark
B30	case manager	community resource centre	Lewisham & N Southwark
F1	psychiatric charge nurse	24 hour community centre	Secteur 1, Paris
F2	psychiatric nurse	24 hour community centre	Secteur 1, Paris
F3	consultant psychiatrist	hospital & community	Secteur 1, Paris
F4	psychiatric nurse	24 hour community centre	Secteur 1, Paris
F5	clinical psychologist	24 hour community centre	Secteur 1, Paris
F6	social worker	hospital & community	Secteur 1, Paris
F7	social worker	hospital & community	Secteur 1, Paris
F8	psychiatrist	hospital & community	Sectuer 1, Paris
F9	movement therapist	hospital & day centre	Secteur 15, Seine-St-Denis
F10	psychiatrist	24 hour community centre	Secteur 1, Paris
F11	psychiatric charge nurse	day centre	Secteur 15, Seine-St-Denis
F12	psychiatric nurse	in-patient ward	Secteur 15, Seine-St-Denis
F13	psychiatrist	in-patient ward	Secteur 15, Seine-St-Denis
F14	psychiatric nurse	in-patient ward	Secteur 15, Seine-St-Denis
F15	psychiatric charge nurse	in-patient ward	Secteur 4, Seine-St-Denis
F16	social worker	hospital & community	Secteur 15, Seine-St-Denis
F17	psychiatric nurse	day centre	Secteur 15, Seine-St-Denis
F18	social worker	hospital & community	Secteur 15, Seine-St-Denis
F19	nurses union official (former psychiatric nurse)		Seine-St-Denis
F20	psychiatrist	day centre	Secteur 15, Seine-St- Denis
F21	psychiatric nurse	day centre	Secteur 15, Seine-St-Denis
F22	psychiatric nurse	day centre	Secteur 15, Seine-St-Denis
F23	clinical psychologist	day centre	Secteur 15, Seine-St-Denis
F24	psychiatrist	in-patient ward	Secteur 4, Seine-St-Denis
F25	clinical psychologist	hospital & community	Secteur 4, Seine-St-Denis
F26	receptionist	day centre	Secteur 15, Seine-St-Denis
F27	social worker	hospital & community	Secteur 4, Seine-St-Denis
F28	psychiatric nurse	in-patient ward	Secteur 4, Seine-St-Denis
F29	psychiatric nurse	day centre	Secteur 4, Seine-St-Denis
F30	clinical psychologist	day centre	Secteur 15, Seine-St-Denis

APPENDIX 5

INTERVIEW TOPIC GUIDE

(Specific probes generated by main questions not included)

A: Daily Practice

- Can you describe to me what your day-to-day work with patients/clients consists of?

- What is your aim in the work you do with patients/clients? What are you trying to achieve?

- Is your work based on certain theoretical models?

- What other factors to you think it is important to consider beyond theory in your practical day-to-day work?

- In general how happy would you say you are with the outcomes of your work for clients / patients?

- What do you think is the best way to care for and treat those with mental illness? (in an ideal world)

- What personal qualities do you think are needed to be a good professional in mental health?

B: Mental Illness

- For you personally, what is mental illness? / How would you describe mental ill health?

- What do you think could be the causes of mental illnesses?

- What do you think of the concept of cure in relation to mental illnesses?

C: The Service

- In general how happy are you with care and treatment strategies which are used in this service?

- If it was up to you, what changes would you like to make?

D: Community Care (British respondents only)

- How has the introduction of community care influenced your work over the last few years?

- Where does your knowledge of community care come from?

- What do you see as the theoretical and historical origins of community care policies?

- How do you see the state of community care at the moment?

- How do you see the future of community care?

- Do you think that community care could work successfully in an ideal world?

- What changes would have to occur for community care to work successfully?

APPENDIX 6

LIST OF NODES CREATED IN QSR-NUDIST DURING DATA ANALYSIS

(1) Background (demographic data for respondents)

(1 1)	/background/profession
(1 1 1)	/background/profession/psychiatrist
(1 1 2)	/background/profession/psychologist
(1 1 3)	/background/profession/nurse
(1 1 4)	/background/profession/social worker
(1 1 5)	/background/profession/other
(1 1 6)	/background/profession/charge nurse
(1 1 7)	/background/profession/OT
(1 1 8)	/background/profession/CPN
(1 1 9)	/background/profession/case manager
(1 2)	/background/place
(1 2 1)	/background/place/france
(1 2 1 1)	/background/place/france/secteur1
(1 2 1 2)	/background/place/france/secteur15
(1 2 1 3)	/background/place/france/secteur4
(1 2 2)	/background/place/britain
(1 2 2 1)	/background/place/britain/lambeth
(1 2 2 2)	/background/place/britain/southwark
(1 3)	/background/location
(1 3 1)	/background/location/hospital
(1 3 2)	/background/location/community
(1 3 3)	/background/location/both

(2) Daily Practice

(3) Treatments

(3 1)	/treatments/medication
(3 1 1)	/treatments/medication/cited
(3 1 2)	/treatments/medication/used
(3 1 3)	/treatments/medication/comments
(3 2)	/treatments/psychotherapy
(3 2 1)	/treatments/psychotherapy/cited
(3 2 2)	/treatments/psychotherapy/used
(3 2 3)	/treatments/psychotherapy/comments
(3 3)	/treatments/relationship
(3 3 1)	/treatments/relationship/cited
(3 3 2)	/treatments/relationship/used
(3 3 3)	/treatments/relationship/comments
(3 4)	/treatments/cognitive and behaviour therapy

(3 4 1)	/treatments/cognitive and behaviour therapy/cited
(3 4 2)	/treatments/cognitive and behaviour therapy/used
(3 4 3)	/treatments/cognitive and behaviour therapy/comments
(3 5)	/treatments/family therapy
(3 5 1)	/treatments/family therapy/cited
(3 5 2)	/treatments/family therapy/used
(3 5 3)	/treatments/family therapy/comments
(3 6)	/treatments/groups
(3 6 1)	/treatments/groups/cited
(3 6 2)	/treatments/groups/used
(3 6 3)	/treatments/groups/comments
(3 7)	/treatments/counselling
(3 7 1)	/treatments/counselling/cited
(3 7 2)	/treatments/counselling/used
(3 7 3)	/treatments/counselling/comments

(4) Models

(5) Assessment

(5 1)	/assessment/mental illness
(5 2)	/assessment/social situation
(5 3)	/assessment/treatment
(5 4)	/assessment/need
(5 5)	/assessment/diagnosis

(6) Aims

(6 1)	/aims/help cope
(6 2)	/aims/understanding
(6 2 1)	/aims/understanding/professional
(6 2 2)	/aims/understanding/patient
(6 3)	/aims/assessment
(6 4)	/aims/support
(6 5)	/aims/accept or manage illness
(6 6)	/aims/reduce distress
(6 7)	/aims/cure
(6 7 1)	/aims/cure/no
(6 7 2)	/aims/cure/yes
(6 8)	/aims/life quality
(6 9)	/aims/change
(6 10)	/aims/others
(6 10 1)	/aims/others/social circumstances
(6 10 2)	/aims/others/psychic structure
(6 10 3)	/aims/others/resolve problems
(6 10 4)	/aims/others/listen
(6 10 5)	/aims/others/social acceptance

(6 10 6)	/aims/others/crisis management

(7) Outcomes

(8) Role

(8 1)	/role/psychiatrists
(8 2)	/role/psychologists
(8 3)	/role/nurses
(8 4)	/role/social worker
(8 5)	/role/charge nurse
(8 6)	/role/occupational therapist
(8 7)	/role/CPN
(8 8)	/role/case manager
(8 9)	/role/other
(8 10)	/key worker

(9) Personal

(9 1)	/personal /qualities
(9 1 1)	/personal /qualities/respect
(9 1 2)	/personal /qualities/openness
(9 1 3)	/personal /qualities/listening
(9 1 4)	/personal /qualities/empathy
(9 1 5)	/personal /qualities/interpersonal
(9 1 6)	/personal /qualities/patience
(9 1 7)	/personal /qualities/stability
(9 2)	/personal /stressors
(9 2 1)	/personal /stressors/uncertainty
(9 2 2)	/personal /stressors/mental illness

(10) Professionals

(10 1)	/professionals/psychiatrists
(10 2)	/professionals/nurses
(10 3)	/professionals/psychologists
(10 4)	/professionals/charge nurses
(10 5)	/professionals/social workers
(10 6)	/professionals/case managers
(10 7)	/professionals/occupational therapist
(10 8)	/professionals/CPN
(10 9)	/professionals/others

(11) System

(11 1)	/system/community care
(11 1 1)	/system/community care/Britain
(11 1 1 1)	/system/community care/Britain/present
(11 1 1 2)	/system/community care/Britain/future
(11 1 1 3)	/system/community care/Britain/resources
(11 1 1 4)	/system/community care/Britain/knowledge
(11 1 2)	/system/community care/france
(11 1 2 1)	/system/community care/france/present
(11 1 2 2)	/system/community care/france/future
(11 1 2 3)	/system/community care/france/resources
(11 2)	/system/teams
(11 3)	/system/wider system
(11 3 1)	/system/wider system/constraint
(11 3 2)	/system/wider system/conflict
(11 3 3)	/system/wider system/therapeutic

(12) Mental illness

(12 1)	/mental illness/fragility
(12 1 1)	/mental illness/fragility/mentally ill
(12 1 2)	/mental illness/fragility/everyone
(12 2)	/mental illness/difference
(12 2 1)	/mental illness/difference/no
(12 2 2)	/mental illness/difference/yes
(12 3)	/mental illness/unclear definition
(12 4)	/mental illness/functioning
(12 4 1)	/mental illness/functioning/type of coping
(12 4 2)	/mental illness/functioning/not coping
(12 5)	/mental illness/neuroses
(12 6)	/mental illness/psychoses
(12 7)	/mental illness/distress
(12 8)	/mental illness/understanding
(12 9)	/mental illness/medical model
(12 10)	/mental illness/comments
(12 10 1)	/mental illness/comments/lay views
(12 10 2)	/mental illness/comments/on question
(12 10 3)	/mental illness/comments/joking
(12 10 4)	/mental illness/comments/on the term
(12 11)	/mental illness/loss of control
(12 12)	/mental illness/others
(12 13)	/mental illness/unpredictability
(12 14)	/mental illness/insight

(13) Causes

(13 1)	/causes/multiple
(13 2)	/causes/don't know
(13 3)	/causes/depends
(13 3 1)	/causes/depends/on person
(13 3 2)	/causes/depends/on illness
(13 4)	/causes/childhood Rs
(13 5)	/causes/biological
(13 5 1)	/causes/biological/not biology
(13 6)	/causes/social
(13 7)	/causes/others
(13 7 1)	/causes/others/psychoanalysis
(13 7 2)	/causes/others/susceptibility
(13 7 3)	/causes/others/stress
(13 7 3 8)	/causes/others/stress/life events
(13 7 7)	/causes/others/drugs alcohol

(14) Cure

(14 1)	/cure/yes
(14 1 1)	/cure/yes/types of illness
(14 1 2)	/cure/yes/how
(14 1 2 1)	/cure/yes/how/management
(14 1 2 2)	/cure/yes/how/understanding
(14 1 2 3)	/cure/yes/how/psychotherapy
(14 1 2 4)	/cure/yes/how/motivation
(14 2)	/cure/no
(14 2 1)	/cure/no/if not, what
(14 2 1 1)	/cure/no/if not, what/functioning
(14 2 1 2)	/cure/no/if not, what/understanding
(14 2 1 3)	/cure/no/if not, what/stability
(14 2 1 4)	/cure/no/if not, what/others
(14 2 1 5)	/cure/no/if not, what/support
(14 2 1 6)	/cure/no/if not, what/work towards
(14 2 1 7)	/cure/no/if not, what/recover
(14 2 1 8)	/cure/no/if not, what/remission
(14 2 1 9)	/cure/no/if not, what/reduce suffering
(14 2 1 10)	/cure/no/if not, what/change
(14 2 1 11)	/cure/no/if not, what/managing
(14 2 1 12)	/cure/no/if not, what/ care for
(14 2 1 13)	/cure/no/if not, what/feel better
(14 2 2)	/cure/no/types of illness
(14 2 3)	/cure/no/why not
(14 2 3 1)	/cure/no/why not/mental illness
(14 2 3 2)	/cure/no/why not/seriousness
(14 2 3 3)	/cure/no/why not/fragility
(14 2 3 4)	/cure/no/why not/lack knowledge
(14 2 3 5)	/cure/no/why not/not in experience

(14 3)	/cure/definition
(14 3 1)	/cure/definition/uncertain
(14 3 2)	/cure/definition/functional
(14 3 3)	/cure/definition/symptom reduction
(14 3 3 1)	/cure/definition/symptom reduction/yes
(14 3 3 2)	/cure/definition/symptom reduction/no
(14 3 4)	/cure/definition/relation to other definitions
(14 3 4 1)	/cure/definition/relation to other definitions/of causes
(14 3 4 2)	/cure/definition/relation to other definitions/of normality
(14 3 4 3)	/cure/definition/relation to other definitions/mental illness
(14 3 5)	/cure/definition/conflict resolution
(14 3 6)	/cure/definition/restructuring
(14 3 7)	/cure/definition/reduce suffering
(14 3 8)	/cure/definition/live with others
(14 3 9)	/cure/definition/stability
(14 3 10)	/cure/definition/change
(14 3 11)	/cure/definition/defined by patient
(14 3 12)	/cure/definition/acceptance
(14 4)	/cure/use of term
(14 4 1)	/cure/use of term/medical
(14 4 2)	/cure/use of term/impact on patient
(14 4 3)	/cure/use of term/professionals
(14 5)	/cure/of interest
(14 5 1)	/cure/of interest/joking
(14 5 3)	/cure/of interest/not the aim
(14 6)	/cure/depends on illness

(99) Strings (text searches for specific words)

(99 1)	/strings/therapies
(99 1 1)	/strings/therapies/psychoanalysis
(99 1 1 1)	/strings/therapies/psychoanalysis/freud
(99 1 1 2)	/strings/therapies/psychoanalysis/psychoanalysis
(99 1 1 3)	/strings/therapies/psychoanalysis/lacan
(99 1 2)	/strings/therapies/medication
(99 1 2 1)	/strings/therapies/medication/medicament
(99 1 2 2)	/strings/therapies/medication/chimeotherapie
(99 1 3)	/strings/therapies/cognitive
(99 1 3 1)	/strings/therapies/cognitive/cognitif
(99 1 3 2)	/strings/therapies/cognitive/comportment
(99 2)	/strings/illnesses
(99 2 1)	/strings/illnesses/depression
(99 2 2)	/strings/illnesses/schizophrenia
(99 2 3)	/strings/illnesses/mania
(99 2 4)	/strings/illnesses/phobia
(99 2 5)	/strings/illnesses/anxiety
(99 2 6)	/strings/illnesses/obsession
(99 2 7)	/strings/illnesses/psychosis
(99 2 8)	/strings/illnesses/neurosis

(99 4)	/strings/coping
(99 4 1)	/strings/coping/french
(99 4 2)	/strings/coping/british
(99 5)	/strings/vulnerability
(99 6)	/strings/listening
(99 6 1)	/strings/listening/french
(99 6 2)	/strings/listening/british
(99 7)	/strings/stability
(99 8)	/strings/relationship

(101) Not coded

APPENDIX 7

CLUSTER ANALYTIC TECHNIQUES

The multivariate quantitative analyses employed in this thesis are based on the recommendations of two commonly used texts on multivariate analysis (Everitt & Dunn 1991, and Manly 1986) and were conducted using SPSS. The technique of hierarchical cluster analysis was chosen as an appropriate way to identify relatively homogenous and distinct groups of variables (Chapter 6) or cases (Chapter 8) on the basis of variations on multiple quantitative measures. The analyses reported in these two chapters are based on the same quantitative data set derived from codes developed in QSR-NUDIST. Binary variables corresponding to the presence or absence of a code in each respondents' interview transcript were created for twenty three variables relating to four key aspects of professional representations:- conceptual understandings of mental ill health; causal models; perceived goals of mental health work; and practical treatment strategies. The table below lists these variables and the names used in the cluster analytic techniques which follow.

There are a number of different techniques for conducting cluster analysis, and as there is no one generally accepted 'best method' (Manly, 1986), a common strategy is to employ several methods to ensure that results are not an artefact of the specific algorithms employed. Accordingly, the analyses reported below were repeated using three of the most commonly used techniques (within-group linkage method, between-groups linkage method, and Ward's methods) calculated using Euclidean distance measures (recommended by Manly, 1986).

Names and definitions of twenty-three key variables used in cluster analyses

THEMATIC AREA	VARIABLE NAME	DEFINITION
Conceptual Understandings of mental illness		Mental illness as:
	DIFFQUAL	- Qualitative difference
	DIFFQANT	- Quantitative difference
	DISRUPTN	- Disruption
	DISTRESS	- Distress
Causal Models of mental illness	BIOLOGY	- Biological / genetic
	CHILDRS	- Childhood experiences or early relationships
	STRESS	- Stress
	SOCIAL	- Social Causes
	FRAGILE	- 'Fragility'
Perceived goals of mental health work	ASSESS	- Assessment
	UNDPROF	- Understanding by the professional
	SUPPORT	- Provision of support
	REDDISTR	- Reduction of distress
	LIVEWITH	- Helping clients to live with mental health problems
	LIFEQUAL	- Improving quality of life
	CHANGE	- Bringing about change
	UNDPATNT	- Helping person to understand their problems
Treatment Strategies	MEDICATE	- Medication
	RELATE	- Developing relationships
	GROUPS	- Group work
	PSYCHOTH	- Psychotherapies
	COUNSEL	- Counselling
	COGBEHAV	- Cognitive-behavioural therapy

Cluster Analysis on Variables (Chapter 6)

This analysis is based on co-occurrences of variables within the whole interview transcript for each respondent, and as such, is a somewhat crude analysis which cannot pick up how variable are positioned in relation to each other within each interview narrative. However, as I have argued in Chapter 4, through its ability to systematically investigate a large data corpus, quantitative analysis such as this can provide useful indications of patterns and inter-relationships to supplement qualitative analysis.

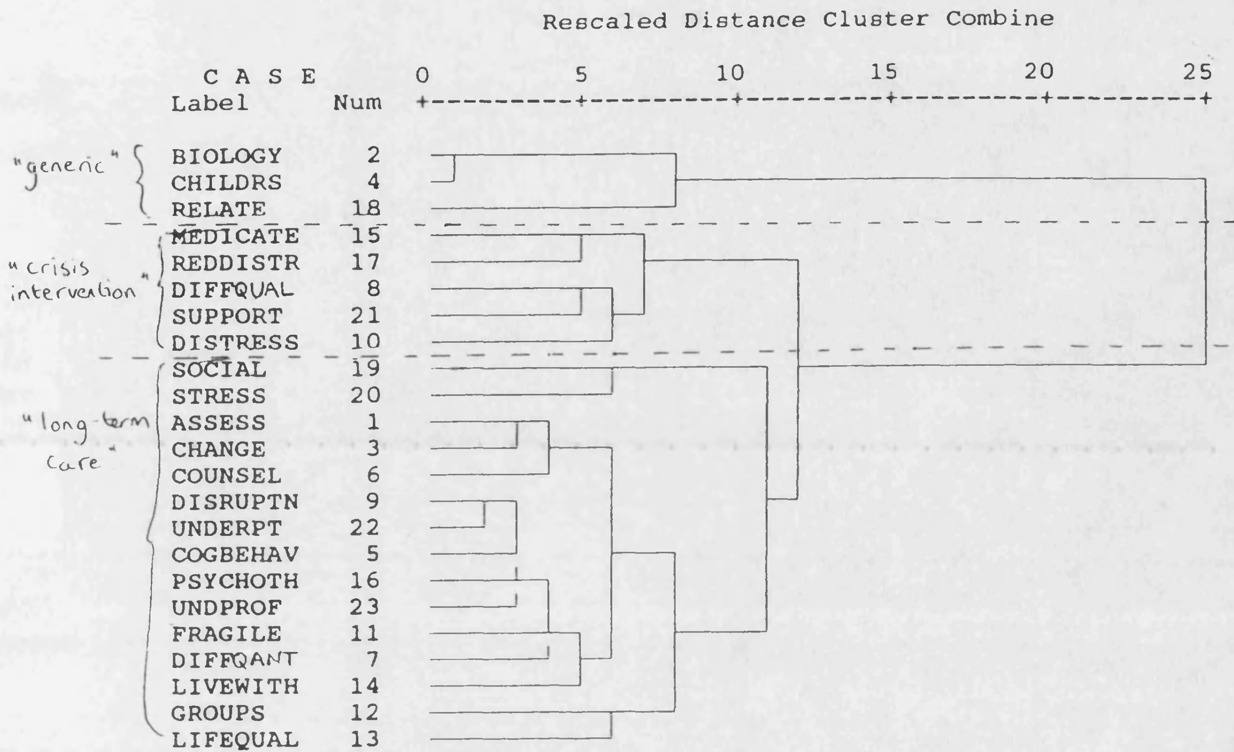
Dendograms produced by clustering the twenty three variables using three different methods (Ward's method, between group linkage method, and within group linkage method) are presented below (these are taken from SPSS output). In these graphical representations of the cluster analysis process, the larger the rescaled distance (right hand side of the horizontal axis) the more distinct is any given cluster. Conversely, linear links between variables or groups of variables which occur close to the left-hand side of these diagrams indicate similarities between variables. Cluster analysis works by successively dividing the set of variables into two groups, then three groups and so on until no more divisions can be made. The first (and most distinct) divisions are indicated in dendograms by separations on the right hand side of the diagrams (corresponding to the highest distance scores).

For all three analytic methods, three relatively consistent clusters of variables are produced. The most robust and distinct cluster (in term of the fact that its components do not vary between methods and it emerges as distinct from other variables relatively 'early' in the analytic process) is a cluster consisting of the use of professional client relationships as a treatment strategy (RELATE) and causal models of mental illness combining the impact of childhood experiences (CHILDRS) and biological or genetic factors (BIOLOGY). For all three techniques, this cluster is the first to separate from the rest of the other variables. Qualitative analysis and various quantitative indicators including the relatively frequent co-occurrence of these variables across all interviews, and the statistical significance of correlations with the other two models of care (see below, and footnote 9 of Chapter 6), suggest that this cluster can be interpreted as a 'generic' model of professional practice.

The other two clusters which emerge later in the analytic process are most clearly represented in the dendogram produced using Ward's method. The 'long-term care' cluster consists of 15 variables including the use of various 'talking therapies' (PSYCHOTH, COUNSEL, COGBEHAV) and practical aims associated with living with the enduring existence of mental health problems (LIVEWITH, LIFEQUAL, UNDPATNT for example). Conceptualisations of mental illness as disruption and as an exaggeration of 'normal' experiences are also included in this cluster (DISRUPTN, DIFFQANT). The majority of these variables (13) are present as a stable 'core' within

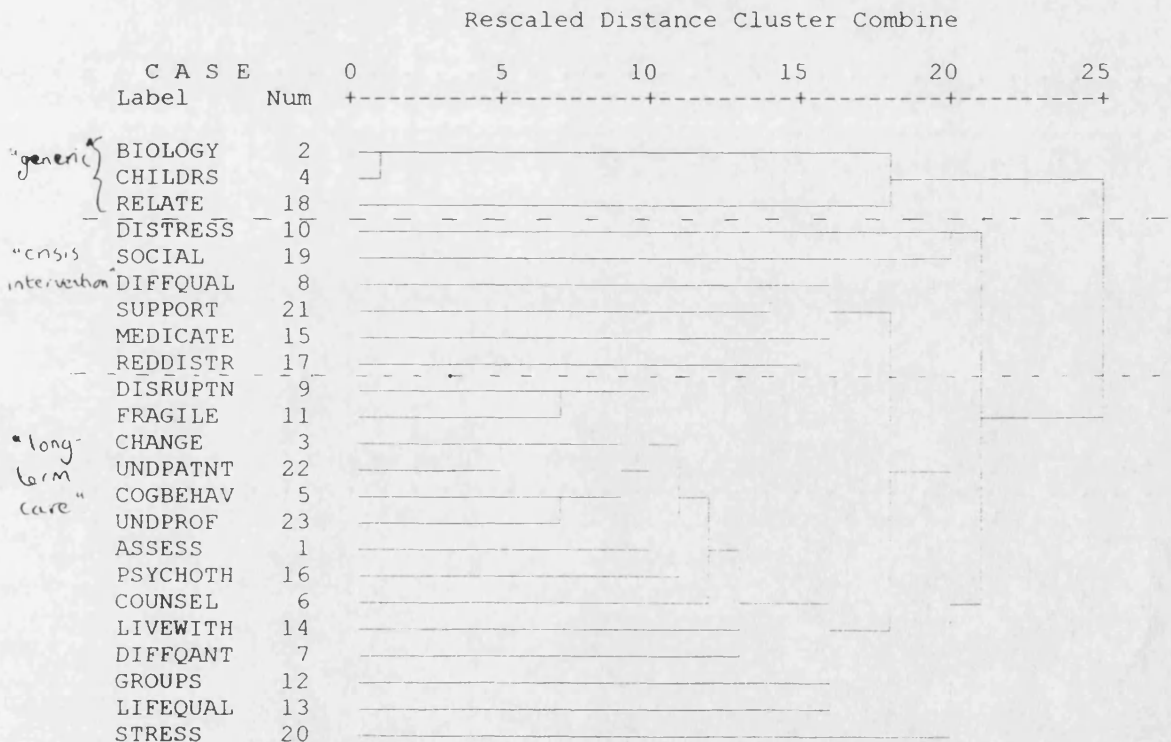
* * * * * * H I E R A R C H I C A L   C L U S T E R   A N A L Y S I S *

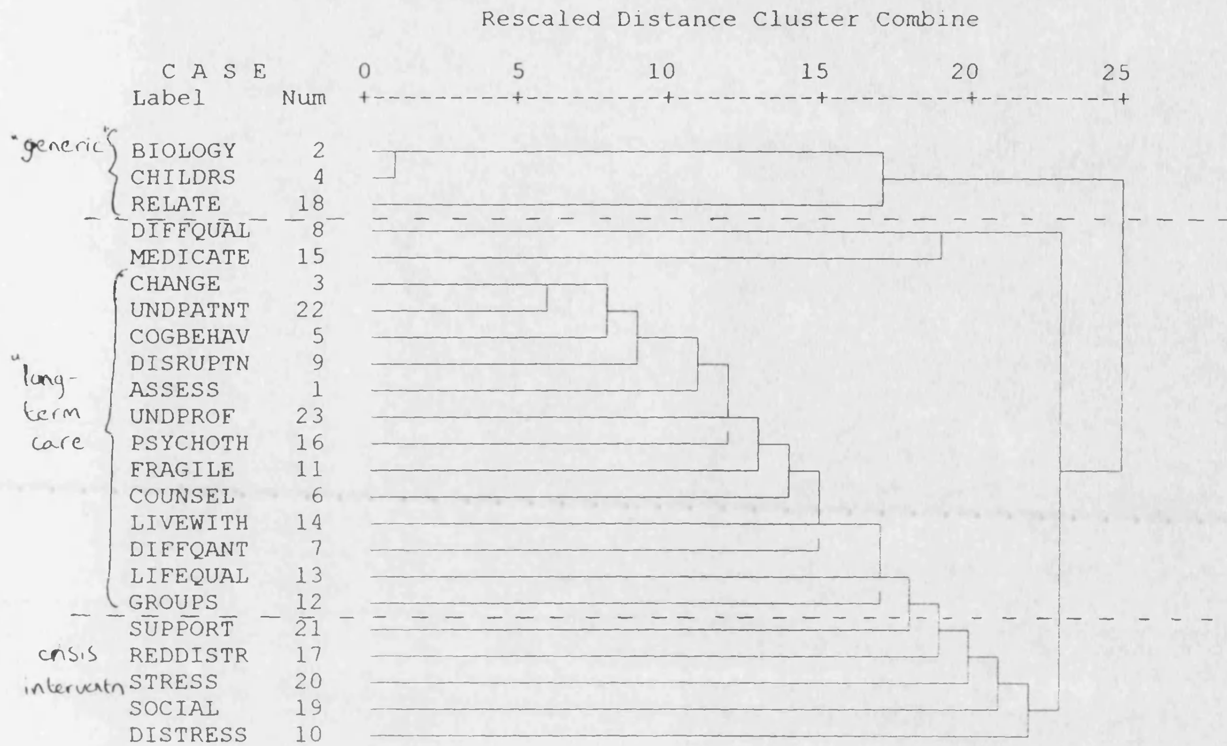
Dendrogram using Ward Method



* * * * * * H I E R A R C H I C A L   C L U S T E R   A N A L Y S I S * *

Dendrogram using Average Linkage (Between Groups)





The third cluster is made up of five variables which appear to relate to 'crisis intervention' strategies. The use of medication (MEDICATE), the reduction of distress and provision of support (REDDISTR, SUPPORT), and a model of mental illness as distress and qualitative difference (DISTRESS, DIFFQUAL) are included in this cluster.

Following this identification of three clusters of variables and their interpretation as three models of professional practice, further analysis focused on answering two specific questions:

i) How are the three models of professional practice related

In order to answer this question, at least in part, using quantitative analyses, new variables were created for each model of practice by summing the variables contained within each cluster. As this analysis is based on binary data representing the presence or absence of a variable in a given interview transcript, it would then be possible for individuals to score between 0 and 15 on 'long term care' (which consists of 15 variables), between 0 and 5 for 'crisis intervention' and so on. Spearmans rank

within each cluster. As this analysis is based on binary data representing the presence or absence of a variable in a given interview transcript, it would then be possible for individuals to score between 0 and 15 on 'long term care' (which consists of 15 variables), between 0 and 5 for 'crisis intervention' and so on. Spearmans rank correlations were then calculated for pairs of variables using these new scores for all 60 interview respondents. The results of this were statistically significant correlations between the 'generic' model and the two other models ($p<0.05$), but not between 'long-term care' and 'crisis intervention' models. This adds further support to the suggestion that the first cluster represents a 'generic' model of care which underpins both other working strategies.

ii) Are models of practice associated with professional status, nationality or location of work?

In order to answer this question, the derived scores described in i) for each of the three models of practice were ranked for all 60 respondents. 'Low scoring' and 'high scoring' groups of respondents for each model were identified as the lowest and highest quartiles of the distribution (in other words, the top and bottom 25% of the sample of 60 respondents, corresponding to 15 respondents in each group). The make-up of each of these high and low scoring groups was then investigated. If models of practice were associated with specific professional disciplines, locations of work or nationality, one would expect these high and low scoring groups to differ from each other in their make-up and / or to be made up of particular groups of respondents. Essentially, the results of these investigations did not reveal any significant patterns or associations between derived quantitative scores relating to models of care and 'demographic' variations within the interview sample (nationality, professional discipline and location of work).

Cluster Analysis on Cases (Chapter 8)

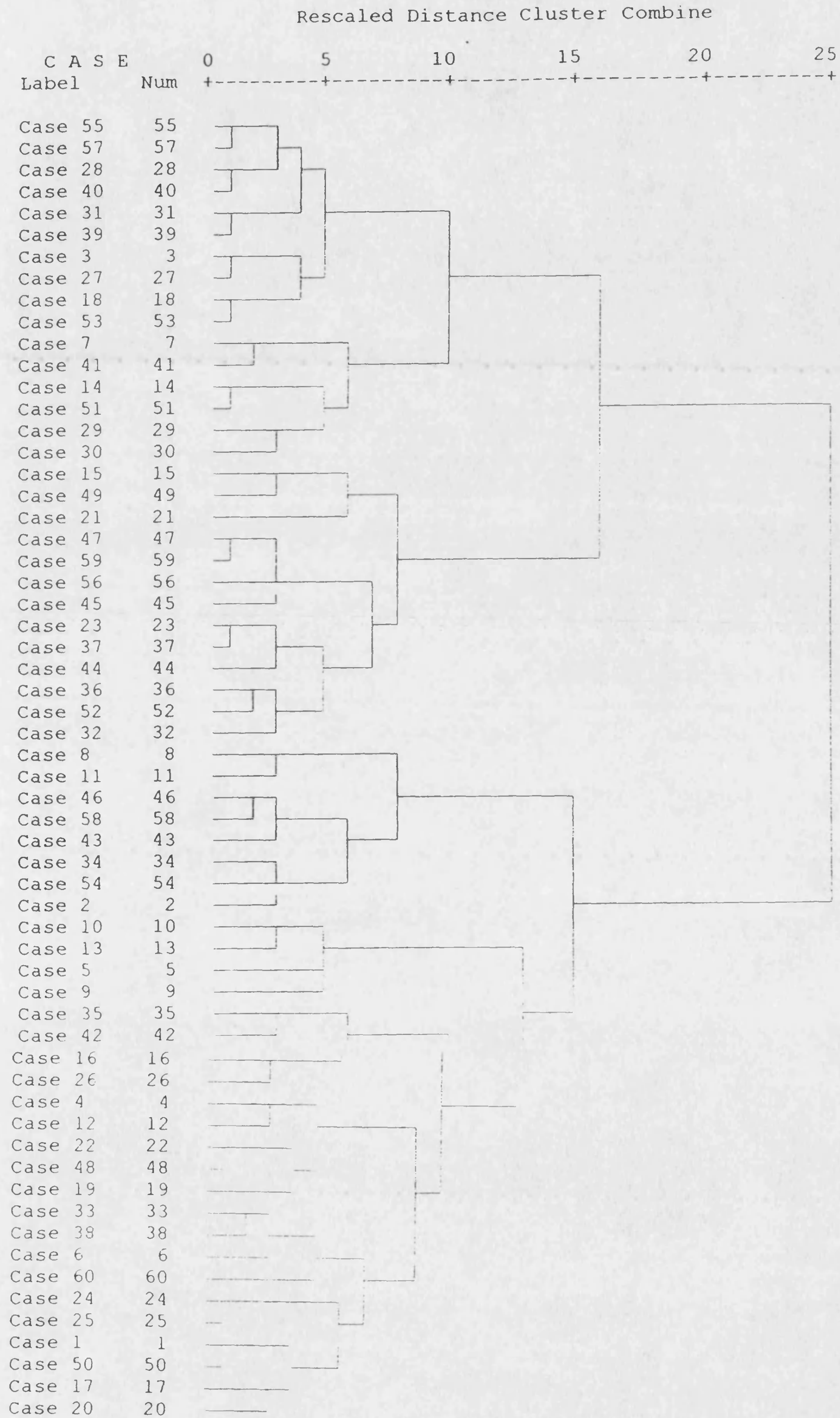
Cluster analysis on cases was done using the twenty three key variables listed and defined in the table above. As with the analysis above clustering by variables, three different analytic methods of clustering (Ward's method, between group linkage and within group linkage) were conducted and compared. The dendograms which represent

the results of these are presented below (see above for an explanation of how these diagrams should be interpreted). Cases 1 to 30 refer to British respondents, and 31 to 60 are French respondents (corresponding to the labels of F1 to F30 in the rest of the thesis). Details of professional disciplines and locations of work can be found in Appendix 4.

Essentially, as these dendograms show, no consistent clusters of cases emerge from these analyses. The solutions generated by each analytic method are so different as to suggest that these are simply an artefact of each method rather than the detection of any 'real' groupings within the sample of respondent. As Everitt & Dunn (1991, p123) note, 'clustering techniques will generate a set of clusters even when applied to random, un-clustered data'. No meaningful and reliable way of clustering interview respondents emerges from this quantitative analysis.

* * * * * * H I E R A R C H I C A L   C L U S T E R   A N A L Y S I S * * * * *

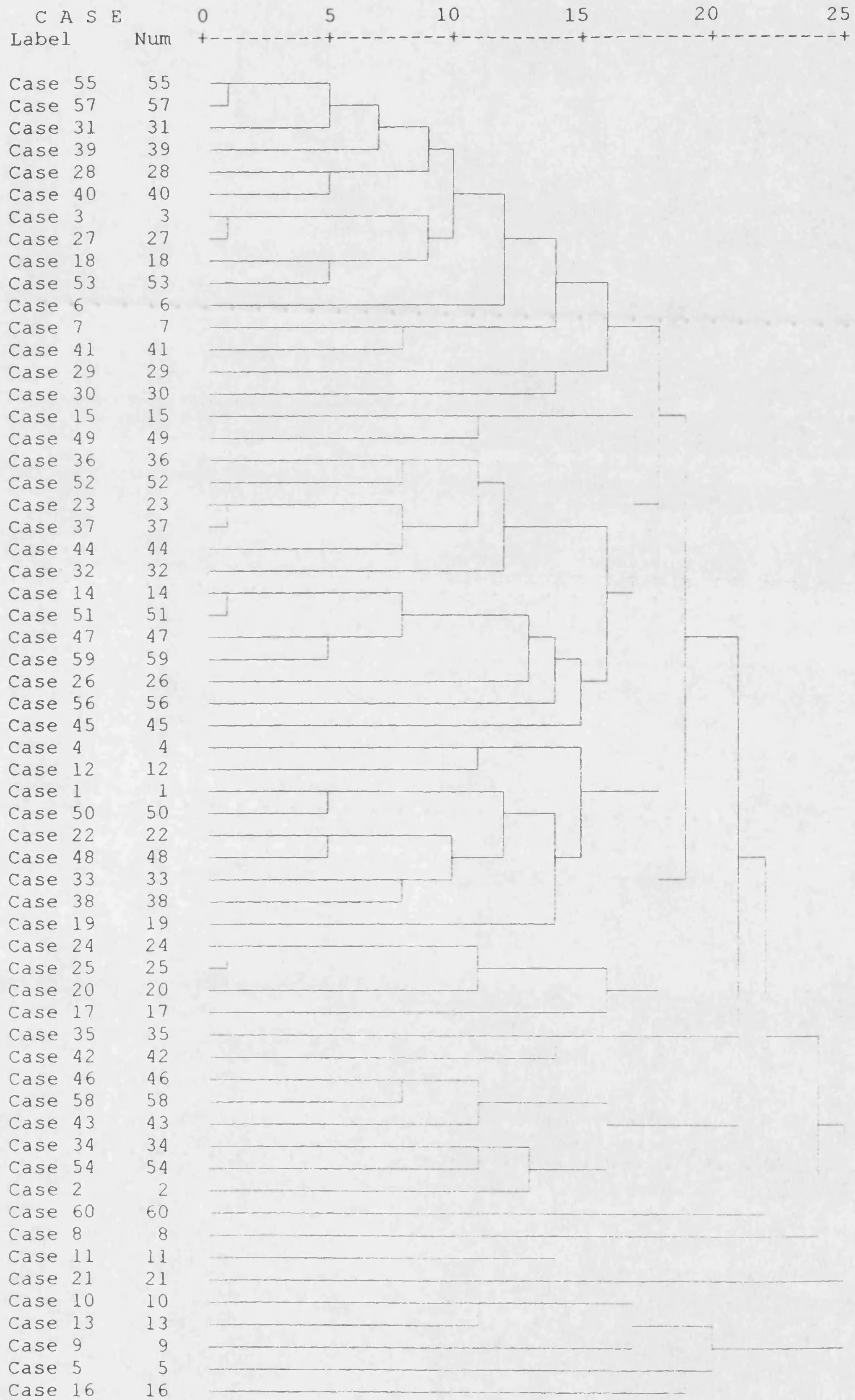
Dendrogram using Ward Method



* * * * * * H I E R A R C H I C A L   C L U S T E R   A N A L Y S I S * * * * *

Dendrogram using Average Linkage (Between Groups)

Rescaled Distance Cluster Combine



* * * * * * H I E R A R C H I C A L   C L U S T E R   A N A L Y S I S * * * * * *

Dendrogram using Average Linkage (Within Group)