ACUTE INSTITUTIONAL MENTAL HEALTH CARE - A CONTESTED FIELD OF SELF AND OTHER POSITIONS

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Abstract

Mental health nursing is polarised between two competing models of care - the social care model, with its emphasis on client autonomy, empowerment and subjectivity and the medical model, with its emphasis on power and control over the patients it treats. Neither model is compatible with the other. However, despite the tensions that exist between these two competing positions (discursive ideologies), mental health nurses working in acute institutional mental health care are expected to effect a significant therapeutic change in their client's mental state by adopting a person-centred approach in their counselling/psychotherapy (therapeutic talk). The extent to which they can *bring this off,* though, in a hospital practice steeped in the traditions of a logocentric, medico-legal discourse, is unknown.

In the narrative discourse analysis to follow (chapters five to ten, this volume) mental health nurses and their patients/clients were asked to give an explanation and/or account of their meaning/understanding of mental illness (diagnosis/ insanity ascription), the system/culture of care in which they are aligned, and their relationship with one another, and they did so in such a way to cast considerable doubt on the possibility of their ever being aligned in person-centred therapy as the social care model would intend. Paradoxically, though, whilst nurses and their patients/clients could not agree an understanding of each other's position in the wider context of their daily interaction, they could in their therapeutic talk - talk which always agreed the client's subjectivity - their version of events.

Declaration

No portion of the work referred to in the thesis has been submitted in support of an application for another degree or qualification of this or any other university or institute of learning.

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In addition, I am conscious that without the support and considerable patience of the mental health nurses and mental health patients/clients on Wards X and Y, this work could never have been contemplated or completed. Most importantly I am indebted to the nurse therapists and their clients who allowed a relative stranger to intrude so obviously into their therapeutic talks. The risk they took with themselves and with each other was considerable and very deeply appreciated.

Dedication

This thesis is dedicated to my wife Ann, without whom it would never have been completed. She has been patient, concerned, loyal and long suffering in her support of this rewarding, but often daunting and wearying activity and I am more grateful to her than I can ever say.

Biography

I am a graduate of the University of Manchester and hold a BSc. (Hons) Psychology and an MSc. in Applied Psychology. When this work began I was employed as a senior lecturer in a department of nursing studies and taught abnormal psychology and mental health nursing. I am currently employed as an Education Officer, Mental Health Nursing, with the English National Board for Nursing, Midwifery and Health Visiting. This is a non-executive department of government which monitors the quality and standard of nurse education in all Higher Education Institutes (HEIs) in England.

Chapter 1: Towards a Context of Mutual Understanding

(1.1)'... whereas the physician produces change by means of drugs, the sophist does it by discourse' (Plato's Theaetetus 167a/Cornford, 1996: p.873).

Introduction

This chapter, and by extension chapter two to follow, provides the context for the reader's understanding of the discourse analysis contained in chapters five, six, seven eight and nine of this volume and reflects a concern that the signs interpreted by the researcher stand in some relation to the reader's own understanding. In this sense, this work is grounded in the belief that, 'pragmatics is the study of the relations between language and context that are basic to an account of language and understanding' (Levinson, 1991: p.21) - that, in effect, 'understanding an utterance involves the making of inferences that will connect what is said to what is mutually assumed or what has been said before' (ibid).

The Social Care Model of Mental Health and Mental Illness

In the early 1970s the *social-care* model[1] of mental health and mental disorder became increasingly influential with mental health workers. In sharp contrast to the orthodoxy of medical psychiatry, with its emphasis on diagnosis and physical treatments (particularly

[1]The term social care model is synonymous with 'community care', but used here emphasises a discursive ideology, rather than the *in situ* treatment the latter intended. Community care, though muted as early as 1931 (cf, the *Seventeenth Annual Report* of the Board of Control: 1931b), did not become a reality until the late 1980s (Prior, 1993: pp.43-46).

drug treatments), the social care model abandoned mental illness labels of the type described by the *International Statistical Classification of Disease* (cf. ICD-10, 1992) and/or the *Diagnostic and Statistical Manual of Mental Disorders* (cf. DSM-IV, 1994) and offered, instead, a description of the *clients*[2] problem state, in terms of their personal, family, social and/or lifestyle needs and treatment based on forms of therapeutic conversation (counselling/psychotherapy[3]) and/or social support.

The social care model though rooted, in part, in the mistrust and scepticism of the anti-psychiatry movement of the 1960s and 1970s (cf. Cooper 1968; Foucault 1961; Laing, 1967, 1990; Laing & Esterson 1970; Szasz 1961; 1973; and Goffman 1961/1986, 1990)[4], also reflected the trend towards Humanistic psychology that emerged at this time (cf. Rogers, 1951 & 1957; Maslow, 1967 & 1970) and a shift in Government policy of the same period (HMSO, 1970; HMSO, 1975), which did much to demedicalise the care of the mentally disordered person - albeit, for motives more pecuniary than truly moral.

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[2]Note, that social care theorists use the term *client,* rather than the more familiar medical referent, *patient,* to describe persons 'who employ another as [their] agent'. A convention which signals their want to achieve a radical redistribution of power and a belief that those individuals who engage with mental health services should not have to 'bear [their] trials without murmuring' (The Modern University Dictionary, 1955).

[3]The terms counselling and psychotherapy are not differentiated here, but assume a commonality of purpose in keeping with definitions framed by Nelson-Jones (1991); Patterson (1974); and Truax & Carkhuff (1967).

[4]The term antipsychiatry, though, rightly describing the existentialist psychiatry movement of the 1960s and 1970s, is used here as a term of art to describe the libertarian resistance of many intellectuals and mental health workers to the dominance of medical psychiatry. In this sense it captures some of the work of Foucault, Goffman and Szasz, none of whom , it must be said, were directly associated with R.D Laing or David Cooper at this time.

Not surprisingly, the social care theorists argued against the prevailing system/culture[5] of *institutional* care, with its emphasis on social control and *logocentric*[6] medical discourse(s), and advocated, in its place, a conception of hospital life based on Main's (1946) idea of, *'The hospital as a therapeutic community'* - a community, in which the client(s) enjoyed the same rights and/or privileges as those who cared for them - not least of which, was the right to speak and be heard.

> 'The anarchical rights of the doctor in the traditional hospital society have to be exchanged for the more sincere role of member of a real community, responsible not only to himself and his superiors, but to the community as a whole, privileged and restricted only insofar as the community allows or demands. He no longer owns "his" patients. They are given up to the community which is to treat them, and which owns them and him. Patients are no longer his captive children, obedient in nursery-like activities, but have sincere adult roles to play, and are free to reach for responsibilities and opinions concerning the community of which they are a part' (Main, 1947: p.67).

This argument was developed by a number of researchers (Alaszewski, 1986; Strauss, Schatzman & Bucher, 1981; Wing & Brown, 1970), who observed that institutional mental health services were not of themselves bad places for patients to be, indeed, patients were able to construct a meaningful social world for themselves in such places (Alaszewski, 1986), but that their wellbeing depended primarily upon the discursive ideologies of the professionals who *cared* for them - which were often thought to be in conflict with their own.

At the heart of the social care model was a concern for client autonomy, empowerment

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[5]System/culture refers here to the 'reproduced relations between actors or collectives organised as regular social practices' (Giddens, 1991: p.25).

[6]Logocentrism refers to 'authority grounded in access to knowledge of reality' (Fox, 1993: p.11).

and the essential legitimacy of their version of reality - their *subjectivity* (cf. Nelson-Jones 1991: pp.16-37; Raskin & Rogers 1989: pp.155-194)[7]. All of which is achieved (or so it is thought) through the creation of a *therapeutic relationship,* which is, itself, the defining condition of the *'person-centred'*[8] therapy they propose (cf. Corsini & Wedding, 1989; Dryden, 1992; Egan, 1990 & 1994; Fiedler, 1950a & 1950b; Nelson-Jones, 1991 & 1993 and Rogers 1951; 1957; 1975; 1967).

The principles underpinning the formation of a therapeutic relationship have been variously described, but invariably draw upon work done by Fiedler (1950b) who claimed that *empathy*[9] was its very core (cf. Nelson-Jones, 1991: ch. 11; Rogers, 1957: p.96). In an attempt to understand what *it* was that experts from three schools of psychotherapy brought to their therapy sessions, Fiedler (1950b) concluded:

> 'it is empathic rather than intellectual understanding of the patient which the experts bring to bear on the patient's problems ... the expert therapist constantly remains sensitive to the patient's feelings' (Fiedler, 1950b: p.443)

Not surprisingly, definitions of empathy have undergone a number of minor changes

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[7]Autonomy argues a freedom from stigmatising labels which undermine personal and social identity; empowerment, argues a freedom from coercion and social control; and subjectivity argues a freedom to assert a self conscious understanding of who you are, or who you claim to be.

[8]Person-centred therapy is synonymous with the social care model and is generally acknowledged to dominate all other forms of counselling/psychotherapy in the UK at this time. Harris (1994: p.7), for instance, claims that 81% of counsellors favour 'confessional' [or person-centred] models of counselling, rather than any other approach.

[9]Empathy derives from the Greek word *pathos* meaning passion/feeling which, when combined with the transitive or causal term *'em'* gives rise to the Greek *empatheia,* which simply means to be *in* or *with* passion/feeling for another. Modern definitions variously describe empathy as 'understanding so intimate that the feelings, thoughts and motives of one are readily comprehended by another' (Readers Digest, *Great Illustrated Dictionary* 1984) or, more intriguingly, 'that emotional effect of imagination which impels a person to assume the identity of another and experience the latter's reaction in some given circumstance' (The Modern University Dictionary, 1955). This second definition clearly resonates with Rogers' (1975) interpretation of the word.

since Fiedler (cf. Gedlin, 1962; Rogers 1957; Truax, 1967), but they invariably describe it as a '*way of being with another person*' (Rogers, 1975: p.2) - a way of being, which emphasises the reflexive self *understanding* of the client in counselling/psychotherapy, rather than any normative precept that might otherwise apply[10]. Rogers (1975) expands this definition to claim that being empathic means:

> '... entering the private perceptual world of the other and becoming thoroughly at home in it. It involves being sensitive, moment to moment, to the changing felt meanings which flow in this other person, to the fear or rage or tenderness or confusion or whatever, that he/she is experiencing. It means temporarily living in his/her life, moving about in it delicately without making judgements, sensing meanings of which he/she is scarcely aware, but not trying to uncover feelings of which the person is totally unaware, since this would be threatening. It includes communicating your sensing of his/her world as you look with fresh and unfrightened eyes at elements of which the individual is fearful. It means frequently checking with him/her as to the accuracy of your sensing, and being guided by the responses you receive. You are a confident companion to the person in his/her inner world. By pointing to the possible meanings in the flow of

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[10]The therapeutic relationship that Rogers describes shares the same idealism as Cixous & Clément's (1986: pp. 78-91) notion the *'Gift'* relationship - but it does so without the same *political* bite. By a *Gift* relationship Cixous & Clément mean a carer's *freely* given generosity, benevolence, love and commitment to persons in trouble and/or distress and they contrast this with something they call the *Proper* relationship that normally obtains in institutional and/or service settings - a relationship which invariably 'signals an emphasis on [the] self-identity, self-aggrandizement and arrogative dominance' of those who have power and authority over others (Fox, 1993). For instance, the dominance of a logocentric medical discourse which demands the *'Selfsame'* in all things, and whose *tithe* is the absolute compliance of those it treats (cf. Herman, 1991: pp.101-125; Maus, 1954/1967).

By *Selfsame* Cixous and Clément mean the selfsame, enduring, institutional practices that are a feature of Western man and Western society - where the domination of subordinate others is central to its activity. Institutional psychiatry would be an example of the *Selfsame*. 'We are [they say] still living under the Empire of the Selfsame. The same masters dominate history from the beginning, inscribing on it the marks of their appropriating economy: history, as a story of phallocentrism, hasn't moved except to repeat itself' (1986: pp. 78-91).

The terms *Selfsame* and *Proper* (Propre) are one and the same. When speaking of the *Propre* Cixous says: 'I have translated this as Selfsame: ownself. It has overtones of property and appropriation. It also means "proper" ... ' (Cixous & Clément, 1986: p.167). Importantly, the ideas that Cixous and Clément espouse are feminist and not medical and speak of the dominance of men over women. To this end they recruit Hegel's concept of tha *master* and *slave* relationship: 'Self-consciousness exists in and for itself when , and only by the fact that, it so exists for another; that is, it exists only in being acknowledged (Hegel, 1979: p.11). Acknowledged, that is, as dominant wherever it can.

> his/her experiencing you help the person to focus on this useful type of referent, to experience the meanings more fully, and to move forward in the experiencing. To be with another in this way means that for the time being you lay aside the views and values you hold for yourself in order to enter another's world without prejudice. In some sense it means you lay aside your self and this can only be done by a person who is secure enough in himself that he knows he will not get lost in what may turn out to be the strange or bizarre world of the other, and can comfortably return to his own world when he wishes' (Rogers,1975: p.4).

The inherent subjectivity of the empathic relationship is clear and speaks of what Mühlhäusler & Harré (1990: p.12) have called, 'the Cartesian myth of mental theatres and mental entities' - that individuals have a *private* mental life that can be revealed in their communication with others. Communication, which requires the therapist to work-out the meaning(s) intended by his/her client (cf. Grice,1957). Cast in this way, knowing what an *other* might mean is a question of knowing what *we* might mean by the same thing, a reworking, one might suppose, of Husserl's (1991) idea of 'analogical apperception'[11].

In essence, the social-care model telescopes three principled conditions together to form a *discursive* framework for the practice of counselling/psychotherapy: first, it argues that psychiatric diagnosis (which it believes to be specious at best and spurious at worst) should be abandoned in favour of a needs-based approach to persons in trouble and/or distress and one which values their autonomy; second, it advocates a

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[11]There are enduring criticisms of Husserl's notion of analogical apperception (and pairing) (Habermas, 1987a; 1991: Schutz, 1970), notably the solipsism this inevitably conjures - this is clearly evident in his treatment of meaning, which for him, 'is reducible to a constituting act of consciousness... [whereby, individual] ... consciousness bestows meaning on the world' (Crossley,1996: p.8).

In essence, what Husserl ignores (and person-centred therapists/social care theorists) is the intersubjectivity of language and, in doing so, he fails to appreciate that meaning is irreducible to individual consciousness, but rather inheres in a context of social relationships. Husserl's narrow concept of intersubjectivity is essentially non-reflexive - a view which tacitly assumes the subjectivity of others - but not the mechanism by which their subjectivity might be made known to others by their intersubjective communication.

system/culture of care which privileges the rights/voice of *all* individuals, rather than just the medically advantaged (powerful) few; and three, it argues that the 'goodness of therapy is a function of the goodness of the therapeutic relationship' (Fiedler, 1950b: p.443) - which is itself, a function of conditions one and two.

The telescopic metaphor is apposite because it describes in a very practical way the essential interdependence of these conditions - which, when aligned with one another, in a discursive symmetry create the conditions within which the practice of counselling/ psychotherapy can work to *magnify* the clients' potential for reflexive self understanding and how, when that discursive symmetry fails, the self revealing project of counselling/ psychotherapy must also fail.

An important feature of the social care model, and the practice of counselling/ psychotherapy that is its *raison d' être,* is the relative ease with which *its* conversational techniques/practices can be learned by those other than a medically qualified elite - a factor which has undoubtedly contributed to its growth and popularity[12]. For instance, Harris (1994: p.10), estimates that by the year 2000, 'over half a million people in the UK will be involved in counselling' and that 'the number of students passing the [British Association for Counselling (BAC)] diploma in counselling [now] exceeds those studying full time for the Church of England priesthood' (ibid: p.13).

[12]Patton (1984) points to a problem many counsellors may fail to appreciate - the difference between counselling communication/techniques (relatively easily learned) and counselling as a therapy that assists their client to better know and understand themselves. In essence, many counsellors view their role as an attempt to 'keep their client talking' - that therapy is just talking (ibid: p.449), rather than a reciprocity of understanding.

The Social Care Model and Mental Health Nursing

Not surprisingly, the effects of this liberating view of mental *illness* (and the equivocal nature of the conversational therapies it proposes), found strong expression in the field of mental health nursing, not least, because a major review of psychiatric nursing undertaken by the Ministry of Health in 1968 (HMSO, 1968), concluded that there was a need for psychiatric nurses to develop their skills in 'psychotherapy'. Ten years later Harries (1978) reported that many psychiatric nurses had done just that and now defined themselves in terms of the social care model, rather than the medical model that otherwise dominates their work - the mental health nurse as a counsellor/ psychotherapist was born.

The development of a social care approach to mental health nursing was given even greater impetus with the publication of the English National Board for Nursing, Midwifery and Health Visiting's (ENB)[13] revised *Syllabus of Training* for Registered Mental Nurses (1982: p.1) - an avowedly social/interpersonal curriculum, which insists that, 'the intentional and conscious use of self' in relation to others is central to the practice of mental health nursing. Four years later a specialist panel commissioned by the ENB to review its *Syllabus of Training* concluded that the development of 'therapeutic intervention techniques' was essential for all practitioners working in mental health services (ENB 1989b).

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[13]The English National Board for Nursing, Midwifery and Health Visiting (ENB) is a non-executive department of government (cf. Nurses, Midwives and Health Visitors Act, 1997) whose function is to 'ensure that [courses of training enabling persons to qualify for registration as nurses, midwives or health visitors] meet the requirements of the [United Kingdom] Central Council [for Nurses, Midwives and Health Visitors] as to their **kind**, **content** and **standard**' (HMSO, 1997: par.6(b), p.4.) - in this sense, the ENB, defines the role of the mental health nurse through education and training it approves.

In consequence, mental health nurses (in common with many other mental health workers) are expected to effect some significant change in their patients'/clients' mental state and/or behaviour by their positive therapeutic interventions - an expectation that has been underlined in recent times by a Department of Health sponsored report, published by *The Sainsbury Centre for Mental Health* (Duggan,1997), which argues that mental health workers, including mental health nurses, must be capable of 'creating *therapeutic* co-operation ... and alliance[s] with service users' (ibid: p.16, my emphasis). A position that has been endorsed by Barker, *et al* (1997) who argue:

> 'As the century draws to a close it is proposed that [psychiatric] nurses' primary attitude should be one of addressing people as human beings first, and patients with problems second. Through the expression of such an attitude, nurses' relationships with the people in their care may be affected for the better. Developing an effective relationship with people-in-care must be the primary concern for all nurses', but should have a more specific concern in psychiatric nursing. Such a relationship may express the necessary respect for the unique experience of the person 'in' psychosis (for instance) but might also provide the beginnings of *their* search for *the* 'truth' about themselves and their life experiences' (Barker, *et al,* 1997: p.666; my emphasis).

The Medico/Legal Mandate

But, the aspiration of mental health workers/nurses to 'turn-away' from the medical model and work (semi-independently) as counsellors/psychotherapists finds powerful opposition from medical psychiatry - not least because of the hegemony of medical diagnosis (cf. *The Hospital Episode Statistics System: HES.* 1997[14]) and the legislative power (system/culture of care) this both promotes and sustains (cf. Mental Health Act,

[14]The HES system is a Department of Health data base generated for 'each consultant episode; the period of care during which an admitted patient is under the care of a particular medical consultant within a *Hospital Provider*'. SD2HES: Version 2.1: p.1 (April 1997).

1983 & Mental Health (Patients in the Community) Act, 1995)[15].

For instance, the Hospital Episode Statistics (1997) insist that *all* patients admitted to psychiatric hospitals (or treated in the community) are diagnosed using either the ICD-9 or ICD-10 classification. There is no exception to this rule and no 'free-text' description of a patient 'problem-state' is allowed unless it can be interpreted/transposed into an ICD diagnosis by a data-base clerk. Despite any assertion that might be made to the contrary, all patients who engage with medical psychiatry receive a mental *illness* diagnosis/label. In essence, condition *one* of the social care model is cancelled by the demands of the Department of Health.

If this diagnostic mandate were not enough, the powers conferred on medical psychiatry by government policy/legislation (Mental Health Acts 1983 and 1995) are formidable indeed - if not without limit. For instance, in a recent High Court Case (The Bournewood Judgement, 1998) it required the intercession of a High Court judge to order the discharge of an *'informal'* patient[16] illegally *detained* in a mental hospital, against the wishes of his foster parents (Moore, 1998: pp.4-5)[17] - a civil *right* that many patients and their carers would assume without question and one which necessarily compromises condition *two* of the social care model.

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[15]Acts of Parliament passed from 1930 to present day are listed as HMSO. Legislation passed prior to this is date are listed as Public General Statute.

[16]Patients not compulsorily detained in hospital under a relevant section of the Mental Health Act 1983.

[17]This judgment was later overturned by the House of Lords and led Mr Boateng (Junior Minister of Health) to claim that 'this [judgment] clarifies the legal basis for the admission to hospital of patients who do not have the mental capacity to give their consent' (Health Care Parliamentary Monitor (August, 1998: Issue No 217, p.4).

In order to resist and ultimately disabuse the uncompromising authority of medical diagnosis and the power this intends through legislation, the social care theorist's posit an elegantly simple injunction: mental illness as they believe it to be, is a medical *fiction*, not a social *fact*:

> 'I am convinced that psychiatric explanations and interventions are fatally flawed and that, deep in their hearts, most people think so too. The evidence for this abounds. If mental illness is common, can strike anyone, and is just like any other illness, as experts claim, then why do people hardly ever think that they themselves have such an illness? Why are they not more afraid that they will get such an illness? And why, if they themselves are so wonderfully free of mental illness, do they find others so terribly full of it? In all these ways mental illness resembles the Scriptural beam in our own eyes and the mote in our brother's much more closely than it does diabetes or cancer. Mark Twain was right when he observed that "Nothing so needs reforming as other people's habits" '[18] (Szasz, 1997: p.5).

A fiction that argues that mental illness is a *disease* described by a persons deviation from some erstwhile social norm. A fiction that is only *real* in the minds of those who have a vested interest in the mental illness model - psychiatrists, and those patients who want to be treated *as if sick* (Szasz, 1997: pp. 19-21).

Importantly, Szasz doesn't dispute the existence of *madness*[19] - in the sense that people sometimes do *crazy* and unexplainable things, but he does dispute the difference between the *object* and the *concept* - between the actuality of a thing and its description and/or explanation (cf. Hacking: 1997: pp.14-15). Simply stated, mental illness labels of the type found in ICD-10 (1992) and DSM-IV (1994) are discursive constructs which

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[18]Twain, M. *Pudd'nhead Wilson*, p.113.

[19]The term 'madness' is not intended to be offensive, but is used as an inclusive shorthand for any behaviour that is thought to be *irrational*.

allow a certain way of speaking and are only truths of a sort (cf. Potter & Wetherell, 1987) - they are, by their very nature, contestable truths. Madness as *illness* is a contestable truth and one that the social care theorists are wont to exploit.

But, the discursive construction of madness as *illness* is both a prop and a pall for the social care theorists. It is a prop because medical diagnosis is so open ended and arbitrary in its definition of deviance that it can be undermined by virtually anyone with a mind to do so, and it is a pall because its over extended pathology (cf. ICD-10, 1992 & DSM-IV, 1994)[20] masks a depth of human misery not always explainable or treatable in terms the social care model would suppose. It is, however, a dilemma the social care theorists choose to ignore and society appears to disregard in favour of a medico-legal complex grounded in sympathy, but always obsessive in its need to control those in its charge.

And here-in lies the paradox for mental health nurses who, one at the same time, are encouraged to develop their skills as counsellors/psychotherapists - with all that this entails in terms of the *relationship* they must develop with their patients/clients, whilst working in institutional settings which link the discursive construction of madness with power and control - 'Empires [as it were] of the Selfsame' and 'Proper' relationships (Cixous & Clément's, 1986; cf. Foucault 1991; 1972/1994).

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[20]Peter Sedgwick (1972: p.220) is illuminating in his description of medical psychiatries expansionism, concluding, that 'the future belongs to illness.'

The Discursive Construction Of Madness - Diagnosis/Insanity Ascription

Southgate, (1995: p.220) argues that 'within the social sciences the grounds upon which [madness] ascriptions are made are often regarded as isomorphic with, and predicated upon, or synonymous with the *disruption* of the *predictability* of everyday life.' Implicit in Southgate's notion of predictability of everyday life is Habermas's (1979: p.28) concept of 'comprehensibility' of talk, and Ingleby's (1982: pp.138-139) conception of conduct that is both 'intelligible' and 'moral'.

By comprehensibility Habermas means that speech acts are redeemed not only by reference to the claim that the conditions for their validity are satisfied, but also by the warrant the speaker holds to say the things he/she does:

> 'a speaker can rationally motivate a hearer to accept his speech act offer ... [when] he can assume the warranty for providing, if necessary, convincing reasons that would stand up to a hearer's criticism of the validity claim (Habermas, 1991: p.302).

Habermas's start point is the recognition that speech acts have a double reflexive structure which combine the content of the communication with the 'relational aspect in which [it] is to be understood' (Habermas, 1979: 43) - and, importantly, it is this second level of validity - the warrant the speaker holds/speaks from in relation to the content of his/her utterance that is fundamental to insanity ascription:

> 'Thus the speaker owes the binding (or bonding: bindende) force of his illocutionary act not to the validity of what is said but to the coordinating effect of the warranty that he offers: namely to redeem , if necessary, the validity claim raised with his speech' (Habermas, 1991: p.302).

Similarly, Ingleby (1982) insists that conduct is not only judged by reference to its rationality or reasonableness (its intelligibility) but also by reference to the power and status of those making the judgment, their moral base - '... less status means that less validity is credited to the agent's point of view' (ibid: p.139).

In both Habermas's and Ingleby's accounts there is a clear and explicit recognition that normative standards of behaviour and social reality are not predicated upon some monothetic ideal, but rather, are constituted in discourses in which 'the social meaning of what has been said will be shown to depend upon the *positioning* of interlocutors which is itself a product of the social force a conversation action is taken to have' (Davies and Harré, 1990: p.45; my emphasis).

Viewed from this perspective madness (however it might be defined) emerges not as stable or fixed entity, but rather, as a category of *being* (social identity) that is constructed discursively out of whatever is, or purports to be, the prevailing concepts of normative personhood; the ontological status of reality and the reality status of universals and particulars.

> 'The 'truths' which create the modern form of sociality are fictions and therefore themselves invented in fantasy. The 'real' therefore becomes a problematic category ... That is, both scientific and cultural practices produce regimes of meaning, truth, representation in which there are particular relations of signification. What is important about these is the production of a sign - is how we enter as a 'relation' and how in actual social and cultural forms we become 'positioned' ' (Walkerdine, 1990: p.202).

Simply stated, definitions of madness as *illness* (or otherwise) are a point-of-view: *positions* taken up in discourse about people and their behaviour. Importantly, they are

discursive constructions which not only describe the person under description, but also the person(s) making that description (see chapter five, this volume).

Taken to its limits any form of human folly can be construed as mental illness - if a society[21] wishes it to be so. In this sense, psychiatry has become expert in the definition of normality and the social control of deviance (Scull 1993: pp. 381-388) - or as Giddens (1991) might reasonably describe it, the legitimacy of one social *position* in relation to an other:

> 'Social positions are constituted structurally as specific intersections of signification, domination and legitimation which relates to the typification of agents. A social position involves the specification of a definite 'identity' within a network of social relations, that identity, however, being a 'category' to which a particular range of normative sanctions is relevant' (Giddens,1991: p.83).

Giddens (1991), in common with Southgate, Ingleby and Habermas describes deviance in terms of a discursive formulation of rules and codified practices: the acceptable and/or allowable behaviours of persons within a framework of law and society - wherein, the paradigm case is (at least for Western societies) the concept of mind and society attributable to Plato.

Madness as Illness - Its Origin and its Consequences

It was Plato who famously divided madness into two major categories: madness which

[21]The term society denotes a social system that is described by the properties of *structure* (rules and resources); *systems* (reproduced relations between actors or collectives); and *structuration* (conditions governing the continuity or transmutation of structures and therefore the reproduction of social systems) (Giddens, 1991: p.25).

was natural (that is, certain persons have a physical and/or psychological proclivity to madness, which, though bad, may be *treated* and even *cured*); and madness which was divine. Madness which was divine was prophetic (given by Apollo); religious or enthusiastic (given by Dionysius); poetic (inspired by the Muses); or erotic (infused by Eros or Aphrodite) - (*Phaedrus* 244-245/Hackforth, 1996: pp.491-492). Whilst the former speaks of a deviance of sorts, the latter lays claim to a prescient *understanding* of the *avant garde*.

Importantly, the distinction Plato made between demonic and divine madness was rooted in his concept of mind and society - as it is today. He argued that the mind was formed of three parts: 'the rational (*logistikon*); the spirited-affective (*thumoedes*), and the appetitive (*epithumetikon*)' (Simon, 1978: pp. 163-164; cf. Plato's *Republic*: 580d-580e/Waterfield, 1994: pp.326-327), and that each part of mind gave rise to a predisposing personality type: 'the philosophical, the competitive, and the avaricious.'

Further more, he claimed that these three parts of mind co-existed in a state of mutual antagonism and that this antagonism was most keenly felt between the rational and appetitive (irrational) parts of mind. Inevitably, he argued, one of these parts came to dominate the other and it did so by harnessing the energy (*Eros*) of the spirited-affective part of mind to its cause (Plato's *Republic*: 581c/Waterfield, 1994: p 327; cf. Trosman 1976 for an insight into *Freud's Cultural Background* and the development of his own architecture of mind). A view which is entirely consistent with modern day perceptions of the inter-relation of thought and emotion in consciousness:

> 'If you can't feel, you can't think. It is currently fashionable to view activities such as thinking, reasoning, learning and memory as processes completely distinct from pleasure and anger. But emotions are consistently at the core of our conscious state from the moment we are born. Our conscious state could be viewed as a combination of emotional "tone" and logical processes, endlessly varying in the *dominance* of their respective contributions, rather than being mutually exclusive' (Greenfield, 1998: p.23; my emphasis).

Significantly, these two potentially dominant parts of mind have their own way of knowing the world - the rational part of mind is capable of knowing 'the truth of things' (Plato's *Republic*: 581b/Waterfield, 1994: p.327); the 'form' or 'idea' of things; 'justice' (morality); and 'self-knowledge' (Plato's *Phaedrus*: 247cd). In contrast, the appetitive (irrational/demonic) part of mind can only know its own sensual pleasure and the distortions of perception and ideation (*hallucinations* and/or *delusions*) this is want to give rise to (*Republic*: 581d/Waterfield, 1994: p.328).

In formulating his conception of the ideal *Republic,* Plato simply (and quite logically) transposed the structure he had conceived for mind onto the structure he conceived for society:

> '... we've reached the reasonable conclusion that the constituent categories of a community and of any individual's mind are identical in nature and number' (Plato's *Republic*: 441c/Waterfield, 1994: p.152).

At the top of his ideal *Republic* Plato placed his *rational,* philosopher king - a man who was capable of true knowledge, morality and law (or *episteme*); in the middle he placed the *spirited-affective* guardians of the city/state; and at the bottom the *appetitive*, grasping, greedy masses - who in their collective folly are capable only of 'opinion' (doxa). Morality, (or as it turns out, sanity) cast in these terms is simply the avoidance

of opinion, or more properly, *knowing* ones 'place'.

> Socrates: 'So we should impress upon our minds the idea that the same goes for human beings as well. Where each of the constituent parts of an individual does its own job, the individual will be moral and will do his own job ..... Since the rational part is wise and looks out for the whole of the mind, isn't it right for it to rule, and for the passionate part to be its subordinate and its ally?' (Plato's Republic: 441de/Waterfield, 1994: p.153).

Implicit in Plato's conception of madness and society is the notion of control - control by *self* in the first instance, but if this should fail (as it clearly does) then control by others - who in their wisdom (ideology/law), *know* better.

> Socrates: 'But you create health by making the components of a body control and be controlled as nature intended, and you create disease by subverting the natural order. ... Goodness, then, is apparently a state of mental health, bloom and vitality; badness is a state of mental sickness, deformity, and infirmity' (Plato's Republic: 444d/Waterfield: p.157).

By accretion and substitution Plato's concept of the *irrational* becomes a form of mental sickness (whether physical or psychological) - a *badness* which constitutes an ever present danger to ideal *Republic* - society, however it is described. In the *Sophist* (227d-228e) he extends his definition of sickness to include 'cowardice, intemperance, and injustice ... all alike are forms of disease in the psyche'; and in *Timaeus* (86b), to include 'ignorance' - a process of equivocal selection which can be reworked to include all manner of behaviour.

To give Plato a modern update it is possible to conclude that any form of individuality or

subjectivity[22] - deviance by any other name, is a form of madness which renders the person's self identity both 'discreditable' and 'discredited' (Goffman's, 1990) and, as-such, in need of social control.

It is interesting that much of modern psychiatry draws its inspiration from Freud - who in turn, drew his intellectual inspiration from the ancient Greeks. A coupling that Szasz (1997) views as regrettable, if not wholly deplorable. He attributes to Freud the blame for denying the possibility to his patients that they might better understand themselves than anyone else. A view that is entirely consistent with the social care theorist's position.

> 'The reluctance to grant explanatory status to the mental patients self-explanation, is of course, an integral part of the modern deification of science as the only key to (correct) explanation. We have somehow forgotten that granting an account the status of explanation is not the same as agreeing with it as true or valid' Szasz, 1997: p.364).

The Social Control of Madness - The System/Culture of Care

Not surprisingly Plato's 'treatment' of madness (subversion by opinion, vice, discord, cowardice and intemperance) was harsh in the extreme and resonates with the worst excesses of many modern day totalitarian regimes.

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[22] Plato's concept of society cast as the ideal Republic - a superordinate state of knowing, is consistent with Hegel's (1892-6/1968) notion of subjectivity. Speaking of this Habermas (1994: p.40) posits that, 'For a subject that is related to itself in knowing itself encounters itself both as a *universal* subject, which stands over against the world as the totality of possible objects, and at the same time as an *individual* I, which appears in this world as a particular entity' - the two positions are not always reconcilable.

> '... let those who have been made what they are only from want of understanding, and not from malice or an evil nature, be placed by a judge in the Sophronisterion, and ordered to suffer imprisonment during a period of not less than five years. And in the meantime let them have no intercourse with other citizens except with the nocturnal council and with them let them converse with a view to improvement of their souls' health. And when the time of their imprisonment has expired, if any of them be of sound mind let him be restored to sane company, but if not, and if he be condemned a second time, let him be punished with death' (Laws: 908e-909/Taylor, 1996: p.1464).

Arguably, it was Plato's concepts of the ideal *Republic* and the role of the *Sophronisterion* in its governance that motivated (if only in part) the development of asylum in 19th century western Europe and north America. A Republic which conceived that certain forms of madness were capable of 'cure' - but wherein, cure was always a euphemism for obedience, temperance and piety.

Though no direct correspondence is claimed or intended, between Plato's *Sophronisterion* and the modern day mental hospital, it is certainly the case that mental health legislation of the last 200 years has sequestered much of Platonic thinking to argue that a person's perceptions, ideations and affect are, indeed, *'a thing to look at'* and a *thing* to be controlled by those who have the *warrant* to do so (Foucault, 1992: p.70) - the *Panopticon* of social control and oppression was born in this apparently mercenary belief.

> 'But one finds in the programme of the Panopticon a similar concern with individualizing observations, with characterization and classification, with the analytical arrangement of space. The Panopticon is a royal menagerie; the animal is replaced by man, individual distribution by specific grouping and the king by the machinery of furtive power' (Foucault, 1977/1991b: p.203).

Legislation and Exclusion

The modern mental hospital in Britain can be traced to County Asylums Act, 1808 (48 Geo. III c. 96), which described in detail the specifications for the construction and maintenance of county asylums 'for the better Care and Maintenance of Lunatics, being Paupers or Lunatics of England.' A programme of planned building, which was intended to sequester the burgeoning number of *lunatics*[23] in society at this time - a number that (though apparently significant) probably never exceeded more than a thousand people. Jones (1972: p. 357) records that in the nine asylums built by 1827 only 1046 pauper lunatics were contained within.

However, the effect of this Act was considerable and by the end of the nineteenth century 77 county asylums had been built (53 between 1850 & 1900) housing a population of 74,000 *lunatics and insane persons* (Jones, 1972: p.357). This remarkable growth in the number of insane persons was fuelled by a combination of unprecedented population growth; poverty and industrialised urban squalor; well meaning evangelical liberalism and social reform; progressive change in the lunacy laws; and most importantly, the development of a medical psychiatry keen to advance its professional status[24].

By the 1970s the in-patient population recorded in British asylums had risen to a record

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[23]Lunacy had no precise legal definition at this time, but those so named were invariably poor and considered a danger to themselves or others.

[24]The Medical Registration Act (1858) set up a medical register for doctors who had passed prescribed examinations.

170,000+[25]. To *manage* these vast numbers of inmates a *system/culture* of custodial care developed that was kindled by a constant stream of legislation[26] - most notably, the Lunacy Act (1890); the Mental Treatment Act (1930); the Mental Health Act (1959) and the Mental Health Act (1983).

The Lunacy Act (1890) was a monolithic piece of *paternalistic* Victorian legislation that provided for every known contingency of asylum life, including, 'the classification, occupation and recreation of patients, the physical condition and diet of pauper patients, the admission, discharge and visitation of all patients, the performance of Divine Service ... and the use or non-use of mechanical restraint' (Jones 1972: p.179). The effect of this Act was to wholly *disempower* those persons who were certified insane and, though vastly dated, is the legal precedent for all modern day mental health legislation - particularly that which relates to compulsory admission and detention to hospital.

Admission to an asylum after 1890 was by legal certification, a *safeguard* which precluded the admission of anyone other than: 'lunatics [*or* an idiot *or* a person of unsound mind]' (Lunacy Act , 1890: Section 16: p.114) - in essence, lunacy was defined by a Justice of the Peace on the recommendation of a physician. Despite the advances made in the classification of madness before 1890, by such luminary figures as Pinel

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[25]The decline in numbers that followed was extraordinary, by 1990 the figure was *thought* to be less than 60,000 (Scull, 1993: p.388). Thought to be, because Department of Health, Hospital Episode Statistics no longer record 'fixed' population figures, but cite instead the number of admissions per annum to NHS hospitals. In 1995 (the last figure available) the number of 'admissions to NHS hospitals under mental illness specialities by sex and age on admission,' was 214,560.

[26]Jones (1972: p.388) lists 26 principal Acts and amendments between 1774 and 1959 - to which the two most recent must be added - the Mental Health Acts (1983 & 1995).

(1745-1826); Esquirol (1772-1840); Moreau de Tours[27] (1804-1884); Maudsley (1835-1918); Freud 1856-1939); Kraepelin (1856-1926) and Bleuler (1857-1939) - the legal definition of madness was stuck somewhere between the Elizabethan Poor Law (1597/1601) and the Vagrancy Act (1714/1744).

The Dubious Status of the Mentally Ill in Hospital

The Mental Treatment Act (1930) did two important things for modern psychiatry: first, it did away with terms such as, *asylum* and *lunatic* and replaced them with the more familiar and less pejorative, *hospital* and *patient*; second, it allowed for a new category of *voluntary* and/or *temporary* patient to be admitted - that is, someone thought to be mentally ill, but not requiring certification and compulsory detention. This was an enormous advance in mental health legislation at this time and did much to recognise the changing scope of mental illness definition - though, interestingly the Act contained no substantive definition of the category mental illness it now recognised - a tradition that continues to this present day.

However, the Act did something else that was of immediate concern - it made possible the apparently *inappropriate* admission of the indigent poor - whom it was thought, would claim a mental illness, in order to relieve their destitution:

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[27]Interestingly, Moreau de Tours conception of psychotic madness was grounded in his belief that all types of madness were a form of mental alienation - that the mad were alienated from the fixed anchor points of an objective reality and, as such, were subject to, the unbridled fantasies of their own mind - madness cast in this way is an unfettered *subjectivity*. 'It appears then that two modes of existence - two kinds of life - are given to man. The first one results from our communication with the external world, with the universe. The second one is but the reflection of the self and is fed from its own distinct internal sources. The dream is a kind of in-between land where the external life ends and the internal life begins' (Moreau de Tours, 1945: p.41. Quoted In Alexander & Selesnick, 1967: pp. 139-140; cf. Hegel, 1982-6/1968).

> 'There are many people ... who would like to make a home in a mental hospital as a voluntary boarder. It would be a relief from standing from day to day outside an Employment Bureau, to have a home in one of the comfortable well-staffed mental hospitals we know of. We shall therefore have to be on our guard against the *malingerers*' (Quote attributed to Sir William Lobjoit in Jones, 1972: p.253).

Having raised the spectre of the malingering patient Lobjoit went on to warn that (cf. Szasz, 1994):

> 'some mental hospitals [will] have difficulty in distinguishing those who were in real need of mental treatment from those whose primary need was a bed and four square meals a day' (Quote attributed to Sir William Lobjoit in Jones, 1972: p.253).

The idea that the mental hospital might be something other that an asylum for the *truly* mentally ill had taken hold and is one that haunts the provision of mental health services to this day. Szasz (1994) is particularly sure that the mental hospital provides a form of secular 'poor relief'.

> 'Society's responses to poverty, unemployment, lawlessness, and craziness have thus merged in a vast quasi-therapeutic bureaucracy whose basic mandate is storing the unwanted' (Szasz, 1994: p.26).

The Informal Patient

The fact that people could voluntarily enter a mental hospital without the *stigmatising* process of legal certification was thought to be an enormous advantage - not least by psychiatrists keen to protect the reputations of patients and/or their families - but it was not without problem. The difference between the *voluntary* patient and the *temporary* patient was construed around their apparent volition - the former were thought to retain

volition, whilst the latter did not. In theory, the *temporary* patient could recover their volition and demand their discharge long before the psychiatrist thought it fit to do so (cf. The Bournewood Judgement). In practice, though, there was 'no precedent, medical, legal, or psychiatric for judging the existence of reasonable powers of volition on this point' (and none that is entirely appropriate today) and it was left to individual psychiatrists to do so (Jones, 1972: p.254).

Pilgrim & Rogers (1994) have argued that the relationship between medical psychiatry, the law and civil liberty has been an uncomfortable one throughout the 20th century, one in which:

> 'therapeutic law with its open-ended clauses and standards ... leads to a tendency towards *ad hoc* rule enforcement and the playing down of the importance of general rules. In other words, where there is a clash between the views of medicine and legal requirements, medical demands tend to be privileged' (Pilgrim & Rogers, 1994: p.140).

The Mental Health Act (1959) emphasised the 'free-choice' inherent in the category of *voluntary* patient by renaming them *informal*, but it did so without benefit of legal or medical definition, simply stating that, 'nothing in this Act shall be construed as preventing a patient who requires treatment for mental disorder from being admitted ... without any application, order or direction rendering him liable to be detained under this Act' (Mental Health Act 1959: Section 5 (1), p.3).

The category of informal patient is simply a legal nicety which allows that anyone *thought* to be mentally disordered can be admitted to hospital - in essence, if you are not

compulsorily detained in hospital, you are, by definition, an informal patient. A fact made clear by the Mental Health Act (1983) which again makes no legal provision for the admission of informal patients other than to make it allowable in law (ibid: Section 131: p.100). Not surprisingly, it has been argued that the rights of the informal patient are completely neglected by doctors and legislators - in the period 1995-1996 over 90% of patients admitted to mental hospitals were categorised as informal patients (HES, 1997).

The criterion psychiatrists (and Registered Mental nurses) use to decide whether a person should be detained in hospital is twofold: one, that the individual is mentally disordered in the meaning of the Act; and two, they are a danger to themselves or to others (Mental Health Act, 1983: Parts II & III), none of which is dependent upon a precise definition of their mental disorder. By mentally disordered, the Act means: 'mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' (ibid: Section 1(1), p.1). The essential criterion is *one* above. If this cannot be demonstrated the person under review cannot be compulsorily detained regardless of their mental status.

Despite the comprehensive diagnostic classifications contained in the ICD-9 (1975) and DSM-II (1968), the Mental Health Act 1983, provides no legal definition of the sub-category of mental illness and there is nothing that can be construed to describe the meaning of the highly inclusive phrase: 'any other disorder or disability of mind.' The reality of this legal fudge is simple - *anyone* thought to be a danger to themselves, and/or others, *can* be construed to be mentally disordered (ill) and can be compulsorily

detained in hospital.

The shadow that falls over informal patients in mental hospitals is the very real possibility of their compulsory detention[28]. If, as is possible, their failure to comply with instruction is construed as evidence of their being a danger to themselves and/or to others. Importantly, it is a sanction that can be imposed, not only by a Consultant Psychiatrist, but also by a Registered Mental Nurse (cf. Section 5 (4), Mental Health Act 1983: p.5) - a fact which deeply implicates the Registered Mental Nurse in the medico-legal complex and one that does much to menace the therapeutic relationships they would aspire to (see chapter six, this volume).

Szasz (1997), in common with others, is wont to disabuse the whole idea of an *informal* category of patient as unsatisfactory and problematic and he suggests that their status emerges as a consequence of their *'lack of choice'* and their coercion to accept the position of informal patient, rather than detained patient that might otherwise apply (ibid, 1997: p.39). Bean (1986: p.5) uses the term *'coactus voluit'* to describe the limited (no)choice option of persons engaging with medical psychiatry - *'at his will although coerced'*, he posits, is the truth of the case.

The system/culture of care that this medico-legal complex describes is one that is marked by the social inferiority of the patients it *cares* for - which is evidenced in the imprecise, over-inclusive and all too often stigmatising system of mental illness diagnosis/labelling it uses to describe their behaviour and by the rules and resources

[28]There are safeguards which would prevent this unlawful circumstance arising, but they are only weakly specified in Section 126 of the Mental Health Act, 1983: pp.97-98.

it uses to limit their civil rights in law.

However, problematic though this is, social care theorists argue that the *debilitating* effects of both medical diagnosis and admission to hospital - the incarnation of a misconstrued discourse of deviance and social control, can be militated by the therapeutic relationship it describes - a relationship that signals a concern for client autonomy, empowerment, and the essential legitimacy of their version of reality - their *subjectivity.*

The Therapeutic Relationship - Understated in its Complexity

The task faced by the social care theorist bent on establishing a therapeutic relationship with a client in a mental hospital is difficult, though not impossible (see chapters eight & nine, this volume). It is difficult because social relationships are inevitably the product of the institutions/societies in which they occur and the interactions these necessarily intend - wherein, 'structuration informs and determines interactions and where interaction creates or recreates social structures' (Brown and Levinson, 1992: pp.240-241).

Caught in this *institutional*[29] trap the therapeutic relationship clearly demands far more than the empathy in which it was first conceived. Rogers (1957) describing the 'necessary and sufficient conditions of therapeutic personality change' posits a

[29]The term *institution* is used to describe both the medical diagnosis/classification and the hospital and/or community care it gives rise to - a manifestation, if you will, of the society it promotes through Platonic and Hegelian concepts of the ideal and the universal..

trascendent set of conditions, which argue that constructive personality change is possible when:

> 1. Two persons are in psychological contact.
> 2. The first, whom we shall term the client, is in a state of incongruence, being vulnerable or anxious.
> 3. The second person, who we shall term the therapist, is congruent or integrated in the relationship.
> 4. The therapist experiences unconditional regard for the client.
> 5. The therapist experiences an empathetic understanding of the clients internal of reference and endeavours to communicate this experience to the client
> 6. The communication to the client of the therapist's empathetic understanding and unconditional positive regard is to a minimal degree achieved' (ibid: p.96).

The first three conditions specify the dynamic of this encounter in terms of the conversational space to be achieved in therapy and the vulnerability of the client and the composure of the therapist in the interaction that follows. Interestingly, Rogers (1962: pp. 417-418) describes the client's *incoming* state as incongruent - by which he appears to mean *disingenuous*. In contrast, the therapist is thought to be *congruent*, that is, 'the counselor is what he *is*, when in the relationship with his client he is genuine and without "front" or facade ... ' (ibid).

In essence, the counsellor is unambiguous about his view of the client - if he believes him/her to be less than *authentic* in their self-disclosure - he will (apparently) say so (cf. Nelson-Jones, 1991: pp.336-342). To reiterate a point made earlier the social care model can only work if the therapists understanding of the client's problem state is complementary to his/her own understanding of it. Simply stated there can be no empathy without this understanding and (more importantly) there can be no relationship without this understanding.

The next condition specifies that the therapist should experience unconditional positive regard for his client. Simply stated, the therapist must *like* and *care* for his client without imposing any condition on that liking or caring - or as Cixous & Clément (1986: pp. 78-91) describe it, a 'Gift relationship' without *tithe* (cf. Herman, 1991: pp.101-125; Maus, 1954/1967). Interestingly, Rogers (1962) describes this aspect of counselling in terms of positive *parenting.*

> 'I believe that when this nonevaluative prizing is present in the encounter between the counselor and his client, constructive change and development in the client is more likely to occur ... The best parent shows this in abundance, while others do not' (Rogers, 1962: p.421).

The fifth condition *re*-states that the primary requirement of the therapeutic relationship is the counsellors's empathic understanding of the client's *frame of reference* (discursive position) - his/her subjectivity. Finally, this inclusive and mutually satisfying triad of counsellor congruence, unconditional positive regard and empathy, is conveyed to the client in their communication.

Empathy, it will be remembered, was described as a *process* by which the therapist enters the private perceptual world of the client and becomes thoroughly at home in it - a *process* that Rogers (1975: p.4) says is only possible for those who are secure enough to know that they won't get 'lost in what may turn out to be the strange or bizarre world of the other.' It is an avowedly subjective orientation that reduces meaning to whatever *an* individual consciousness supposes it to be - (Husserl's, 1991) idea of 'analogical apperception' .

It is a model weighted by the subjectivity of the client, rather than the inter-subjectivity[30] of the counsellor and counsellee. In essence, what the counsellor tries to do is explore the client's self conscious understanding whilst limiting his/her own self referent behaviour to a minimum[31]. It is a complex form of communication that is nicely captured in the idea of a diorama: a scenic representation in which a painting is viewed through an opening in the wall of a darkened room and wherein the varied effects of reality are realised by the skilful manipulation of lights - or in this circumstance, the probing words/utterances of the therapist[32].

Importantly, the clients subjectivity, is not a static *representation*, but a discourse - or more properly, a multiple of potential discourses, in which, they *position* themselves and others and, within which, (rightly or wrongly) they fashion an identity consistent with their meanings/understandings (cf. Davies and Harré, 1990; Harré and Van Langenghove, 1991; Van Langenghove and Harré, 1993a; 1993b; 1994). Speaking of this Harré & Gillet (1994) suggest that:

> 'Mental life is a dynamic activity, engaged in by people, who are located in a range of interacting discourses and at certain positions in those and who, from the possibilities they make available, attempt to fashion relatively integrated and

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[30]Intersubjectivity is cast as a process of claim and counter claim - argumentation of a type Toulmin (1991) describes intends a mutuality and reciprocity of meaning/understanding (Graumann, 1995; cf. Marková, 1990; Taylor, 1994).

[31]Counselling acknowledges that appropriate self disclosure (confession) is an important dimension of human relationships, but argues that 'such disclosures are best made by skilled counsellors who are functioning reasonably well in their own lives ... and reflect the clients rather than the counsellor's needs (Nelson-Jones, 1991: p.337. Importantly, Carkhuff (1969, Vol 1: pp.186-186) observes that 'although a helper may be genuine and not self disclosing or self disclosing and not genuine, frequently, and particularly at the extremes, the two are related.' Little wonder that therapist view this activity with caution.

[32]There is a parallel between the idea of a diorama and Foucault's (1984; 1986) notion of *self surveillance*.

coherent subjectivities for themselves' (Harré & Gillet, 1994: p.180).

However, it is an interaction which always privileges the client's position - their *voice*, their *perspective* and their *identity* and one which invites no challenge to the things they disclose - other than their own. The logical error this summons is described by Crossley (1996), who posits that:

> 'Subjectivism [of the type this describes] focuses exclusively upon the contents of representations and understandings, taking these as an index of reality of the subject's world. It thereby fails to either situate representations or to consider its role in a more general structure of action. Representations do not stand outside of the social, as a picture of it. They are within the social' (Crossley, 1996: p.75).

If this is strictly interpreted the client is trapped - or so it must seem, in a self-reflexive discursive loop that is only ever resourced by their subjectivity and/or, their therapist's empathic understanding of the problems they describe (their subjectivity retold) and not, as one might hope for, or suppose, the mutuality and reciprocity of their shared meaning/ understanding. A subjectivity that, in effect, represents itself as the only challenge they have to the mental illness label (diagnosis/insanity ascription) they have been ascribed and the system/culture care in which they are treated - which is, itself, a manifestation of societies concept of the norm.

Summary

Chapter one, has argued that the social construction of madness is a complex and multi-faceted discourse, one which invariably privileges the voice of a dominant logocentric medical discourse over that of the social care model. The two positions are deeply

opposed. From the vantage of a rational and empirical science, the medical model argues a notion of normative personhood and collective understanding that is the premise for its diagnostic mandate and legal powers. In contrast, the social care model argues a case for client autonomy, empowerment and the essential legitimacy of their version of reality - their *subjectivity*[33].

Despite the tension that exists between these two positions (discourses), mental health nurses have been encouraged by government wont (Ministry of Health, 1968); professional imperatives (ENB, 1982 & 1989b); and social policy (Duggan, 1997), to work as counsellors/psychotherapists[34]. The question this begs, though, is can they bring it off - can they effect a resolution of their clients troubles and/or distress by ignoring a contrary social reality?

At the heart of this expectation is a set of assumptions which may or may not be true, notably:

1 that mental health nurses *can* construe a meaning/understanding of their clients trouble(s) and/or distress (*diagnosis/insanity ascription*); the *system/ culture* of care in which they work; and their *relationships* with them, in terms described by, or acceptable to, the social care model (chapters five, six and seven, this volume).

2 that mental health nurses *can* construe a counselling/psychotherapy (therapeutic conversation) with their clients that privileges their *subjectivity*, rather than their or own, or any others (chapters eight and nine, this volume).

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[33]The argument is reminiscent of Hegel's (1892-6/1968 & 1979) conception of a *universal* subject in conflict with an *individual* subject (cf. Habermas, 1994: p.40).

[34]Mental health nurses, though trained in counselling and/or psychotherapy do not refer to themselves counsellors or psychotherapists. A sensitivity, that led a number of nurses in the second study (this volume) to describe their client interactions as therapeutic talks, rather than counselling and/or psychotherapy. For this reason all of the conversations cited in chapters eight and nine are referred to as therapeutic talk, though the nurses were using 'counselling techniques ... to ensure the conversations happen[ed] in the first place' (Patton, 1984: p.449)

3 that mental health clients *can* construe a complimentary view of themselves and the mental health nurses who care for them (ibid).

However, given that these assumptions hold true (and, there is good reasons to believe they do not - see chapters five, six & seven, this volume) it is questionable whether the subjectivity intended by person-centred therapy is the most meaningful form of communication there is, or can be, given that claims to *truth, right* and *sincerity*, are rarely (if ever) certain and ultimately rest on the validity claims they make to those to whom they speak (see chapters eight & nine, this volume).

In the next chapter (two) the limits of this form of Cartesian subjectivity are explored as a prelude to the analysis undertaken in chapters eight and nine of this volume. This is achieved through a critical review of Grice's (1957; 1975) and Searle's (1969/1990; 1994) subject centred paradigms of intentionality and rejected in favour of Habermas's (1991) intersubjectivist paradigm of communicative action - one which agrees that the meaning/understanding of what ever is said inheres in a context of talk and not in the *private* mental life of any individual.

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The Study - An Overview

The study that follows is divided into three parts: Part one (chapters two, three and four) describe the theoretical premise and methodological framework used to support and inform the empirical study to follow: Parts two and three (chapters five, six, seven, eight, nine& ten) are the discourse analytic reports of the empirical studies undertaken in this

research and the conclusions drawn from them.

The Aims of the Research Studies

The aim of the first research study is to describe and interpret the *positions* taken up by mental health nurses and mental health patients in their talk about *mental illness (diagnosis/insanity ascription)*; the *system/culture of care* in which they are aligned; and the *relationships* they have with one another and to offer a *descriptive* and *interpretative* explanation/account of these.

The aim of the second research study is to describe and interpret the 'interior' of the *beginning* of ten counselling episodes (see Mcleod, 1994: ch 9) to discover how nurse therapists and their clients position themselves and others in their talk and to discern what sort of communication this intends.

Chapter Two: This chapter describes the limitations imposed upon Grice and Searle's subject centred paradigms of meaning/understanding and argues instead a case for Habermas's intersubjectivist paradigm of communicative action as a more complete and appropriate orientation to, and interpretation of, interpersonal communication, one which acknowledges that the intention-meaning of a speaker is not specified by him or her alone, but rather, is co-authored/co-sponsored by participants in that talk - a view which casts doubt on the subjectivity - self revealing communication intended by person-centred therapy and the therapeutic talks that are later described in chapters eight and nine of this volume.

Chapter Three: This chapter posits that in keeping with Habermas's intersubjectivist paradigm of communicative action Davis and Harré's (1990) concept of 'position'[35] argues that meaning/understanding and the personal and/or social identities they insinuate, are not to be understood as some enduring and/or describable entity (as Cartesian philosophy and person-centred therapy imply), but rather, as discursive constructs realised in the positions participants in talk describe - positions which are always immanent, mutable and negotiable.

Chapter Four: This chapter describes the method of data collection and narrative (positioning) discourse analysis used in the research activity reported in Parts two and three.

Chapter Five: This first analysis describes and interprets participants' *self* and *other* positions in talk framed by the topic: *Mental Illness* (diagnosis/insanity ascription) and concludes that mental health nurses are positioned either by reference to the social care model of mental illness/disorder, or the medical model of care, or by some accretion and/or confusion of the two. In contrast, the patient group are more homogenous and, in part (at least) accept their medical diagnosis/insanity ascription (and the medical model this might imply) as a rational anchor from which to validate their experience of trouble and/or distress, but they do so whilst *resisting* its constraining influence and emphasising their subjectivity - their *singular* view point (cf. Hegel, 1892-6/1968).

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[35]Position is 'a metaphor to enable investigators to grasp how persons are "located" within conversations as observably and subjectively coherent participants in jointly produced storylines' (Van Langenhove and Harré, 1993a: p.82).

Chapter Six: This second analysis describes and interprets participants' *self* and *other* positions in talk framed by the topic: *The System/Culture of Care*. Overall, the mental health nurses argue that their work demands an acceptable degree of patient control and signal an asymmetry of power in their role that militates against the *empowerment* and/or civil *rights* of patients in their care. Interestingly the patient group also acknowledge the need for control by professional *others* and a sympathy with the nursing staff that was unexpected, but more intriguing than this, an antipathy towards one another that once again does much to emphasise the subjectivity of their person experience.

Chapter Seven: This third analysis describes and interprets participants' *self* and *other* positions in talk framed by the topic: *Relationships*. The majority of nurses in this topic of talk adopted a disappointing view of their patients/clients and were disinclined to conceive that their relationship with them was anything more than an exigency of their work. Similarly, the majority of patients in this topic of talk believed that the friendship of nurses was largely pretended and would disabuse any assumption that their friendship was to be taken for granted.

Chapter Eight: This fourth analysis (and the fifth analysis to follow) describes and interprets participants' *self* and *other* positions at a *beginning* in an ongoing series of therapeutic talks (counselling/psychotherapy). Not surprisingly the central feature of these conversations is the orientation of talk to the client's subjectivity - their diorama, which, in this particular instance, is always *resistant* to, or incompatible with, the counsellor's own understanding.

Chapter Nine: This fifth (and final) analysis is a continuation of the description/interpretation that began in chapter eight of participants' *self* and *other* positions at a *beginning* in an ongoing series of therapeutic talks (counselling/ psychotherapy). In contrast to the resistance/incompatibility that was so apparent in chapter eight the conversations in this series of talks take the form of an assisted story telling - a complicity if you will between the counsellor and the client to tell a particular version of events.

Chapter Ten: This chapter suggests that the paradox observed in the *institutional* and *therapeutic* position of nurses and their patients/clients might be explained by reference to the concept of position espoused by poststructural theorists, such as Foucault (1972/1994), Hindess and Hirst (1977) and Laclau and Mouffe (1985), all of whom contend, that subjectivity is not the product of a self reflexive consciousness, but, exists in the material character of some preexisting autonomous discourse - repertoires, if you will. (Parker, 1990).

PART ONE: THE LIMITS OF INTERPRETATION - SUBJECTIVITY IS NOT ENOUGH

Chapter 2: A Critical review of Grice and Searle's Intentionalist-Semantics and Introduction to Habermas's *Theory of Communicative Action*

(2.1) Socrates: 'Crito, we owe a cock to Aesculapius; pay it, therefore, and do not neglect it.'
Crito: 'It shall be done, but consider whether you have any thing else to say' (Plato's Phaedo 118a7-8/Cary, 1848: p.127).

Introduction

In the last chapter (one) it was suggested that the subjectivity intended by person-centred therapy was not necessarily the most meaningful form of communication there is, or can be, given that claims to *truth, right* and *sincerity,* are rarely certain and ultimately rest on the validity claims they make to those to whom they speak. In this chapter this assumption is tested as a prelude to the discourse analysis to follow in chapters eight and nine of this volume and also as the premise on which all the analysis is based (see chapter three, this volume).

To this end, the Socratic dialogue (2.1)[1] above is used throughout this chapter to explore the limits of meaning interpretation, and then, in chapter three, to support and explicate the concept of *positioning* (Davies and Harré, 1990; Harré and Van Langenghove, 1991; Van Langenghove and Harré, 1993a; 1993b; 1994). This is

[1]The choice of this particular text arose out of readings that were undertaken to support/understand Plato's concept of madness and society(cf Plato's *Phaedrus* 244-245/Hackforth, 1996: pp.491-492) - in this sense, it implies no greater knowledge of the works of Plato than that which supports this text. However, it did appear to be a useful vehicle for this discussion, given the stature of its author and the limited *pragmatic* understanding a host of well meaning philosophers have brought to it over the years.

achieved through a critical review of Grice's (1957, 1975) and Searle's (1990, 1994) subject centred intentionalist-semantics and Habermas's (1991) theory of communicative - action.

It is claimed that these were the last words spoken by Socrates on the day of his execution (see Burnet's 1900/1911, *Introduction* to *Plato's Phaedo* for specific claims to historical accuracy). They occur at the end of a short dialogue more famous for the introduction of his theory of forms and ideas, and his thoughts on the immortality of the soul, than an account of his impending death. They were recorded by one of his followers Phaedo and later transcribed by his pupil Plato; not surprisingly, given Socrates' philosophical stature, their 'significance has been the subject of considerable debate' (Hamlyn, 1987: p.38).

That his words had meaning, and continue to have meaning, is self evident. But what meaning? Crito's response makes possible a literal, conventional, and by no means improbable explanation, wherein, Socrates *asserts* that he, and possibly others, owe a ritual sacrifice to the god of healing Aesculapius and Crito is *directed* to pay it. Crito makes a future *commitment* and *directs* his friend and mentor to think more of what he might say. This literal or *manifest* reading of the text exploits, in a simple and ingenuous way, the linguistic resources of truth-conditional, formal semantics (Chomsky, 1957; Frege, 1952) and, by extension, the categorical resources of speech act theory, and the intentionalist-semantics this might imply (Searle, 1969/1990, 1994).

As such, only two interpretations of the text are possible: the first would assert that

meaning/understanding immures in the system of syntactic and semantic rules of a language, that, Socrates meant no more than what he said; the second, that meaning/understanding is realised by reference to the speakers', audience directed intention, that Socrates meant what he intended to those present on that occasion and also, though less obviously so to those not present, but with third party access to his utterance - notably, Plato, absent due to illness and, presumably, all future readers of the text

These two theoretical perspectives differ in 'the relations between the meaning-determining rules of the language, on the one hand, and the function of communication, on the other: one party insists, and the other (apparently) refuses to allow, that the general nature of those rules can be understood only by reference to this function' Strawson (1990: p.94). But how is function (intention) to be explicated, if not by reference to the literal meaning/understanding of the text? Did Socrates mean more than what he appears to have said? And if he did, how would we know?

This is a problem not easily resolved. It is taken as axiomatic that, 'what is conveyed by any particular segment of a literary text can as a rule only be fully understood in the light of preceding and/or subsequent segments,' Rommetveit (1974: p.22)[2], and that the non-literary contextual parallel is equally apposite. But is it always the case that the intention-meaning/understanding of a speaker is known to him/her prior to the utterance made and that this intention is signalled in prior speech? The problem is evident in the Phaedo where no prior indication of speaker intention is apparent to support anything, but the

[2]Interestingly, Eagleton (1993: p.74) argues that the opposite is often the case - that cohesion and integration of the text cannot be assumed in this way.

literal interpretation already given. Gallup, (1990) supports this view with reference to the text and states that:

> 'the offering of a cock to Aesclepius (sic) is sometimes supposed to be for healing Socrates of the sickness of human life ... But the idea that life is a sickness ... is no where espoused by Socrates ... It is simpler to take the words as referring to an actual debt, incurred in some connection unknown' (Gallup, 1990: p.225).

Burnet (1900/1911: p.118), an acknowledged authority disagrees and suggests that, 'Socrates hopes to awake cured like those who are healed by ... (*incubatio*) in the Asklepieion at Epidaurus.' An assumption, one presumes, that draws on a more extensive corpus of Classical literature and Platonic dialogue - but is this appropriate? Is it right to recruit the contemporaneous record in this way? Foucault (1972/1994: p.25) suggests not, and rejects the possibility of ever knowing a speaker's intention by this means: 'that beyond any apparent beginning, there is always a secret origin - so secret and so fundamental that it can never be quite grasped in itself.'

Difficulties arise when one assumes that Socrates had prior intention in uttering the words he did, and that his intention-meaning/understanding was known only to himself. A view that speaks of Cartesian dualism and the myth of privileged mental states and mental entities - that 'strictly speaking the actor and he alone knows what he does, why he does it, and when and where his action starts and ends,' (Schutz 1963: p.243) - the social care theorist's *position* in a nutshell one must presume. That this might have been the case is clearly a possibility, but as Coulter (1987: p.40) notes, 'an avowal or denial of some intention cannot by itself defeat a situationally warrantable ascription of an intention.' Whatever intention-meaning/understanding Socrates had in uttering the words he did, they are inextricable bound to their context of talk.

What begins to emerge is the idea, or at least the possibility of the idea, that the intention-meaning/understanding of a speaker is not specified by him or her alone, but rather, is something confirmed or denied by participants in that talk (cf. Graumann, 1995; Leudar, 1991 & 1994; Leudar & Antaki, 1996a & 1996b). If this is so, then the intention-meaning/understanding of Socrates is not instantiated in him, or by him, but in a context of talk that *positions* him and others in 'a spatio-temporal structure of things and events ... having a point of view [and] a sense of moral responsibility' (Mühlhäusler and Harré, 1990: p.88).

Subject Centred Paradigms of Intentionality

Merleau-Ponty (1986: pp.183-4) observing that, 'thought and expression ... are simultaneously constituted,' and that the words uttered by a speaker do not work by arousing in the hearer the representations associated with them, suggests that 'speech is not an explicit thought, but a certain lack which is asking to be made good'. He goes on to say that 'intention is not a process of thinking ... but a synchronizing change in ... existence, a transformation of ... being.' In doing so he correlates a speaker's sense-giving intention with a hearer's uptake of that intention, without which, an utterance is simply evanescent.

Such a view, however, is tenable only if there exists, *a priori*, a rational means of cooperative communicative exchange, wherein, a speaker's *possible/probable* intention-meaning/understanding is recognised and accepted as intended by a hearer (made good, as it were), as opposed to meanings/understandings which may otherwise be

construed - minimally, one assumes, a set of universal preconditions for communication.

Grice's Conversational Implicature and Meaning-nn.

Grice (1975), specified such a means and proposed a number of over-arching assumptions guiding the conduct of conversations - his so-called conversational maxims. In essence, he suggested that a speaker making a conversational contribution will implicate that he is telling the truth (maxim of quality); that he is telling the listener all he needs to know (maxim of quantity); that he is telling only what is relevant to the conversation (maxim of relevance) and that he is clear and unambiguous in his speech (maxim of manner).

In Gricean terms, it is the speaker's utterance which specifies the intended meaning and not the sentence spoken, and whilst most ordinary talk would probably violate one or more maxim, participants in conversation are thought to orientate themselves to some degree of cooperation - though, what this cooperation amounts to is the source of some debate (see Kreckel, 1981: ch.3; Levinson, 1992: ch.3).

Grice's cooperative principle is highly plausible, as it makes economy of speech possible and the interpretation of meaning removed from the fixed sematic meanings of sentences, statements or propositions *in vacuo*. However, he readily concedes that there are at least four ways by which a speaker may fail to cooperate, or appear to mislead a hearer (Grice, 1975: p.49), he/she may: (1) violate a maxim; (2) opt out of a maxim; (3) be faced with a clash of maxims; or (4) flout a maxim, but (and this is the nub

of his thesis) in all cases it is for the hearer to decide the degree of speaker commitment to cooperation and the inference(s) he/she must draw.

Was Socrates, in his dying moment, true to this co-operative principle? Crito gives no impression of misunderstanding and one is led to conclude that Socrates made known what *he* intended to be known - whether conventional, ironic, metaphoric, coded or otherwise figurative. To the modern analyst, though, this is of little consequence and Socrates is guilty of parsimony (maxim of quantity) and possibly even some degree of artful deception (maxim of quality).

With an eye to posterity and the sensibility of his future reader Plato may well have considered a more expansive reporting of his friend and mentor's final few words - in a form that Burnet (1900/1911) would both recognise and appreciate: 'Crito, we owe a cock to Aesculapius, **[he must heal me of this sickness of human life]**; pay it therefore, and do not neglect it.'

But to what effect? He robs an enigmatic passage of its needless profundity, but in doing so he transforms the historical record and, more importantly, the very architecture of its apparent inter-subjectivity (see Rommetveit, 1974: ch.4) - Socrates, in extremis, *now* appears to violate the maxims of quantity and relevance and talks to Crito, his friend and fellow Pythagorean, as if he were a stranger.

In Grice's formulation conversational implicature is minimally grounded in the speaker and hearer's mutual 'background knowledge' (Grice, 1975: p.50), without which a

speaker's intention-meaning/understanding could not be recognised as intended by a hearer. It is a dialogical formulation reflecting, 'the embeddedness of the individual human mind in the cultural collective' (Rommetveit, 1990: p.84), but it is one that singularly ignores the contribution to speaker meaning/understanding made by other participant actors (hearers as possible future speakers) and, in this sense, miscarries. In essence, hearers are invited to recognise the intention-meaning/understanding of a speaker utterance rather than actively contribute to its formulation. A charge that all too readily falls at the door of person-centred therapists who invariably privilege the meaning/understanding of their clients over that which might otherwise be agreed.

> 'The practice of person-centred therapy dramatizes its differences from most other orientations. Therapy begins immediately, with the therapist trying to understand the client's world in whatever way the client wishes to share it' (Raskin and Rogers, 1989: p.172).

More promising than this (but ultimately deceptively so) is Grice's (1957) earlier theory of meaning, his meaning-nn. His start point here is to distinguish between two types of expression: a natural expression, where-in, *x meant that p* and *x means that p* entails *p*: and his so called, non natural expression, where-in, *x means that p* and *x meant that p* do not entail *p*, (pp. 377-378). From this he posits that a non natural meaning or meaning-nn (non-literal, though possibly conventional) will be defined in the following terms:

(a)

> S *meant-nn z* by uttering U if and only if:
> (i) S intended U to cause some effect *z* in recipient H
> (ii) S intended (i) to be achieved simply by H recognizing the intention (i) (Levinson, 1988: p.16).

Important to this formulation is the emphasis Grice places on the role of the audience: 'for *x* to have meaning$_{nn}$, the intended effect must be something which in some sense is within the control of the audience, or that in some sense of "reason" the recognition of the intention behind *x* is for the audience a reason and not merely a cause' (Grice, 1957: p.385) - the active participation of the audience now appears to resonate with Merleau-Ponty's (1986) phenomenological insight.

However, Grice fails to say how the effect *z* is achieved, if not by the literal meaning of the utterance U? He rejects Stevenson's (1944: p.57) causal theory: wherein, recognition is 'dependent on an elaborate process of conditioning attending the use of the sign,' and asserts instead that: meaning-nn, is achieved when S utters U, 'with the intention of inducing a belief by means of the recognition of this intention' (Grice, 1957: p.384).

But how is this recognition of intention to be achieved? For example how would the effect *z* in (b) below be explicated from the text, if the literal meaning/understanding were rejected?

(b)

> Socrates meant-nn *z* by uttering: *'Crito, we owe a cock to Aesculapius; pay it, therefore, and do not neglect it.'* if and only if:
> (i) Socrates intended: *'Crito, we owe a cock to Aesculapius; pay it, therefore, and do not neglect it.'* to cause some effect *z* in Crito
> (ii) Socrates intended *z* to be achieved simply by Crito recognizing the intention (I)

The possibility of success appears limited. Crito's response (see 2.1 above), an apparent future promise, gives no indication of Socrates meaning-nn by his utterance

U, if indeed, such a meaning/understanding was intended. To do so, Grice insists, Socrates must intend the effect *z* to be recognised as intended and that his utterance U is 'capable of being worked out,' (Grice, 1975: p.50) - note, that it is the hearer's task, *to work out*, the speaker's intention-meaning/understanding. And, this, he states, is possible only by participants invoking the co-operative principle against a background of mutual knowledge:

(c)

(I) S has said *p*
(ii) there's no reason to think S is not observing the maxims, or at least the co-operative principle
(iii) in order for S to say that *p* and be indeed observing the maxims or the co-operative principle, S must think that *q*
(iv) S must know that it is mutual knowledge that *q* must be supposed if S is to be taken to be co-operating
(v) S has done nothing to stop me, the addressee, thinking that *q*
(vi) therefore S intends me to think that *q*, and in saying that *p* implicates *q* (Levinson, 1992: pp.113-114)

The intention-meaning/understanding of the speaker S is construed because it possesses 'certain features', which predict its non-conventional realisation (Grice, 1975: pp.57-58). Features which determine meaning-nn in a particular context. These features predict that a generalizable conversational implicature may be 'explicitly cancelled by the addition of a clause that states or implies that the speaker has opted out [*of one or more maxims*], or it may be contextually cancelled, if the form of utterance that usually carries it is used in a context that makes it clear that the speaker is opting out' (Grice, 1975: p. 57). Additionally, he suggests that implicature is non-detachable (could not be said in any other way); calculable (from c above); non-conventional (not part of the conventional meaning/understanding of the linguistic expression) and indeterminate (contextually), (cf. Levinson, 1992: pp.114-118).

From this, one must suppose, that both subjectivity and intentionality stand prior to both the language and the context in which it is used! But, can this be so, can an utterance meaning/understanding be so open-ended as Grice appears to allow? Searle (1969/1990) thinks not.

Searle's Speech Acts

Searle's approach to this question, through his work on speech acts, incorporates a revision of Grice's meaning-nn, which usefully extends the analysis so far. To begin, Searle (1969/1990: pp.42-50) retains the bones of Grice's meaning-nn, (a) above, but adds some flesh in the form of rules and/or conventions, and also, by making a conceptual cut between illocutionary and perlocutionary acts - meaning and intended effects, 'saying something and meaning it is a matter of intending to perform an illocutionary act, not necessarily a perlocutionary act' (1969/1990: p.44).

To extrapolate from this, Crito's future promise: *'It shall be done',* would not (in Searle's terms) bear on the interpretation of Socrates dying words! This apparent disregard for hearer uptake has, however, been the source of some significant criticism of Searle's account - not least, Habermas (1991: pp.274-275 & 1993: pp.17-29) and Mühlhäusler & Harré, (1990: pp.41-42).

Searle cautions that in its original form Grice's account implies that, 'any sentence can be uttered with any meaning whatever, given that the circumstances make possible the appropriate intention' (1969/1990: p.45). Clearly this is problematic and Searle offers the

following revised formulation of Grice's meaning-nn:

(d)

> S utters sentence T and means it (ie., means literally what he says) = S utters T and
> (a) S intends (*i*-I) the utterance U of T to produce in H the knowledge (recognition, awareness) that the states of affairs specified by (certain of) the rules of T obtain. (Call this effect the illocutionary effect, *IE*)
> (b) S intends U to produce *IE* by means of the recognition of *i*-I.
> (c) S intends that *i*-I will be recognized in virtue of (by means of) H's knowledge of (certain of) the rules governing (the elements of) T. (1969/1990: pp.49 & 50)

Central to Searle's formulation is his belief that, 'the semantic structure of a language may be regarded as a conventional realization of a series of sets of underlying constitutive rules' (1969/1990: p.37)[3]. These constitutive rules, by their very nature, create and define illocutionary acts/speech acts and are conceptualised in the form: 'doing X counts as Y, or X counts as Y in context C' (1969/1990: p.35). It is these rules which specify the illocutionary force *F*, of any proposition - *p*: *F(p)*!

Inextricably bound to Searle's idea of constitutive rules are the conditions he believes necessary and sufficient for the successful performance of an illocutionary act - his, so called, preparatory, sincerity and essential conditions (1969/1990: pp.66 & 67). Together they form a matrix defining his five categories of illocutionary act/speech act: *representatives; directives; commissives; expressives and declarations* (1969/1990; 1976: pp.10-16). For example, the category of representative (assertive) illocutionary act, is defined in terms of the following rules:

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[3]Hegelian (1892-6/1968) *universals*, one must suppose.

Table: 2.1

Representative Illocutionary Act

Conditions	**Rules (i,ii,iii,iv & v)**
Preparatory	1. *S* has evidence (reasons, etc.) (i) for the truth of *p* (ii) 2. It is not obvious to both *S* and *H* that *H* knows (does not need to be reminded of, etc.) (iii) *p* (ii)
Sincerity	*S* believes (iv) *p* (ii)
Essential	Counts as an undertaking (v) to the effect that *p* represents an actual state of affairs (ii)

(Table: 2.1 above and table: 2.2 below, are modified after Kreckel, 1981: pp.45-46 and Searle, 1969/1990: pp.66-67)

Table 2.1 specifies that if Socrates utters sentence T (*'Crito, we owe a cock to Aesculapius'*) meaning literally (and truthfully) what he says, then rules (i)-(v), Table: 2.1 above, must apply, if, and only if, his utterance of T, is to *count* as an undertaking to the effect that *p* represents an actual state of affairs - *count* in this sense is analogous to Austin's, (1962/1975: pp.14-15) felicity conditions. It is this undertaking that *p* represents an actual state of affairs which is the illocutionary point or purpose of the utterance of T. Crito is invited to recognise that this is Socrates intention (belief). This, he does with reference to what ever are the normative social, moral and/or institutional practices of the day.

To further satisfy these condition Searle introduces the notion of direction of fit (1976: pp.3-4). Direction of fit simply refers to the fit of words to the world, or the fit of the world to the words. To assert that *p* is true, Socrates must believe that *p* represents an actual state of affairs, rule (iv). If so, his utterance of T is said to have a word-to-world direction

of fit. Direction of fit adds refinement to illocutionary point and, is, 'always a consequence of illocutionary point.' (1976: p.4)

Similarly, when Socrates utters, *'pay it, therefore, and do not neglect it'*, he is attempting to bring about a world-to-word direction of fit, that is, bring about some change in the world by virtue of his request or order. A directive of this type would insist the following rules apply:

Table: 2.2

Directive Illocutionary Act

Conditions	**Rules (i,ii,iii,iv & v)**
Preparatory	1. *H* is able to do *A* (i) *S* believes (ii) *H* is able to do *A* (i). 2. It is not obvious to both *S* and *H* (iii) that *H* will do *A* (i) the normal course of events of his own accord.
Sincerity	*S* wants (iv) *H* to do *A* (i)
Essential	Counts as an attempt (v) to get *H* to do *A* (i).

The stress that Searle places on the speaker's psychological state is implicit throughout his taxonomy (1976: pp.10-16). This specifies that when Socrates expresses his belief that *p,* and his wish that Crito will do *A*, he expresses an intentional state - 'the Intentional state is the sincerity condition' (1994: p.9). In doing so, Searle appears to anchor the intention-meaning/understanding of the utterance T, to the realisation of certain goals or effects in action. This he denies. To do so Searle invokes the idea of a double level of intentionality: 'a level of the psychological state expressed in the performance of the act and a level of the intention with which the act is performed which

makes it the act that it is' (1994: 164).

In essence, what Searle says is, that whilst 'the conditions of satisfaction of the speech act and the conditions of satisfaction of the sincerity conditions are identical' (1994: p.165) - the conditions of satisfaction of meaning intention are not - meaning intention is satisfied only in the intention to perform a speech act of a certain type.

In developing this argument Searle makes a clear distinction between illocutionary acts and, their possible, perlocutionary effects: between representation and communication. A speaker may intend to represent a certain state of affairs, but he need not intend to communicate this fact to his audience. This, says Searle, entails two levels of meaning intention, each with its own conditions of satisfaction: the intention to represent and the intention to communicate.

Did Socrates, in uttering the words he did, do no more than represent a certain state of affairs he believed to be true and express his desire that a debt he thought owed be paid[4]? Did he do so, without intending to induce in Crito, either belief or obligation? If so, Crito was not required by word or deed to acknowledge the truth of Socrates claim that *p*, or desire that he, or some other person, do *A*, but simply recognise that it was his intention to represent these things as so - 'a speaker can perform an illocutionary act in a meaningful utterance and produce perfect understanding in the hearer even though the hearer does not agree and the speaker may be totally indifferent as to whether or not he agrees' Searle, (1993a: p.92).

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[4]Though, Socrates addresses Crito by name it does not preclude the possibility that some other person present and attending was the intended target.

This last statement perfectly demonstrates the position taken up by client and therapist in person-centred therapy - wherein the intention of the therapist is to allow the client to express their own reflexive self understanding of meaning/understanding rather than construe any mutual understanding of the validity claims so made:

> ' ... if a therapist proves able to offer a facilitative climate where genuineness, [unconditional positive regard] and empathy are all present then therapeutic movement will almost invariably occur. In such a climate clients will gradually get in touch with their own resources for self understanding and will prove capable of changing their self concept and taking over the direction of their life. Therapists need only to be faithful companions, following the lead which their clients provide and staying with them for as long as is necessary (Thorne, 1992: p.118).

There is no deception intended by either party in this circumstance of talk, rather there is a *tacit* understanding that the position of the other is immutable in terms of the *truth, right* and/or *sincerity* it describes.

Searle's account raises a number of difficulties. Firstly, and most importantly, like Grice before him, he implies that the function of language is determined by the subjectivity and intentionality of the speaker - their psychological mode of being and that their subjectivity and intentionality stand prior to the language system in use. Secondly, his account does not require any show of recognition or uptake by a hearer, or indeed, any contribution by a hearer to utterance meaning/understanding. Thirdly, he fails to account for or include other participant actors[5]. Finally, his notion of context is fixed by the rules and conventions of social, moral and/or institutional practices, within which a speaker's representation of states of affairs, either fit or do not fit - a definition of context that

[5] See Clark and Carlson (1982) for a comprehensive review of this issue.

would seem to limit the creative transcendence implied by Merleau-Ponty's phenomenology (1986: pp.183-4).

Grasping Merleau-Ponty's point, Rommetveit (1974: p.22) states that, 'the search for the appropriate word in order to make something known to somebody else may often, in authentic speech, actually serve to make that something known to the speaker himself' - a singularly difficult proposition if deictic referents are not considered relevant to speaker meaning/understanding.

Habermas's Intersubjectivist Paradigm of Communicative Action

In contrast, Habermas (1991) proposes a theory of communicative-action that is fundamentally opposed to the intentionalist-semantics of both Grice and Searle. Central to his *intersubjectivist* paradigm is the belief that a speaker will 'successfully perform a given speech act, if, and only if, he reaches an understanding with his addressee about something in the world' (Habermas, 1993: p.18). The aim of a speaker therefore, is not to represent (in the case of a constantive speech act) a particular state of affairs, but to reach a mutual consensus with his/her hearer about the possible questionable status of that state of affairs.

Habermas's *Theory of Communicative Action* is a conceptualisation of reason framed by Marxist ideology and Critical Theory. His start point is his concept of the life world which he derives by way of the Popper's (1968; 1972) critique of knowledge; Husserl's (1991) and Schutz's (1972) phenomenology; Mead's (1934/1967) pragmatism; and

Wittgenstein's (1953/1992) and Austin's (1975) linguistic philosophy (see Crossley, 1996: ch.5). Importantly, he draws much of his inspiration from Poppers *three world conception*:

> 'We may distinguish the following three worlds or universes: first world of physical objects or physical states; secondly, the world of states of consciousness, or mental states, or perhaps of behavioural dispositions to act; and thirdly, the world of *objective contents of thought*, especially of scientific and poetic thought and works of art' (Popper, 1972: p.106).

But he does so positing a revision that conceives a pre-existing, intersubjectively shared, life world, one which derives from the cultural store of human knowledge and against which all communicative action takes place. A cultural store that is both a resource for interpretive action and the object of interpretative enquiry. In contrast to Popper, he also includes the non-cognitive elements of a cultural tradition in his life world conception - morality and law, and art and eroticism, but does so recognising the need to interpret these elements in terms of their own particular validity claims.

Habermas, retains the spirit, if not the essence of Popper's three world distinction by way of his own *objective, social* and *subjective* orientation and asserts that, 'only one, namely the objective world, can be understood as the totality of true propositions' (Habermas, 1991: p.84). These three worlds, he contends, co-exist to form the reference system by which there can be understanding about anything, and against which, validity claims must ultimately be measured.

> 'The speech act of a person succeeds only if the other accepts the offer contained in it by taking (however implicitly) a "yes" or "no" position on a validity claim that is in principle criticizable' (Habermas, 1991: p.287).

Habermas claims that speakers and their hearers interacting in relation to this three world system have at their disposal, not only the means by which they can *describe* objects and states of affairs, but also a means by which they can *express* their subjective experience and *signal* their appeal for addressee action. The three *functions* of the linguistic *use* of signs first described by Buhler's (1934) organon model of language.

Habermas extends his analysis by mapping onto his three world system the potential actor world relationship - a relationship which he defines in terms of the 'four action concepts relevant to theory formation in the social sciences' (Habermas, 1991: pp.75-76): *teleological action; normatively regulated action; dramaturgical action* and the all encompassing - communicative action.

Teleological/Purposive Rational Action

Teleological action, or purposive rational action, presupposes one world, the objective world of existing, or potential states of affairs, and allows for just two linguistically mediated relations between actor and world - the representational and the interventional. Habermas, (1991: p.323) claims that this actor-world relationship is the conceptual home-ground of intentional semantics, wherein, an actor's utterance is measured in terms of its direction of fit - a criteria that allows for only truth and/or efficacy. Intentional-semantics is thus bound to the truth claims of statements so made: 'Speakers and hearers understand the meaning of a sentence when they know under what conditions it is ***true***' (Habermas, 1991: p.276: my emphasis)

Normatively Regulated Action

In contrast normatively regulated actions presuppose a two world actor referent - the objective world of existing, or potential states of affairs and, a social world of institutional and moral practices. It is in the social world that actors are situated as role playing subjects and, *what is the case* and *what might be the case*, in the objective sense, must now be qualified by, *what normally is the case* and *what normally ought to be the case* - an appeal to normative ***rightness*** that is both socially and contextually bound.

> 'The point of departure for the normative model of action is that participants can simultaneously adopt both an objectivating attitude to something that is or is not the case, and a norm-conformative attitude to something that is commanded (whether rightly or not). But as in the teleological model, action is represented *primarily* as a relation between the actor and a world - there, as a relation to the objective world over against which the actor as a knower stands and which he can goal-directly intervene' (Habermas, 1991: p.90).

The Dramaturgcal Model of Action

Habermas's third action concept, the dramaturgical model of action, is derived by way of Goffman's (1959) work on *The Presentation of Self in Everyday life*, in which he argues that social actors only ever present a partial, or *subjective* view of themselves to their audience and that they do so as a means of ingratiation, self promotion, exemplification, intimidation, and/or supplication (cf. Jones and Pittman, 1980 & Tedeschi, 1981 for a more extensive review of this area of impression management theory).

At first sight the dramaturgical model of action appears to imply a three world actor

referent, but Habermas (1991) argues that this is not the case:

> 'According to the dramaturgical model of action, a participant can adopt an attitude to his own subjectivity in the role of an actor [animator] and to the expressive utterances of another in the role of public [audience], but only in the awareness that ego's inner world is bounded by an external world. In this external world the actor can certainly distinguish between normative and nonnormative elements in the action situation; but Goffman's model of action does not provide for his behaving towards the social world in a norm-conformative attitude. He takes legitimately regulated interpersonal relations into account only as social facts. Thus it seems correct also to classify *dramaturgical action* as a concept that presupposes *two worlds*, the internal world and the external' (Habermas, 1991: p.93).

Norm conformity exists as a given in Goffman's model and this implies that dramaturgical action has, as Jones and Pittman (1980) have suggested, an inherently strategic (intentional) quality. The extent to which self presentation succeeds in any given situation (counselling/psychotherapy) is, however, contingent upon an audience accepting an actor's claim to **sincerity**.

Habermas insists that the *teleological* model of action casts the speaker in the role of self interested manipulator; the *normatively regulated* model of action the conduit for pre-existing cultural values and social consensus and the *dramaturgical model* of action the expression of stylistic and aesthetic forms of speech. In each case only one function of language is ever realised.

Taken to its logical conclusion this would insist that the meaning/function of Socrates last words (dialogue 2.1) could only be interpreted in one of three ways: *teleologically*, he hoped to ensure that the debt he believed owed was paid; *normatively*, he was conforming to the existing social norm and saying what he thought ought to be said on

that sort of occasion; or *dramaturgically*, he was attempting to present a view of himself he considered appropriate to the situation. But, which ever it was, Grice (1957) would probably insist that it was for his audience to 'work out' - an audience which must now include all readers of the text!

The problem with these three action concepts is threefold: first, they each perceive meaning/understanding as something 'out-there' - an objective or social fact that can be grasped by anyone who has an inclination to 'understand' it; second, they each explicate only one possible meaning/understanding of the semantic structure of the *sentence/utterance*; and third, in virtue of the latter, it can only pretend a partial explanation of why, Socrates (or anyone) *uttered* the words he did.

The Communicative Model of Action

Speaking of this, Habermas (1991) posits that:

> 'Only the communicative model of action presupposes language as a medium of uncurtailed communication whereby speakers and hearers, out of context of their preinterpreted life world, refer simultaneously to things in the objective, social and subjective worlds in order to negotiate common definitions of the situation' (Habermas, 1991: p.95)

It is Habermas's contention that a speaker, whose aim is to reach an understanding, will relativise his utterance within a framework of understanding (life world) that integrates all three world concepts and, that he will do so, conscious that his claims to validity will be tested against a background of mutual knowledge and understanding. And, that it is against this background of understanding that speakers and hearers will judge the *truth,*

right and *sincerity* of an utterance made, and to which they take up a 'rationally motivated position' (Habermas, 1991: p.99).

Importantly, this implies a relationship between speaker and hearer that is both reciprocal and immanent:

> 'Reaching an understanding functions as a mechanism for coordinating actions only through the participants in interaction coming to an agreement concerning the claimed *validity* of their utterances, that is, through intersubjectively recognizing the validity *claims* they reciprocally raise' (Habermas, 1991: p.99).

This approach signals a distinct shift in emphasis and one which insists that the *position*/perspective of an other is implicit in the determination of utterance meaning/understanding - a notable absence in both Grice and Searle's subjective/intentional-semantics. Speaking of this in terms of the 'perspectival relativity of human cognition' and its relation to language and meaning, Rommetveit (1990; p.90) posits that:

> '... in order to decide whether what is asserted about any particular state of affairs is true, we must in principle first identify the position from which it is viewed and brought into language' (Rommetveit, 1990: p.89).

A conclusion that is captured by Habermas when he claims that:

> (a) 'a *validity claim* is equivalent to the assertion that the *conditions for the validity* of an utterance are fulfilled'.
> (b) 'the permissible reactions are taking a "yes" or "no" position or abstaining'.
> (c) 'these "yes" or "no" reactions to *power claims* are themselves the expression of *arbitrary choice*' and that 'such positions are the expression of *insight or understanding*' (Habermas, 1991: p.38)

Returning to dialogue (2.1) above the meaning/function of Socrates dying words might now be tested by reference to the speech act(s) they *imply* and the validity claims they raise:

> (e) *'Crito, we owe a cock to Aesculapius'* would be heard/should be read as a constantive if, '[Socrates] refers to something in the objective world, and in such a way that he would like to represent [this actual] state of affairs'.
>
> 'The negation of [this] utterance [would] mean that *H* [Crito or possibly some other] *contests* the validity claim raised by *S* [Socrates] for the proposition stated.'
>
> (f) *'Pay it therefor and do not neglect it'*: would be heard/should be read as an imperative if, '[Socrates] refers to a desired state in the objective world, and in such a way that he would like to get *H* [Crito or possibly some other] to bring about this state of affairs'.
>
> 'Imperatives [of this type] can be criticized only from the standpoint of whether the action demanded can be carried out, that is, in connection with conditions of satisfaction. However, refusing imperatives normally means rejecting a claim to power; it is not based on criticism but itself *expresses a will*' (Habermas, 1991: p.325).

Alternative readings of the text are possible if, and only if, the validity claims raised are rejected - that is, if the claims to truth and power they suppose are rejected by their hearers (note here Habermas's insistence on 'power' as the determining sociological concept rather than 'right', which he previously implied). That these speech acts are not immediately rejected, is evidenced in Crito's response:

> (g) *'It shall be done'*: would be heard/should be read as a future commitment if, '[Crito] refers to something in the common social world, and in such a way that he would like to establish an interpersonal relation recognized as legitimate.'
>
> 'The negation of such an utterance means that *H* [Socrates and those others present and attending] *contests* the normative rightness claimed by *S* [Crito] for his action (or for an underlying norm)' (Habermas, 1991: p.326).

Interestingly, it is a matter of historical record that Socrates considered the payment of this particular debt extremely important, for instance in *Plato's Republic* (Waterfield, 1994: p.7-8/*Plato's Republic 330d-331b)*:

> (2.2) Socrates: 'What do you think is the greatest benefit you've gained from being rich'.
> Cephalus: 'Something which many people might find implausible ... You see, Socrates, when thoughts of death start to impinge on a persons mind, he entertains fears and worries about things which never occurred to him before. ... I mean, the possession of money has a major role to play if one is to avoid cheating or lying against one's better judgement, and also avoid the fear of leaving this life still owing some ritual offerings to a god or some money to someone'

On this basis, it is reasonable to suppose that if Socrates believed that he, or someone else, owed such a debt and he wish it paid. It is equally unlikely that his friend Crito would doubt his plausible claim to power (right) and not wish to bring about his desired goal.

Habermas/Searle

The emphasis that Habermas places on interpretation, empathy and negotiation is clearly very important, but it is also evident that there is a similarity between his account and Searle's, in-as-much-as, Searle's three conditions - Tables (2.1) & (2.2) above, might just as easily substitute for the three validity claims raised in (e) to (h). For his part, Searle (1993a: p.93) has no doubt: Habermas's validity claims 'are all strictly derivable from [his] account of the structure of assertions'. The three sorts of conditions in question are specifically:

> 1 The essential condition on assertion. A statement is a commitment to the truth of a proposition - *truth*.
> 2 The sincerity condition. In making a statement the speaker expresses a belief in the truth of the proposition expressed - *sincerity*.
> 3 The preparatory condition. The speaker is required to have evidence or reasons for a statement - *right (or power)*' (Searle, 1993a: p.93).

Further more, Searle posits that Habermas's validity claims do not stand prior to the conditions he specifies for illocutionary acts, or indeed substitute for them, but rather, are their consequence. However, this apparent agreement shades to nothing when set against Searle's belief that an utterance owes its meaning/understanding to the representation of certain states of affairs and that its meaning/understanding is dependent on knowing under what conditions it is true. A thesis Habermas (1993: pp.17-29) vigorously contests when he posits that: 'most speech acts are not about the existence of states of affairs' (ibid: p.21).

Larrain (1994) attemps a conciliatory note when he suggests that there is something in both these claims:

> 'the orientation towards reaching understanding does not stand in opposition to egocentric calculations between several individuals ... the distinction should be a matter of degree, whereby in purposive-rational actions 'the calculated pursuit of individual interests predominates over considerations of reciprocity' whereas in communicative interaction 'the orientation to reciprocity based on mutual understanding is decisive' (Larrain, 1994: pp.132-133).

However, whilst he effects a partial reconciliation between these two powerful perspectives, he also foregrounds their essential difference, that is, the degree to which participants in interaction are required to negotiate a meaning/understanding by way of the validity claims raised. A difference that Mühlhäusler and Harré (1990) insist,

distinguish a speech action from a speech act:

> 'Searle does not see, according to Habermas, that there must be a 'building of consensus'. We have expressed the same point in our insistence that a speech act proper only exists when the avowed intention of the speaker is completed by a display of uptake by the presumptive target. ... Searle lacks the important distinction between speech action and speech act' (1990: p.41).

Problematic, though, is the reflexive nature of accounting which is implicit in Habermas's account - one which appears to render any reasonable reading of an utterance plausible. In this sense, both Gallup, (1990) and Burnet, (1900/1911) might claim to be right. But, Habermas is more cautious, it is not simply a matter of recruiting one's own insights and understanding in some arbitrary way, but doing so, by reference to the thematic segment of the life world negotiated by participants in talk. Nor is it appropriate to neglect 'the complexity of reason effectively operating in the life world, and restricting reason to its cognitive-instrumental dimension' (Habermas, 1985: p.197)[6].

> 'In arguing that the process of rationalization in the area of communicative interaction consists in the expansion of communication free from domination, Habermas is linking rationalization to the overcoming of ideology. If communicative rationalization means the elimination of power-relations which are concealed in the very structures of communication and which prevent real conflicts from becoming conscious and regulated by genuine consensus, then rationalization in this area means the overcoming of systematically distorted communication, the defeat of ideology' (Larrain, 1994: p.134).

Habermas's theory of communicative action does much to assuage the earlier criticism of Searle's description and definition of speech acts. First, he stipulates that subjectivity and intentionality do not stand prior to the language system in use, though, intriguingly

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[6]The readers attention is drawn to the type of discourse analysis this position describes - one which grounds the meaning/understanding of an utterance in a context of talk indexically referenced by that talk (see chapters eight and nine this volume).

he retains the concept of initial subjectivity himself - (see Agacinski, 1991 for a more comprehensive discussion of this issue):

> 'This concept of *communicative rationality* carries with it connotations based ultimately on the central experience of the unconstrained, unifying, consensus-bringing force of argumentative speech, in which different participants overcome their ***merely subjective*** views and, owing to the mutuality of rationally motivated conviction, assure themselves of both the unity of the objective world and the intersubjectivity of their life world' (Habermas, 1991: p.10/my emphasis).

Second, his classification of speech acts by reference to intersubjectivity and validity claim entails that a hearer's contribution to utterance meaning/understanding is a constant that cannot be ignored in any rational communication[7].

Summary

This chapter briefly explored the limits of interpretation imposed by the intentional semantics of Grice and Searle and the opportunity for intersubjective communication invited by Habermas's *Theory of Communicative Action*. In the former, the speaker's intention of meaning/understanding (subjectivity) is privileged over that of hearer's, in the latter, both speakers and hearers negotiate a meaning/understanding on the basis of the validity claims they each reciprocally raise.

Interestingly, whilst, Grice (1957; 1975) and Searle's (1969/1990; 1994) subject centred paradigms of intentionality do much to undermine the communication that can be

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[7]It follows, that if the hearer doesn't agree the validity claims of a speaker there has been representation, but not necessarily communication (cf. Searle, 1969/1990). Given, that this is the case person-centred therapy is no more than that - a representation of meaning/understanding.

achieved in person-centred therapy - essentially, to the representation of speaker meaning/understanding, Habermas's intersubjectivist paradigm of communicative action does much more and suggests an inevitable, if unintended, complicity between participants in the realisation of the meanings/understandings they intend. Whether, they agree it or not, person-centred therapists actively contribute to their clients' meaning/understanding (see chapters eight and nine, of this volume, which do much to support this claim).

In the next chapter Davies' and Harré's (1990) concept of *positioning* is introduced as a natural complement to Habermas's intersubjectivist paradigm of communicative action and also as the premise on which the discourse analysis used in this research activity is based.

Chapter 3: Positioning

> (3.1) ... nothing is in its own right, but is always being generated in some relation ... We should [therefore] adapt our speech to the way things are, and describe them as undergoing generation, production, destruction and alteration. In fact ... speech which suggests stability is easily refuted. And this is how we should talk' (Plato's Theaetetus 157ab/Waterfield 1987: p.40).

Introduction

In the last chapter (two) Habermas's (1991) theory of communicative action was posited as a challenge to the subjectivity of person-centred therapy and the communication this entails and it was argued that his intersubjectivist paradigm of communicative action insists that meaning/understanding (subjectivity) is always conditional on the *validity claims* raised by participants in talk. That, in effect, participants in talk must agree or disagree the meaning of the things that are said in the context of their mutual understanding.

In this chapter, the concept of 'position/positioning'[1] (Davies and Harré, 1990; Mühlhäusler and Harré, 1990; Harré and Van Langenghove, 1991; Harré and Gillet, 1994; Van Langenghove and Harré, 1993a; 1993b; 1994), is introduced as 'a metaphor to enable investigators to grasp how persons are "located" within conversations as observably and subjectively coherent participants in jointly produced storylines. The act of positioning refers to the assignments of "parts" or "roles" to speakers in the discursive construction of personal stories that make a person's actions intelligible and relatively

[1]There is considerable overlap in the use of these two terms, but position is taken here to mean a *tacit* state of meaning/understanding, whereas, positioning expresses an *intentional* action in relation to the positions taken up by others in talk.

determinate as social acts' (Van Langenhove and Harré, 1993a: p.82). Simply stated, position (subjectivity) is a speech act that raises validity claim that can be agreed or disagreed by participants in talk.

In this sense the concept of position/positioning offers itself as a form of discourse analysis to describe and interpret the explanations and/or accounts of mental health nurses and mental health patients talking about: mental illness (diagnosis/insanity ascription); the system/culture of care in which they are aligned; the relationships they have with one another; and the conversations they engage in, in person-centred therapy[2].

Position and Positioning Theory

Unlike Cartesian dualism, the concept of position/positioning defines subjectivity, not by the myth of mental entities, but by reference to actual conversations in which subjects are, or have been engaged. In effect, conversations provide the referential grid by which, and in which, self and other positions are made available. A view which stresses the constitutive force of discourse in the determination of utterance meaning/understanding, rather than the moral or institutional order of roles they may otherwise insinuate. Important to this conception is Davies and Harré (1990) claim that the:

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[2]'However, this does not suggest a simple speech act analysis which would limit the analysis of the function of conversations to little more than a 'fairly flat, utterance-level analysis which means to tease out some regularities in the way that people use various speech acts in their alternating turns at speaking' rather, it implies the 'action that talk does in uttering of discourse in certain ways and in certain circumstances' (Antaki, 1994: p.119).

> '... individual emerges through the processes of social interaction, not as a relatively fixed end product but as one constituted and reconstituted through the various discursive practices in which they participate. Accordingly, who one is always an open question with a shifting answer depending upon the positions made available within one's own and others' discursive practices and within those practices, the stories through which we make sense of our own and others' lives' (Davies and Harré, 1990: p.46).

Implicit in their account is the idea of a shared narrative - a story line whose linguistic form expresses the conceptual categories, social acts and social icons that make meaningful the talk in progress and, within which, a person's identity is located. An example of which is Plato's *Phaedo* - a rhetorical redescription of institutions and macro social events that positions both speakers and hearers in reciprocal recognition of the validity claims they each make.

Importantly, readers of this text are also positioned - by their own world view and by that of others. Where others, might be those characters in the text whose view they espouse, or experts, such as Burnet (1900/1911) and/or Gallop (1990), whose prior reading and interpretation of the text determine meaning/understanding for them. In this way, multiple readings of the text are made both possible and plausible.

Position as Self and Other Identity

Position and positioning theory stand close to the heart of the social constructivism paradigm of life-span identity theory (Gergen, 1985) and, as such, do much to capture the essence of this tradition - a tradition which Merleau-Ponty (1986) mirrored, and Bakhtin (1992) gave voice to when he said:

> 'when the listener perceives and understands the meaning (the language meaning) of speech, he simultaneously takes an active, responsive attitude towards it. He either agrees or disagrees with it (completely or partially) augments it, applies it, prepares for its execution, and so on. And the listener adopts this responsive attitude for the entire duration of the process of listening and understanding' (Bakhtin, 1992: p.68)

Social constructionism rejects the subjectivism of the Romantic's and the objectivism of modernity, in favour of a theory of subjectivity defined in terms of reflective social interactions. Subjectivity is no longer something 'waiting to be discovered or uncovered [as person centred-therapists imagine].... but is found in the different kinds of linguistic practices articulated now, in the past, historically and cross culturally' (Potter and Wetherell, 1987/1992: p.102).

From within this ferment of past and present conversations, social constructionism posits, 'that all the other socially significant dimensions of interpersonal interaction - with their associated modes of being: either subjective or objective - originate and are formed' (Shotter, 1993: p.10). A perception that not only acknowledges the three world validity referent implicit in Habermas's *Theory of Communicative Action*, but also one that recognises the centrality of 'self-other dimension of interaction' in the formulation of utterance meaning/understanding (Shotter, 1993: p.10).

In Shotter's (1993) account the subjective and objective modes of being - the expressive and rational purposive actor world relationships, are only secondary or derived dimensions of being - the *'person-world dimensions* of interaction' - and he posits that:

> 'if we think of the main self-other dimension as a horizontal dimension, the person-world dimension can be thought of as orthogonal to it. Where what one

> is as a self includes the whole of one's diffuse, embodied being, while what one is as a person includes just those aspects of one's self for which one is able to be responsible, and answer for' (Shotter, 1993: p.24).

A view which provides a model of selfhood that does much to ease the tension that exists in what are essentially incommensurable accounts of continuous personal identity and discontinuous social diversity, by describing their essential paradox in the context of a discursive paradigm that is itself the generative force for both. The effect of which is to render to personal identity a set of spacio-temporal locations, and to social diversity the narrative possibility in which they might both exist and, wherein, they reciprocally contribute to each other's meaning/understanding.

Position as Voice

Contributing to this idea are the related notions of *genre* and *voice* which are implicit in the rhetorical redescription of institutions and/or macro social events and the responsiveness of social actors to each other in talk. Speech genres were described by Bakhtin (1992) by reference to their thematic content, style and compositional structure, three elements which he thought:

> 'inseparably linked to the *whole* of the utterance and [which] are equally determined by the specific nature of the particular sphere of communication. Each separate utterance is individual, of course, but each sphere in which language is used develops its own *relatively stable types* of these utterances. These we may call *speech genres*' (Bakhtin 1992: p.60).

More simply stated, speech genres describe a way of talking in a particular context of talk and are defined by the function of that talk, the conventions (construction and

permitted variations) of that talk and the allowable contribution of participants to that talk (cf. Bhatia, 1993). Having a *voice,* is learning how to talk in a particular genre of talk and, more importantly, learning how to be heard in that genre (cf. Parker, 1990: pp.189-204). Analytically, though, one may treat the idea of genre and voice as one and the same.

An important point to capture here is that the concept of *voice* is polyphonous - one which allows participants in talk to choose from an array of potential *voice(s)* in their contribution to talk - not least, to tell their story as others might tell it (cf Levinson, 1992)[3]. Traditionally, person deixis encodes the 'role of participants in [a] speech event in which an utterance is delivered: the category first person is the grammaticalization of the speaker's reference to himself, second person the encoding of the speaker's reference to one or more addressees, and third person the encoding of reference to persons and entities which are neither speakers nor addressees of the utterance in question' (Levinson, 1992: p.62)[4].

However, though, this register is important to the interpretation of voice and its relationship to the meaning/understanding intended, it is not without its problems and Mühlhäusler and Harré (1990) argue that pronouns are both situation-creating and situation-dependent and in this sense their analysis is often difficult - if not impossible.

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[3]Tannen's, 1992 notion of synchronic and diachronic *repetition* makes an important contribution to this idea - and is a feature of talk that emerges in the studies to follow.

[4]Not -with-standing the problems of pronoun grammar it is generally accepted that third-person referents are inter-subjective, but as McCulloch (1990: p.220) points out: 'It is a sheer, unthinking mistake to switch to the third-person perspective whilst uncritically carrying over the subject-centred orientation.' - the fact that people do adds to the complexity of language and the problems of deictic analysis.

Note for instance that in dialogue 2.1 Socrates uses what appears to be an inclusive *we* (which seems to be the pronominal hinge on which most interpretations swing) in his claim to owe a debt to *Aesculapius*, but it may also be interpreted in its singular form as simply egocentric.

Speaking of this particular problem Mühlhäusler and Harré (1990: p.57) posit that 'years of indexing, co-indexing and filtering do not seem to have led to a significant increase in our knowledge of pronoun behaviour.' In effect, pronouns are not simply 'basic' referential units of speech, but 'indicators of complex relationships between selves and the societies these selves live in' and as such, must be treated with caution and certainly never out of context (ibid: p.47).

Position as a Perspective or Viewpoint

Implicit, to the polyphonous concept of *voice* is the phenomenologist's conception of *perspective,* who posit the elegantly simple injunction that, 'from a subject's particular point of view an object is seen in those aspects that correspond to the given viewpoint' (Graumann, 1990: p.109; cf. Husserl, 1965; Merleau-Ponty, 1986). In effect, if we view an object from a certain position - vantage of understanding and identity, we will see it in a very particular way.

Graumann extends his analysis by emphasising the dynamic nature of the subject-object/*person-world* relationship within the 'thematic field' of inner and outer life-world experience: 'being related intentionally to an object in one of its aspects implies being

related referentially to further aspects of that object by a process of mental *locomotion* in a cognitive field' (Graumann, 1990: p.110).

That, contained in the actuality of subjective experience there inheres the potential for change in the perception of that experience; that, whatever might be known now, might be better known later by interaction and negotiation. Note, the similarity here between the intersubjectivist representation of mental *locomotion* and Vygotsky's (1992: p.187-196), *zone of proximal development*.

Both, conceive that a reciprocity of perspective carries with it the potential for individuals to shape and develop a meaning/understanding they can agree with others - an idea captured by Litt (1924) when he suggested:

> '... that within each 'perspective of ego' I as an individual am bound to discover 'objects' whose peculiarity it is 'to have a perspective of their own' and which, hence will have me contained in their perspective' (Litt, 1924: p.33).

Confronted, as it were, by this difference in meaning/understanding, 'one can fashion one's own "position" within the tradition (the argument), in the relation to the positions of the others around one' (Shotter, 1993: pp.8-9). Harré and Van Langenhove (1991: p.394) propose that positioning of this sort entails an orientation removed from the Newtonian/Euclidian space time referential grid and posit, in its place, a 'person-conversation referential grid.'

Person-Conversation Referential Grid

It is in this 'person-conversation referential grid' that who one is, or purports to be, emerges - not as the product of a social role oriented to the already in place (see Goffman's concept of footing, 1981 & 1986), but something one might wish to be, or is prepared to be, or is allowed to be, in a particular context of talk. Taylor (1994) puts this nicely when he says that being:

> 'a self is inseparable from existing in a space of moral issues, to do with identity and how one ought to be. It is being able to find one's standpoint in this space, being able to occupy, to *be* a perspective in it' (Taylor, 1994: p.112).

In effect, all conversations unfold to reveal a conflation of 'position, story-line and relatively determinate speech acts mutually [defining] one another' (Van Langenhove and Harré, 1991: p.401). Cast in this immanent frame of reference the Socratic dialogue (2.1) can be re-read to emphasise the importance of participant position(s) in the determination of its meaning/understanding. An analytical approach that is captured in Harré and Van Langenhove's (1991) idea of 'modes of positioning' and Mühlhäusler and Harré's (1990) related discussion on 'pronominal grammar' and the self other relationships this implies.

The former posits that a position is 'specified by reference to how a speaker's contributions are hearable with respect to [their moral and personal attribute]' (Harré and Van Langenhove's, 1991: pp.395-396). The latter, argues a general scheme of pronoun grammar for expressing the narrative voice - which, though, fulsome in its treatment also

recognises the limits of this interpretation.

Modes of Positioning - First, Second and Third Order Positioning

A first order position 'refers to the way persons locate themselves and others within an essentially moral space by using several categories and story-lines' and in so doing, invite others to agree the claims they make (Harré and Van Langehove, 1991: p.396). However, should these claims be rejected, then a second order position instantiates in the rejoinder that refuses the position offered. Importantly, in most institutional and/or moral orders of talk, no second order position is allowable and their practice achieves the status of ritual or convention. For instance:

> 'if Jones says to Smith: "Please iron my shirts", then both Smith and Jones are positioned by that utterance. Jones as somebody with the moral right (or as someone who thinks he has the moral right) to command Smith and Smith as someone who can be commanded by Jones. When such a positioning occurs, two things can happen. Smith can indeed do Jones' ironing (in that case Smith is perhaps Jones' servant) and the story will evolve without any questioning of the positioning. E.g., Smith can continue the conversation by saying: "Yes of course, which one do you need immediately?" But Smith can also object to what Jones said and answer something like "Why should I do YOUR ironing? I'm not your maid". We can imagine that in this case Smith is for instance Jones' wife. At this moment a second order positioning occurs in which the first order positioning is questioned and has to be negotiated' (Harré & Langenhove, 1991: p.396).

When second order positioning occurs the claims made by the first speaker will be challenged in one of two ways; as a second-part rejoinder in the ongoing conversation or, as is often the case, as a topic, in a later conversation, about the conversation in which the validity claims so made were questionable - this latter form of positioning is referred to as third order positioning. In both instances the positioning is reflexive and

accountive[5].

Tacit and Intentional Positioning

The positions invoked by a speaker are always intelligible at two levels of interpretation: one, they are tacit, that is, they are a function of a particular social role or social identity, expressed in a particular moral order of talk[6] or, two, they are intentional and represent some element of speaker agency that resists the position(s) offered by the other and counters it with their own. The former implies no misunderstanding of the position/positioning intended, whilst the latter clearly does. Speaking of this Davies & Harré (1990: p.57) describe how powerful/influential this situated interpretation is, when they describe the entrapment of *'Sano* and *Enfermada'* in a storyline that ultimately became a quarrel:

> 'Here two well disposed people of good faith and reasonable intelligence conversing in such a way that they were entrapped into a quarrel engendered in the structural properties of the conversation and not at all in the intentions of the speakers. He [*Sano*] was not being paternalistic and she [*Enfermada*] was not being priggish yet each was driven by the power of the story lines and their associated positions towards the possibility of such mutual accusations' (Davies & Harré, 1990: p.57).

Importantly, first order positions are always *tacit* acts of position, whilst, both second

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[5] Marková (1990: p.142) makes the same point when she refers to *initiative* and *response* sequences and argues that 'words and speech actions have a diagnoses and prognoses built into their meanings' and that 'even in the simplest dialogue there are always at least two perspective, that of the interlocutor A and that of B, both mutually co-developing in a dialogical interaction' (ibid: p.140)

[6] It is important to emphasise that *tacit* positions of the type described here are (in an idealised world) always immanent, mutable and negotiable - in effect, can be *done* in any number of ways and are clearly different from the representations implied by Searle's (1969/1990) speech acts. There is no absolute prescription of social role or social identity that carries into *all* talk, only the belief and/or understanding of individuals that it is *done* in the way they suppose - or others might insist..

and third order positioning are always intentional (argumentative)[7] in form.

Considered in these terms dialogue (2.1) above *might* now be read to realise an interpretation that emphasises how meaning/understanding is jointly produced and realised by reference to the speakers, audience directed intention - in essence, what Socrates meant to say, depends on how he and Crito (and possibly others) were positioned in the moral order of their talk - in essence how he heard it or was prepared to hear it.

Implicitly, first order, tacit position(ing) limits participants allowable contribution to talk to that which is permitted by their alignment to one another - the grammatical pairing of social identities, such as, interviewer/interviewee, or counsellor/ counsellee, which invariably insist that 'the rights of one identity constitute the duties of the other' (Levinson, 1988: p.174).

If the relationship between Socrates and Crito is construed simply in terms of revered teacher and faithful pupil (tacit positioning) then Crito's allowable contribution to talk is probably constrained by this inbuilt asymmetry. Cast in this light, when Socrates utters the words: *'Crito,* we *owe a cock to Aesculapius ...'* (an avowal carrying a request or possibly even a demand implying his position of authority), it is plausible to assume that he meant just that - that he and Crito (whom he refers to by name) owe a debt to *Aesculapius* and that he must pay it.

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[7]Argumentative implies no more than Toulmin (1991: p.11) intended: 'A man who makes an assertion puts forward a claim - a claim on our attention and to our belief ... the claim implicit in an assertion is a claim to a right or to a title' - a view which resonates entirely with Habermas (1991).

In contrast, intentional positioning is not constrained (as a pre-condition) by a moral order of talk, but describes a rhetorical tradition of argumentation that recognises 'the irresolvable, dilemmatic nature of our commonsense knowledge ... the fact that every way of speaking embodies a different evaluative stance, a different way of being or positioned in the world' (Shotter, 1993: p.13; cf. Billig 1991: pp.22-26).

Repositioned, (as it were) as trusted friends and fellow Pythagoreans it might be argued that there was no asymmetry in their relationship and no grounds to suppose that Socrates could count on Crito's sense of reciprocal duty to ensure the debt he thought owed was paid. In this instance Crito can refuse the position offered (servant/agent) and assert his own *singular* understanding.

But, this is conjecture and Socrates may have meant more than he actually said (and infinitely more than is inferred here (cf. Burnett, 1900/1911), but the important point to bear in mind is that meaning/understanding was never gifted to him alone, but was always immanent, mutable and negotiable in a moral order of talk that positioned him and others present and attending. In essence the limits imposed upon meaning/ understanding is always a function of the positions assumed or allowed by participants in talk

Summary

This chapter argued that the concept of position/positioning is a dynamic alternative to the more static concept of role (cf. Goffman, 1981 & 1986) - one which acknowledges

that the discursive construction of meaning/understanding and the subjectivity this will imply. In effect subjectivity is not a mental entity that can be unearthed by the sensitive probing of person-centre therapists (cf. Rogers, 1975), but is something carried in the discursive explanations and/or accounts of individuals and/or groups and, as such, can be agreed or disagreed - in effect, whatever people claim to be, is only what others will allow them to be.

Two categories of position/positioning emerged from this discussion: tacit positioning, which agrees that the meaning/understanding intended by individuals in their talk is a function of a particular social identity/relationship and (in relative terms, at least) is non negotiable. In this case people talk and position themselves in a certain way because it is the convention to do so. But, even in these ritualised speech events the position of participants in talk is not immutable and can be *done* in any number of ways - in essence, being a mental health nurse/therapist or mental health patient/client, isn't scripted, but created in the discursive explanations and/or accounts of individuals in particular moments of talk. In contrast, many speech events/acts are *intentional* (argumentative) - that is, they allow participants to accept, modify or resist the position(s) offered by an other.

Chapter 4: Method

> (4.1) 'I can't as yet 'know myself,' as the inscription at Dephi enjoins, and so long as that ignorance remains it seems to me ridiculous to inquire into extraneous matters . Consequently I don't bother about such things; but accept the current beliefs about them, and direct my inquiries, as I have just said , rather to myself, to discover whether I really am a more complex creature and more puffed up with pride than Typhon, or a simpler, gentler being who heaven has blessed with a quiet, un-Typhonic nature' (Plato's Phaedrus 230a/Hackforth 1996: p.478).

Introduction

Two discourse analytic methodologies suggested themselves for this research activity: the paradigmatic approach (Potter & Wetherell, 1987; Gilbert and Mulkay, 1982; 1984); and the narrative approach (Leudar & Antaki, 1996a; Billig, 1988). Whilst, the former attempts a logico-scientific understanding and explanation of a text - an essentially quantitative (averaging) analysis (cf. Gergen, 1982), the latter, argues a much *freer* interpretation of text based on an inductive, hermeneutic and qualitative inquiry (Rennie & Toukmanian, 1992).

Logico-scientific explanations adhere to a realist philosophical attitude - one which assumes that there is a world external to the observer that can be objectively understood. Not surprisingly, this approach to text analysis stresses the importance of valid and reliable measures of quantification; interobserver agreement on the indices of what are, or purport to be, the causes and effects of the meanings/understandings they describe; and, most importantly, the procedures they use to control for threats to the cause-effect relationships they claim.

In contrast, the narrative approach insists that the credibility of an explanation of a meaning/understanding of a text is always a matter of conjecture (cf. Burnet, 1900/1911; Gallop, 1990). It is a consensual approach that relies on the researcher's ability to convince the consumer that he/she has been even-handed in his/her investigation and that he/she is able to offer an explanation that is capable of being judged by the consumer as sensible and appropriate in the light of their own particular understanding of the phenomena under discussion (Giorgi, 1989; Billig, 1988; Rorty, 1979). In effect, that the consumer is able to agree the *position* the author has taken in his/her reading of the text.

To this end narrative researchers impose a meaning/understanding on the text that is framed by that segment of the life world that is the context of the talk it describes - in this instance, the discursive construction of madness and the competing positions this describes (chapter one, this volume). As such, validity claims are always an expression of the perceived accuracy of the intertextuality of informants talk in relation to the discursive ideology/ ideologies that is its frame.

In this regard, the expert knowledge of the analyst is always crucial to the meaning/understanding of a text[1]. Speaking of this, Billig (1988) disabuses the concept

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[1]Presumptuous, though it might appear, it is hoped that chapters one and two of this volume were an adequate preparation for the reader to be 'able to compute out of utterances in sequence the contextual assumptions they imply' to the analyst (Levinson, 1992: p.49). A position of understanding that captures something of Leudar & Antaki's (1988: p.155) concern that the limitations of their own analysis may have paid 'too little attention to the content of the conversation, the participant's roles, and the macro-structure of the interaction in general? The worry is [they say] is that by emphasising its formal character, we overlook the conversation's idiosyncratic flavour. We might also be losing sight of how an episode functions as a discourse, that is to say as a rhetorical display that has an implied or explicit social force' - which is the intention of this work. In essence, chapter one, was designed to prepare the reader for the descriptions and interpretations contained in chapters five, six and seven of this volume and chapter two, for the descriptions and interpretations contained in chapters eight and nine of this volume.

of scientific methodology in the 'analysis of everyday explanations' - discursive accounts, in favour of readings of texts that draw upon the 'scholarship' of the researcher and he argues that:

> 'Social scientific investigation is frequently presented as being based upon the following of methodological rules. However, [I] will recommend an alternative approach: that of traditional scholarship. The approach of the traditional scholar can be considered anti-methodological, in that hunches and specialist knowledge are more important than formally defined procedures' (Billig, 1988: p.199).

However, this is not to suggest the abandonment of scientific method in favour of the 'quirkiness' of scholarship (Billig, 1988), but rather is a reminder that the researcher is always aligned to the text under discussion from a position of knowledge and understanding that is itself part of its description. In this sense it emphasises not only the importance of working within the conceptual framework/repertoires of those persons under description - an emic analysis of talk, but also, working within the life world that is their experience - an etic analysis of the context of their talk (Fielding & Fielding, 1986; Silverman, 1993:p.24).

Problematic, however, for both the scientific method and the narrative approach is the unit of analysis their approach claims. For the scientific method whole texts and multiple texts can managed with relative ease by a process of reduction and averaging - despite the contradictions in the text this might ignore (cf. Eagleton, 1993). In effect, texts of variable size and often variable number can be reduced by a process of categorization and coding into 'manageable chunks' (Potter & Wetherell, 1987: p.167)

and it is the 'chunk' that becomes the unit of analysis[2]. In this way (often quite small) extracts of discourse can used as exemplars of a type of talk consistently or variably found in the text and in a way that is thought to be pathognomic to the person or persons (corpus) under description (cf. Schiffrin, 1987).

In contrast, the narrative approach - particularly as it relates to position/positioning in conversational discourse, demands a more inclusive approach - one which emphasises the individual, rather than the group. By definition a narrative is a story telling made meaningful in a particular context of talk by those individuals *doing* the talking and is not (in strict terms) reducible to the sort of averaging the scientific method would insist. In this sense, the unit of analysis can only be the story told by certain individuals in certain moments of talk.

However, a concession to this relatively arch (and impossible) position hinges on the polyphonous concept of *voice*, which argues, that when speaking, participants in talk will often speak for some absent other (ideology or agreed understanding) and that this is particularly true of institutional talk, where the 'motive, form and content' of a message is often *tacitly* agreed and determined by a source distant from the actual speaker (Levinson, 1988: pp.71-74; cf. Goffman, 1981). In this circumstance, narrative analysis will concede that when there is a similarity and/or consistency in individual story telling the most persuasive, radical, extreme or opinionated *voice* (position) will be heard. Not surprisingly, the discourse analysis adopted in this study was a narrative analysis - one

[2] A good example of this is Gill's (1990) *Ideology and Popular Radio: a discourse analytic examination of disc jockey's talk,* in which she reduced twenty-four hours of radio talk into a very small number of quotable instances.

which emphasised the construction and variation of person accounts, rather than just the *average* position they effected to describe. In principle, though, this approach accords with a standard also captured by Heritage's (1988: ch.9) three stages of analysis: (1) the inductive search for regularity; (2) deviant case analysis and (3) theoretical integration with other findings.

As reported in chapter one of this volume the research described below involved two separate, but linked empirical studies, entitled: *Acute Institutional Mental Health Care - A Contested Field of Self and Other Positions* (chapters five, six and seven) and *A Therapeutic Way with Words: Exploring the Interior of the Beginnings of Therapeutic Talk* (chapter eight and nine).

Aims of the Research Studies

The aim of the first research study is:

> to describe and interpret the *positions* taken up by mental health nurses and mental health patients in their talk about *mental illness (diagnosis/insanity ascription)*; the *system/culture of care* in which they are aligned; and the *relationships* they have with one another.

The aim of the second research study is:

> to describe and interpret the interior of the *beginning* of ten counselling episodes to discover how nurse therapists and their clients position themselves and others in their talk and to discern what sort of communication this intends.

To this end, ten mental health nurses and ten mental health patients were recruited to

the first study and ten nurses and ten mental health patients were recruited to the second study. Three nurses from the first research study also participated in the second study (informants M; N and G3).

The Location of the Study

Both research studies were conducted in two adjacent acute, psychiatric admission wards (wards X and Y) which were situated in the annex complex of a large 'Victorian', county mental hospital[3]. Ward X was a thirty bedded, single sex, male acute admission ward and ward Y was a twenty five bedded, single sex, female acute admission ward, which also incorporated a small eating disorder unit/clinic. Both wards shared the same medical staff and admitted from the same catchment area - a catchment area that included a transient population of holiday makers and seasonal workers. However, though similar in many respects (sharing many nurses from the same staff pool), ward X experienced a significantly higher degree of aggression and violence than did ward Y.

The annex complex in which these wards are situated is typical of the 1930's[4] new asylum build, much of which postured a villa design that was typical of the medical sanatorium of the day and, as-such, is situated on a hill a mile distant from the main

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[3]The hospital was subsequently closed in 1997 following the recommendations of the NHS & Community Care Act (1990).

[4]Following the 1930 Mental Treatment Act patients no longer had to be certified insane (cf. 1890 Lunacy Act) to be admitted and were admitted as informal or temporary patients with the right to discharge on request. To facilitate this new mood in psychiatry many county asylums provided purpose built accommodation to facilitate the needs of this new breed of patient.

hospital complex. Both wards have an open aspect with panoramic views of the surrounding rural countryside.

The annex complex is a distinctive unit that has a certain sense of its own specialness in relation to the main hospital complex - which was thought to be more 'typical' of a mental hospital. Relationships between staff and between staff and patients and also between the two wards was thought to be good (see chapter seven to realise the true position their relationships described). Interestingly, all of the nursing staff had been trained on site in a School of Nursing that was situated only two hundred yards away - in this sense, they presented as a homogenous, like-minded group of nurses, with a strong sense of group identity.

Permission to Conduct the Research Study

Permission to conduct this research study was obtained from the Director of Nursing Services, the four consultant psychiatrists admitting to the two wards in question and the hospitals Ethical Committee. This was greatly facilitated by the work the researcher was doing in the hospital at the time in his capacity as a senior lecturer in a near-by Higher Education Institution.

Method of Analysis

The method of analysis used in this research was an abridged version of Potter and Wetherell's (1987: pp.58-175) 'Ten Stages' of discourse analysis, but instead of the

categorisation and coding they use, a form of 'distributional accounting' (Schiffrin, 1987)[5] was substituted to identify those variations in informants' accounts that were sufficiently different from others to form the corpus of text used the final analysis. This modification to the process realised the following six stages of analysis:

- Stage 1: The Research Question(s)
- Stage 2: Sample Selection
- Stage 3: Data Collection - Interviews/Therapeutic Talk
- Stage 4: Transcription
- Stage 5: Analysis
- Stage 6: Report

Stage 1: The Research Question

Given the pressure placed on mental health nurses to work in a system of care that is pitched between two opposing positions - the medical model and social care model, it was thought timely to ask how they, rather than others, positioned themselves in relation to these complex and essentially incompatible discursive repertoires. Do they, as mental health nursing syllabi and a substantial body of professional opinion suppose (ENB,1982; ENB, 1989b; Duggan, 1997; Barker *et al.* 1997), possess the discursive ideologies (theories/storylines) to meet the aspirations of a social care model with its emphasis on client autonomy, empowerment and the essential legitimacy of their version of reality - their *subjectivity*. Or are they, as many would contend (Foucault, 1991; 1972/1994; Sedgwick, 1972; Szasz, 1994;1997) drawn by an impossible *institutional gravity* towards the exigencies of a medico-legal complex that sometimes

[5]Distributional accountability is a method of 'focus[ing] on the generalities within a relatively large corpus' of text material (Schiffrin, 1987: pp.19-20), rather than the particularities that occur in a smaller corpus of material.

appears more insistent on social control and its own *logocentric* medical discourse(s) than the rights of the patients it cares for.

The problem these two positions might pose the mental health nurse becomes even more acute when they engage (or are asked to engage) in therapeutic talk - a counselling/psychotherapy that both encourages and supports the client's version of reality, rather than any other - not least the medical version of reality that signalled their admission in the first place (HES, 1997; ICD-10, 1992; DSM-IV, 1994). In this complex form of communication, the question that arises, is, can they *bring it off ?* Can, they fulfill the aspiration of person-centred therapy, that is, not to intrude their own, or any other persons version of reality into their talk, whilst exposed to construals which are probably at variance with their own meaning/understanding of the events their clients describe - and, if so, what sort of interaction does this intend?

Stage 2: Sample Selection

The sample used was a convenience sample of mental health nurses and mental health patients/clients working, residing or attending wards X and Y[6]. In all cases, informants were recruited on a voluntary basis. All of the staff were Registered Mental Nurses (RMNs)[7] with varying degrees of experience. In the first study, six nurses were male and four were female. In the second study five of the nurses were male and five were female (see Appendix 1 & 2).

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[6]No discrimination is meant between ward X and Y in terms of the pool of Registered Mental Nurse's and patients/clients available for the study proposed.

[7]All future reference to nurses in this study will mean Registered Mental Health Nurses (RMN).

A single over-arching criterion governed the inclusion of patients/clients to both research activities and this was that they were not psychotic at the time of their interview or therapy, though they may have been diagnosed as such (HES, 1997)[8]. Similarly, a single over-arching criterion governed the inclusion of all clients to second research study and this was that they were already engaged in therapeutic talk of the type this research activity described with the nurses who were to be their partners. In the first study, six of the patients were female and four were male. In the second study six of the clients were female and four were male (see Appendix 1 & 2).

The total number of Registered Mental Nurses (RMNs) working in ward X and Y at the time of the study was 22. Of these, 7 worked in ward X and 10 in ward Y. In ward Y, 3 nurses worked specifically in the eating disorder unit/clinic[9]. In addition 5 nurses formed a small community team servicing the needs of both wards and having some in-patient responsibility for those patients/clients formerly in their care, or who were to be discharged to their care[10]. In ward X, 6 RMNs were male and 1 was female. In ward Y, 2 RMNs were male and 8 were female. The community nurses were composed of three female and two male nurses. Therefore, the total pool of RMNs available for this study was 22. The total pool of patients/clients available for this study at any one time in ward

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[8]This was a discrimination made easy by the fact that no patient/client diagnosed with a functional (enduring) psychosis was included in the study. Those who were diagnosed as psychotic at the point of admission (informants B, H, G4 & B3) were diagnosed as having a 'mental and behavioural disorder due to psychoactive substance use' (HES, 1997/ ICD-10: F1x0: pp.73-74) and were not intoxicated at the time of their interview or therapeutic talk.

[9]These three nurses were all employed on a part-time basis a factor which contributed to, but in no way decided, their omission from study one.

[10]The primary in-patient responsibility of these community nurses was patient/client assessments and counselling/psychotherapy.

X and Y was 65: 55 in-patient and 10 day/sessional patients/clients[11].

In study one, 5/7 RMNs from ward X were interviewed and this sample included the one female nurse working in this ward at this time (informant N). In ward Y, 5/10 RMNs were interviewed and this included the two male nurses working in this ward at this time (informants M & G2), but omitted the 3 nurses working in the eating disorder unit/clinic. In both instances the five nurses working in the community were also omitted from the sample[12]. Therefore, the sample drawn for this study was 10/22 RMNs, or 45% of the total pool available.

In study one, 5/30 patients/clients from ward X were interviewed and 5/35 from ward Y. Therefore, the sample drawn for this study was 10/65 patients/clients, or 15% of the total pool available.

In study two, 3/7 nurses from ward X participated, two male and one female (informant N), 4/10 nurses from ward Y (2 of theses were from the eating disorder unit/clinic), three female and one male (informant M) and 3 nurses from the community team. Of the 10 nurses interviewed in study one, only 3 (informants M, G3 from ward Y, and N from ward X) agreed to participate in this study. Once again the sample drawn for this study was 10/22 RMNs, or 45% of the total pool available.

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[11]Once again, no discrimination is meant (other than that already described) between the patients/clients in ward X and Y in terms of the total pool available for the study proposed.

[12]The omission of the 3 nurses working in the eating disorder unit/clinic and the 5 community nurses at this time was a pragmatic decision that simply reflected the researchers lack of 'working' contact with these particular nurses at the time of the first study and not a discrimination based upon some unstated concern that they represented a special or otherwise different 'group' of nurses.

In study two, 5/30 patients/clients from ward X and 5/35 from ward Y participated in the therapeutic talks. Therefore, the sample drawn for this study was 10/65 patients/clients, or 15% of the total pool available[13].

Stage 3: Data Collection - Interviews/Therapeutic Talks

In the first study, a semi-structured interview/discussion was used to explore informants understanding of the topics under discussion: mental illness (diagnosis/insanity ascription); the system/culture of care in which they are aligned and the nurse patient/client relationship. They were, as might be supposed, conversations contrived for the purpose of this study, which *tacitly* positioned participants, in an alignment of talk that the researcher did much to control and from a position (particularly in relation to the patients/clients) that was far from certain. They were, however, 'speech events' (Mühlhäusler and Harré, 1990: p.41) that were never intended to be disputational or consensual in terms of the validity claims they raised, but, rather, conversations that positioned both nurses and patients/clients in some describable and interpretative relationship to the topics under discussion[14].

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[13]An important point to bear in mind is that the choice of patients/clients participating in this study was negotiated by the nurses involved, all of whom were engaged with more than one client in therapeutic talk at this time.

[14]Though it was never intended, the researcher R's involvement as both interviewer and analyst in this first study is problematic and speaks of a flaw in the conduct of this part of the research, which, whilst it may have been predicted, could not have been avoided given the sensitivity these interviews invariably elicited in the minds of potential informants and the need there was to negotiate a *right of entry* into their lives grounded in their prior knowledge and acceptance of him. Problematic, is that R can be read to be leading his informants in the direction he apparently wishes them to go, an assumption that is refuted, but one that is recognised as a credible base from which to view these co-constructions of talk and the interpretations made.

In the second study informants were invited to participate in three therapeutic talks (counselling/psychotherapy), which, though, planned to meet the requirements of this research study, were a part of the (everyday) therapy talks nurses were engaged in with their clients at this time. In this sense, the conversations were more *real,* and the paired social identities of the participants more certain, than that which obtained in the first study, but they were identities, none-the-less, that were always thought likely to disagree in the positions they described - if for no other reason, than it is simply human to do so.

Recording Dialogues

All of the interviews and all of the therapeutic talks were conducted *off ward* in an occupational therapy centre which allowed the use of a small office. This office was a pre-fabricated, half-wood, half-glass structure, which had been designed to allow the non intrusive observation of patients attending the centre - consequently, the interior of the office was in full view of other patients and staff. This was thought to be particularly important for the female patients/clients who were reassured by the close proximity of familiar people.

In the first study the ten nurses and ten patients were interviewed by the researcher on just one occasion. This study took approximately six months[15]. In the second study the nurse counsellors (in the absence of the researcher) conducted three taped episodes

[15]A variety of factors conspired to delay these interviews, not least, the work activity and shift pattern of nurses and, also, rather more importantly, the need to screen patients/clients to ensure their participation did not compromise their care. In most instances, patients/clients found this activity a welcome addition to their day.

of therapeutic talk with a single client of their choice - this study, took almost a year. The delay encountered in this instance, not surprisingly, was due to the reluctance of some nurses (particularly junior nurses) and/or their clients to be tape recorded in talk that was always of a very sensitive and personal nature.

The 'risk' that staff and clients took with themselves (and sometimes others) was commendable and greatly appreciated - a measure of which, was the refusal of seven staff in the first study to be involved in the second - which was the original intention of this research activity.

Tape recordings were made using a portable Sanyo audio Compact Cassette Recorder (M112). Each interview/discussion and therapeutic talk lasted approximately 30 minutes (the duration of one side of audio-tape) and yielded a total of 10 hours of recording in the first study and 15 hours of recording in the second study. The audio-tape recorder was set to *play* prior to informants entering the room.

Stage 4: Transcription

The audio tape-recordings were then transcribed yielding between 17 and 25 pages of single spaced written text and generated an average of 5500 words per transcript. The transcriptions were then re-transcribed by the researcher using orthographic conventions attributable to Sacks, Schegloff & Jefferson (1974; cf Heritage 1992;

Jefferson 1984a)[16]. However, the problems of this sort of transcription process are well known and are comprehensively discussed in Brown & Yule (1991: pp.9-19) and Potter and Wetherell (1987: pp.163-165) - not least of which, is the time this process takes to complete. This second transcription took approximately 10 hours per tape recording and afforded a detailed first analysis of the text.

Stage 5: Analysis

Given the size of both data bases: study one and study two, some method had to be found to reduce the overall burden of the task of analysis - to squeeze an unwieldy body of discourse into manageable chunks whilst preserving the narrative analysis the study intended. In study one, the data base was first reduced to informants' talk about mental illness (diagnosis/insanity ascription), the system/ culture of care and relationships - a task made more difficult than it might first appear by the researcher's sometimes circumspect questioning of informants (particularly of patient informants) and their avoidance of, or elision away from, issues they clearly didn't want to confront. However,

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[16]Silverman (1993), Brown & Yule (1991: p.9) and Fairclough (1995: p.229) make clear that there can be 'no *perfect* transcript of a tape-recording' (Silverman, 1993: p.124) and that in general terms, discourse analysis (DA) works with 'far less precise methods of transcription' than conversational analysis (CA) (ibid: p.121). However, not-with-standing the relatively limited requirements of DA transcription to the 'isolation of a set of basic categories or units of discourse' (Levinson, 1992: p.282), the Sacks, Schegloff & Jefferson (1974) system offered a method of transcription that was as precise and well meaning in its attempt to accurately record the spoken text as any other explored by the researcher (cf. Silverman, 1994: p.118; Stenström, 1994: pp. vii & ix & Tannen, 1992: pp.202-204). But it was a transcription never intended to be read in a way that would satisfy CA analysts - the structural and sequential organisation of talk which 'ignores the orientations and motives of speakers' - though this is clearly a temptation and one which must inevitably generate alternative (sometimes micro) readings of the text (Silverman, 1994: p.125). Rather, it was to be read to 'show how discourse is shaped by relations of power and ideology, and the constructive effects discourse has upon social identities, social relations and systems of knowledge and belief, neither of which is normally apparent to discourse participants' (Fairclough, 1995: p.12). In this sense the analysis of position is grounded in the rhetorical redescription of macro-social events and/or biographies and not just, or with, an over-reliance on the *micro* features of that talk - turn alternation, pause, intonation, etc.

not-with-standing the difficulty this first discrimination posed, there still remained a significant (and unwieldy) amount of text that was unreportable in the terms the study proposed - which was intended to be a description and interpretation of individual informants texts.

Here, Mulkay's (1981)[17] view that variability of talk is the central plank of discourse analysis proved invaluable and the text was then searched for the most persuasive, radical, extreme and/or opinionated explanations and/or accounts - variations, which, though they appeared to be superordinary in the things they said, were never so different that they spoke of other things. This was a pragmatic activity that simply argues that in certain instances of talk - institutional talk particularly, there is likely to be a common view that supports the ideology and understanding of that group and wherein, the *loudest* voice - the one most likely to be heard, is the one most likely to amplify their consensus, or their difference.

To quote a little out of context - this first reading of the texts did no more than provide an opportunity to 'collect instances [of talk] for [future] examination' (Potter and Wetherell, 1987/1992: p.167) - instances, which were to give a first indication of the variations and similarities that were to be found in informants' accounts.

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[17]Mulkay (1981: p.170) argues that the search for variability has a number of distinct advantages: 'Firstly, one is no longer trying to use observable evidence to explain unobservables such as past actions or ideas in peoples' heads [positions they may or may not attest]. Instead one is concerned only with interpreting given documents or recorded utterances. Secondly, all the detailed inconsistencies between accounts which occur in all qualitative analyses cease to be specially troublesome as such, once one stops trying to get through to what really happened. Material which is utterly incompatible when taken literally, can nevertheless reveal a highly recurrent pattern of interpretation - as in the asymmetrical accounting for error.'

Having established the corpus of the units of analysis - essentially, the positions espoused by six mental health nurses and six mental health patients[18] in relation to some or all of the questions posed - the next step was to explore how, in these instances of talk, informants positioned themselves and others by: (1) reference to their avowals, their explanations and/or accounts and (2), the pronominal grammar they used to refer to themselves and others, both, of which were described and interpreted against a background of reading[19] that was the likely source of their meaning/understanding - that is, the discursive ideologies that purport to support or explain the medical and social care models they describe - here Billig's (1988) injunction to research having regard for scholarship is apposite.

At this point it is useful to be reminded that the concept of position/positioning is a metaphor for subjectivity that describes a conflation of ideas, that is:

- a rhetorical redescription of institutions and/or macro social events; biographies/autobiographies).
- a perspective of meaning/understanding that is occasioned by the talk in progress.
- a validity claim that can be agreed or disagreed - if agreed the communication is tacit, if not, it is argumentative (first/second intentional order positioning).
- immanent, mutable and negotiable
- polyphonous allowing speakers to speak for themselves, for themselves as others, or as others - as singulars and/or collectives, using a register of pronominal and/or anaphoric referents and proper names.

Ideas that don't necessarily *name* themselves in a manner convenient to the researcher, but ideas, never-the-less, that can *always* be described and interpreted in relation to the

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[18]Mental health nurses: informants M; G; G2; M2; G3 and N and mental health patients: informants B; H; L; J; J2 and M3.

[19]The term reading is used here in its most expansive form to refer to their mental interpretations of things and events.

positions they described[20].

In the second study a different approach to the choice of the unit of analysis was taken, one that was to *cut* the text, not by *variation*, but by what Rennie and Toukmanian (1992) have called the 'therapeutic episode or event'. The rational for this kind of approach to 'process' research into counselling/psychotherapy, is that talk of this type is made up of 'circumscribed number of important types of occurrences in therapy, each with its own parameters and ideal performances' (ibid: p.244) - none of which, though, might be coherent with any other (Eagleton, 1993). Speaking of this, Rice (1992) argues that:

> 'Our most central point was that, rather than assuming that a given kind of process has the same significance at any time in therapy, and thus sampling randomly from interviews, we recommend the segmenting of therapy into episodes in which a particular kind of clinically meaningful event seemed to be taking place' (Rice, 1992: p.17)

Such a clinically meaningful event in therapeutic talk is its 'beginning' which invariably signals the premise on which that talk is to be based and the set of identities participants in that talk are wont to deploy.

In this instance nurse counsellors were given the transcripts of all three counselling/psychotherapy episodes they had conducted and asked to choose a

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[20]The logic of this is straightforward: names will always impute a description, but a description does not necessarily impute a name (McCulloch, 1990: ch.8).

beginning[21] that most satisfied them in terms of the outcomes they intended - an approach that did much to involve them in the research activity and one which also offered an objective discrimination of the texts under description (Rennie & Toukmanian, 1992; Rice, 1992). Beginnings were marked by the opening to the topic of talk and then its closure - which was always marked by a shift in the topic of talk - a period of talk that never exceeded more than ten minutes[22]. These ten 'beginnings' were then analysed in the same way as in first study - by description and interpretation..

Stage 6: The Report

The report is presented in two parts: part one (chapters five, six & seven) and part two (chapters eight & nine). In both, the report is 'more than a presentation of the research findings, [they] constitutes part of the confirmation and validation procedure itself' (Potter & Wetherell, 1987/1992: p.172). To this end, the analysis and the discussion this entails are a *position* the researcher assumes in relation to the discursive data and the life world it purports to describe or support, that the reader will agree or disagree. In this sense, the extracts of talk presented are '*not* characterizations or illustrations of the data, they are examples of the data itself ... they are the topic itself, not a resource from which the topic is built' (Potter & Wetherell, 1987: p.173).

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[21]The term 'beginning' is amorphous in the context of an ongoing series of therapeutic talks and should be treated with some caution - recognising, that once begun, 'beginnings' of this type stand somewhere between the middle and the end of an indeterminate number of therapeutic encounters. Importantly, the process of 'beginning' new talk does much to reaffirm the positions that participants have conceived for themselves and others in their previous talk - positions they will use again unless persuaded otherwise.

[22]In their seminal work on *Therapeutic Discourse*, Labov and Fanshel (1977) analysed informants talk using 15 minutes of their psychotherapy session.

Summary

The method of analysis chosen for this study - a narrative, discourse analysis, is a complex and time consuming process of analysis that has rendered an unwieldy amount of discursive data into manageable 'chunks' to describe the complexity of self and other positions mental health nurses, their patients and/or their clients, describe in their talk about acute institutional mental health care and in their therapeutic talk with one another.

It began with an unwieldy data base consisting of idiosyncratic, often mundane and sometimes trivial and occasionally unintelligible accounts and has concluded with a set of reports (parts two & three, this volume) that offer a significant and sometimes worrying insight into the world of acute mental health care that is not always discernable from the outside - not least, from the vantage of the social care or medical model position.

PART TWO: ACUTE INSTITUTIONAL MENTAL HEALTH CARE - A CONTESTED FIELD OF SELF AND OTHER POSITIONS

Chapter 5: The Discursive Position(s) of Mental Health Nurses and Mental Health Patients/Clients in Talk Framed by the Topic Mental Illness (Diagnosis/Insanity Ascription)

> (5.1) '... That would be right if it were an invariable truth that madness is an evil, but in reality, the greatest blessings come by way of madness, indeed of madness that is heaven-sent' (Plato's Phaedrus 244/Hackforth, 1989: p.491)

Introduction

This first analysis describes and interprets participants' *self* and *other* positions in talk framed by the topic: *Mental Illness* (diagnosis/insanity ascription). Surprisingly, this turned out to be a problematic conceptualisation/categorisation for mental health nurses to make and one which highlighted significant differences in both their use and understanding of the term. Not surprisingly, though, given their centrality to practice, nurses were either positioned by reference to the social care model of mental illness/disorder, with its emphasis on *client* autonomy, empowerment and subjectivity - the mental illness is a *fiction* position; or by reference to the medical model of care, with its narrow definition and labelling of symptom complexes (Scheff, 1966 & 1975; ICD-10, 1992 & DSM-IV, 1994) - the mental illness is *real* position - or by some accretion and/or confusion of the two.

In contrast, the patient group were relatively homogenous in their meaning/ understanding of the terms used and, in part (at least) accepted their *sick role* (and the medical model this might imply) as a rational anchor from which to validate their

experience of trouble and/or distress, but they did so whilst *resisting*[1] its constraining influence. Their self positioning was, in every sense, an assertion of personal identity that made light of the symptom complexes and diagnostic categories that others ascribed to them.

Importantly, the patients in this talk (and also chapters six and seven to follow) never spoke as a collective - an erstwhile patient-group sharing some common understanding of their circumstance, but spoke only for themselves, in talk that was invariably marked by either first person or second person singular forms of address. However, the opposite tended to be true of the nurses whose deictic registers not only included first, second and third person referents, but also their singular and plural forms.

The Mental Health Nurses Position(s)

Typical of those nurses who espouse a social care orientation to practice - though emphatically more articulate and expansive than most - was informant M (extracts: 5.1, 5.2 & 5.3, below) who does much to capture the doubts and concerns of many mental health workers when he questions the very legitimacy of the phenomena under discussion.

M was one of two ward Managers/Charge nurses on ward Y interviewed in this study (see G3: extracts 5.9 & 5.10, below). At the time of interview he was aged about forty

[1]The term *resist* or *resistance* as it is deployed here refers to Goffman's (1986: p. 172) concept of *'secondary adjustments'*, by which he means: 'ways in which the individual stands apart from the role [position] and the self that were taken for granted for him by the institution.'

and had twenty plus years experience as a nurse, complemented by some 'in-house' training as a counsellor/psychotherapist - he had no formal academic[2] qualifications. He was an easy going man with strong views about everything - not least his relationship with his clients (see extracts' 7.11-7.17, particularly)[3].

In the following extracts of talk (5.1, 5.2 and 5.3, below) M accepts the position offered - that is, respondent in this occasion of interview/discussion talk, and he speaks confidently and consistently for himself and about others - his commitment to and responsibility for the things he says is invariably marked by first person self referents such as *I* or *my*.

Extract 5.1: Informant M[4]

01 R: ..... if we just kick off with mmm me
02 asking you about about your thoughts your
03 feelings about mental illness?
04 M: That was the question I was dreading
05 I suppose in that I'm torn between whether
06 it actually exists or not ( ) that's
07 one of my biggest problems - when the
08 words come - it's a bit like talking about
09 mental health you know it's difficult to
10 categorise actually what it means nobody
11 knows what it means -

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[2]Registration as a nurse is not an academic qualification, but a professional one.

[3]Potted biographies such as these were derived from field note records kept at the time of interview and are listed in Appendix One & Two, this volume

[4]Portions of the text are highlighted throughout this chapter and also in chapters seven, eight, nine and ten to improve reader understanding. The following conventions apply: the researcher R's utterances are highlighted in blue, respondents are highlighted in red. Personal deictic referents are highlighted in green.

Asked to say something about his *'thoughts* [and] *feelings about mental illness'*[5] (extract 5.1: lines 02-03, above), M responds (untypically for the nurse group) by saying that it '*was the question* [he] *was dreading* (line 04, above). It is an emotive response that hints at the dilemma, not to say the frustration, faced by many mental health workers whose definition of mental disorder is at odds with the prevailing medical-*illness* model, but whose practice is invariably described by its compass (the term *mental disorder* is borrowed with all its ambiguity from the *Mental Health Act* 1983: Part 1, Section 1, and is used throughout this chapter with the same *fuzzy* and imprecise meaning).

Importantly, it is also a first and very determined step in what was to be M's emphatic resistance to the medical model and what might be described as the *Proper*[6] practice of psychiatry (cf. Cixous & Clément's, 1986; see also chapter six: extracts, 6.1-6.4 & chapter eight: extracts, 7.11-7.17[7]) - a logocentric medical discourse he clearly disapproves of. He is, he says, *'torn between whether it* [mental illness] *actually exists or not'* (lines 05-06 below).

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[5]Note, particularly here, R's (mis)leading use of the term *mental illness* in the question posed in extract 5.1 below, which is reminiscent of Goffman's (1973: p.102) concept of 'betrayal-funnel':

> '... through words, cues, and gestures, [the informant] is implicity asked by the current agent to join with him in sustaining a running line of polite small talk that tactfully avoids the administrative facts of the situation, becoming, with each stage, progressively more at odds with these facts ...'.

This unintentional reflexive 'cueing'/positioning of the interviewee was repeated in the opening question to all nurse participants in this text of talk. Interestingly, it was never challenged directly though, M below comes very close to doing so - a fact which suggests it has a *common descriptive currency* in mental health services (see ch.4: p.102: footnote 14 for further discussion).

[6]In chapter one, this volume, the *Proper* relationship was described in terms of the 'arrogative dominance' of those who have power and authority over others (Fox, 1993). For instance, the dominance of a logocentric medical discourse which demands the *'Selfsame'* in all things, and whose *tithe* is the absolute compliance of those it treats (cf. Herman, 1991: pp.101-125; Maus, 1967).

[7]It is intriguing to note that M shifts from the first person singular *I* to the first person plural *we* when talking about relationships - chapter seven, this volume)

That M genuinely wrestles with the problem of *'its'* (mental illness's) existence is clear and he admits, in common with other nurses in this topic of talk, that he has difficulty in *'categorising actually what it means'* (line 10, above), but rather conclusively, that *'nobody knows what it means'* (lines 10-11, above).

Interestingly M acknowledges the hold the medical psychiatry has over him and admits that he is, *'quite willing to tell people what mental illness is and where it exists and point to the brain'* (extract 5.2: lines 13-15, below) and, if that were not enough, that he can *'intellectually describe what mental illness is and err pour out some kind of biochemical explanation'* (lines 17-19, below). There is a real tension (not to say contradiction) in M's account that is only partly assuaged by his conviction that experience alone leads him to believe that *'mental illness* [is] *more .. a social consequence than an actual condition as such'* (lines 25-26) - a social consequence which makes a liar of the medical model (see also extract 5.3 below).

Extract 5.2: Informant M

so I think that's the same for me with
mental illness - I'm quite willing to tell
people what mental illness is and where it
exists and point to the brain and such like
stuff but I still have trouble although I can
intellectually describe what mental illness
is and err pour out some kind of
biochemical explanation about what
mental illness is but I think at the back of
my mind I'm still not I'm still not sure - I'm
still not entirely convinced that it does
exist per se - when I look around and read
what I read and visit the wards I'm seeing
illness mental illness more as a social
consequence than an actual condition as

Note, that in pondering the very existence of mental illness M reiterates much of the moral high-ground that has been the bastion of the antipsychiatry/libertarian movement for the last thirty years - not least by those who contend that mental *illness* is a phenomena reinforced by those with a vested interest in its *existence* (Goffman, 1961/ 1986; Barrett, 1988a, 1988b).

Extract 5.3: Informant M

such - that leads to all sorts of err
problems for people that work in mental
illness service of course because you see
that the ( )medical model is still very
much to the fore and that and that people
seem to be having err err a good
existence out of err mental illness and
without the product being particularly
exciting - there's no shiny car at the end of
it except people's lives are mucked about
basically.

To add weight to his argument M claims that, *'people seem to be having a good existence out of mental illness'* (lines 31-33, above) - by which he probably means mental health workers (though some reference to mental health patients cannot altogether be discounted). He then deploys a quite powerful metaphor - the car (line 35, above), to draw a comparison between the work of the mental health worker (in the context of the medical model) and the lack lustre nature of the work he or she does, the *'product'* [is not] *particularly exciting'* (line 34-35, above) - *'there's no shiny car at the end it'* (lines 35-36, above), he says, *'except people's lives are mucked about'* (lines 36-37, above).

M's position is entirely consistent with Szasz (1962, 1994 & 1997) who attributes the

ills of the mentally disordered person to the psychiatrist who confuses the social problems of individuals with symptoms of an erstwhile disease. The argument that Szasz (1997: pp.92-98) deploys is straightforward: there is no such thing as an objective sign of mental illness, only behaviours construed (constructed) and pathologised as symptoms of disease. Further, he contends that there is no such thing as a literal symptom of mental illness only its metaphorical substitute - a substitute on which the practice of medical psychiatry is founded:

> 'In psychiatry, not only is the word *illness* used metaphorically and interpreted literally, but so also is the word *symptom*. This is crystal clear from the way we use what we call the two *classic symptoms of psychosis*, namely *hallucinations* and *delusions*. For example, unlike precordial pain, which may or may not point to coronary insufficiency, hallucinations and delusions *do not point* to psychosis; they *are* (the same as) psychosis' (Szasz, 1997: p.95).

Cast in this way the *service industry*[8] that M alludes to must always be seen as bogus and at odds with the aspirations of the social care theorists with whom he appears to align.

Inevitably, whilst many of the important insights of this highly enlightened movement, notably: the enculturation of patients/clients into dependent mental illness roles; the impact of *patient* shaping interviews; the use of documentary writings as evidence of disease pathology; and the sociopolitical functions of mental illness labelling (Barrett, 1988a & 1988b), have been blurred by the arch refusal of many antipsychiatry/

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[8] The notion of service industry derives from Goffman's 1986: pp.285 concept of a *personal service occupation,* which is founded on 'an expertness that involves a rational, demonstrable competence that can be exercised as an end in itself and cannot reasonably be acquired by the person who is served ... the ideals underlying expert servicing in our society are rooted in the case where the server has a complex physical system to repair, construct, or tinker with - the system here being the clients personal object or possession.'

antipsychiatrists/libertarians to concede that mental suffering/dysfunction, however it might be conceived (labelled and/or described), is neither a consequence nor corollary of the existence of mental illness services (Note particularly the work of Foucault 1961; Laing, 1967; 1990; Laing & Esterson 1970; Szasz 1962, 1973; 1994 & 1997 and Goffman 1961/1986, 1990).

The point they are wont to miss, be it intentional or otherwise, is that, in the absence of these services[9] the phenomena, no matter how it is named, remains. In contrast to M, informant G (extract. 5.4, below), asserts the primacy of the diagnostic categories that underpin the medical model of care (see also extract 5.5: lines 38-39, below), but interestingly disavows the admission policy of his medical colleagues - they, it would seem, are not admitting the *truly* mentally ill - certainly not as he would know them to be (extract 5.5: lines 51-52, below), but rather, something else besides. In doing so, he does much to undermine the credibility of the classificatory systems he would otherwise support (see ICD-10, 1992 & DSM-IV, 1994).

Extract 5.4: Informant G

20 R: ((Laughs)) Mmm what I want to know
21 is how you define mental illness?
22 G: How I define mental illness m m m
23 I'm not sure I do (.) its for the medics to
24 diagnose and me to treat
25 R: You're as bad as ((Name of
26 M: 5.1 -5.3 above))
27 G: ((Laughs))
28 R: But you must operate with some sort of
29 idea some sort of definition (.) how {else

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[9] The NHS & Community Care Act, 1990 and the Mental Health Act (Patients in the Community, 1995) did much to dismantle these services only for the government to concede this error in their *vision* for 'Modernising Mental Health Services 1999.

30 could you-
31 G: Well} I:I probably do (.) but I don't see
32 the point we've got twenty seven men on
33 the ward yeah three on sections (.) and
34 hardly any of 'em should be in here

Informant G, was a particularly interesting respondent, because, whilst he readily agreed to participate in this interview/conversation, he was invariably *argumentative* in his response to the questions asked - an evaluative positioning of self in relation to others that clearly captures much of what (Shotter, 1993: p.13) means by 'the irresolvable, dilemmatic nature of our commonsense knowledge.' However, he was for all that a very popular ward Manager/Charge Nurse of ward X (an all male acute admission ward) with both patients and staff and he had a physical presence that was entirely in keeping with the very disturbed environment he *managed*. His manner, though, despite his relatively young age, was altogether reminiscent of a type of paternal, custodial, institutional psychiatry, dominant in the period up to 1970 (cf. HMSO, 1968; Harries, 1978) - a manner which though pragmatic, was at odds with the therapeutic intention of 1982 Syllabus (ENB, 1982).

To begin, subject G adopted a simple, though rather woolly (if immanent) view of mental health/illness. G's start position was a simple, though understandable, prevarication, a claim, *'not* [to be] *sure that* [he did define mental illness]' (line 23, above) and to assert that it was for '... *the medics to diagnose and* [for him] *to treat'* (lines 23-24, above) - a distinction in role that he later uses to privilege his position over that of his medical colleagues, all of whom, it appeared, were acting in a manner more socially expedient

than clinically appropriate - the social care position exactly[10].

However, when pressed, G concedes that he probably does operate with some sort of definition of mental illness - it would be surprising if he didn't , but he does so reluctantly and by disavowing its importance - he '[doesn't] *see the point*' (lines 31-32, above) in the context of his current practice.

A practice which requires him as an individual to care for *'twenty seven men ... three* [of whom are] *on sections'* - note here, his elision from the first person singular to the first person plural when describing this circumstance - an inclusive use of *'we'* that appears to militate his responsibility in this regard and his dissatisfaction with the outcome (lines 32-33, above). Note that G refers here to patients detained under the *Mental Health Act*, 1983 - a curious linking/conflation of facts which apparently justifies the claim that, *'hardly any of 'em should be in here'* (line 34, above) - a reference which insinuates (though not explicitly so) something of the socially deviant and criminal propensity of some of the men in his charge. Men that Szasz, 1994 refers to as society's undesirables[11] (or *indigent*, 1994).

> 'Once established, the public mental hospital system turns out to be a method for warehousing society's undesirables' (Szasz, 1994: p.195).

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[10]Evidence of reflexivity and repetition are clearly visible as R forces G to respond to questions he would rather not answer: e.g. lines 28-34, 35 -37 & 47-52.

[11]It is instructive to compare Szasz's definition of indigent with the *Vagrancy Act* (1744) which was 'An Act to amend and make more effectual the Laws relating to Rogues, Vagabonds, and other idle and disorderly Persons, and the Houses of Correction' (ibib: p.139). Interestingly, though, *'Lunaticks'* are represented as something other than those titled in the Act (ibid: p.153).

Whether it was intentional or not G alludes to one of the central controversies in psychiatry - the status and diagnosis of persons with non-psychotic and/or non-neurotic disorders - the so-called personality disorder - a seemingly catch-all diagnostic label that has an imprecise legal definition (*Mental Health Act*, 1983: Section 1), though an expansive medical categorisation. Currently the ICD-10, lists upwards of fifty personality disorders which encompass the mundane, the criminal and the sexually bizarre (ICD-10, 1992: pp.198-224/F60-F69). In its turn, DSM-IV lists ten categories with a broadly similar compass (DSM-IV, 1994: pp.629-673). Szasz (1997: pp.109-112) confirms, though with obvious reservation, that the most frequently encountered mental patient in any psychiatric service are those 'persons suffering from a *personality disorder* '(Szasz, 1997 p.110).

> 'In short, although persons with personality disorders exhibit none of the criteria of mental illness ... they are nevertheless classified as suffering from a mental illness. Why? Because they are functionally disabled' (Szasz, 1997: p.110).

Extract 5.5: Informant G

R: You mean they're not mentally ill?
G: Not by the text book
R: Text book?
G: Yeah you know schizophrenia mania depression (1.5) that's what I was taught
R: So why are they in here ((he shrugs his shoulders)) somebody diagnosed yeah?
G: Yeah (1.5) you want me to say who?
R: ((Laughs)) If you wouldn't mind?
G: Most of ours come from doctor ((name omitted)) clinic (.) {if not him then his registrar
R: Are you} mmm are you saying they got it wrong (1.0) most of the patients on ((name of ward omitted)) are not mentally ill?
G: I know what the labels mean but I don't

52 know what I see is what they see.

Asked to confirm that the men on the ward are not mentally ill (extract 5.5: line 35, above), G answers affirmatively, if obliquely, *'not by the text book'* (line 36, above) a position which aligns him rather more conclusively than informant M, above, to the anonymous voice of an absent medical authority, but one unknown to anyone but himself. To this end, G references *'schizophrenia*, *mania* [and] *depression'* (lines 38-39, above) as the archetypes of his definition of mental illness - all of which are psychotic (or potentially psychotic) conditions of vivid and/or sometimes really quite startling expression.

Note, that he ignores the disputed claim that schizophrenia is nothing more than a '*scientific delusion*' (cf. Boyle, 1990; Hacking, 1997 - see, also chapter eight: conversation two: extracts 8.15-8.22, this volume for an instructive account/insight of this particularly thorny issue), that it is a social construction apparently no more credible than the *indigents* he wishes to disavow and asserts that his medical colleagues operate an admission policy that is at variance with his own understanding of these diagnostic categories - *'I know what the labels mean but I don't know what I see is what they see'* (lines 51-52, above).

It is certainly the case that many of the patients admitted to G's ward did fall into the category of personality disorder (problematic though this category might be) - his ward having an over-representation of *functionally disabled* men - not to say the criminal and the violent, but it was also evident from the HES returns for the ward that these patients

were also diagnosed as psychotic or neurotic. G's position though undoubtedly medically oriented - his faith in the text book is undiminished by his experience - accepts the legitimacy of only certain categories of mental disorder, but not others. A far from unusual circumstance in the context of these interviews - a moral high ground no less formidable than informant M's.

Though they say it in different ways, both informant M and G say something similar - mental illness, as they perceive it to be in the context of their work, has little or nothing to do with the medical model of mental illness which specifies both symptom complexes and meaningful diagnostic categories. Rather, mental illness is a consequence of a person's social, lifestyle or family circumstances. For M, this is appears to be unproblematic, for G it is very much the heart of his concern - he, it would appear, aspires to a purity/legitimacy of medical diagnosis that is impossible to achieve.

However, whilst informant M is entirely persuaded by the validity of this (his own) argument, G is not. G concedes that people experience social problems: '*... if the world were a better place*' people wouldn't be admitted to mental hospitals (see extract 6.8: lines 198-199), but not the primacy of the social care model. Instead, he argues that '*the men [in his care] don't want to talk*' they '*want somebody to pay their rent buy their beer and smokes*' (extract 6.8: lines 199-206) - they have social problems, but not of a type that mental health services can or ought to be dealing with.

It is interesting to note that The Sainsbury Centre for Mental Health: *'Pulling Together'* (Duggan, 1997), makes a similar point:

> 'Conceptually, the notion of severely mentally ill individuals as people who have severe and persistent disabilities that result primarily from mental health problems is well accepted. But agreement as to the specific diagnostic categories, the nature and degree of disability, the length of illness and the relative importance of each has been harder to arrive at. It appears that a consensus about a definition of severe and enduring mental illness is still in the process of evolving' (Duggan, 1997: p.20) [12].

and is one that recalls the concerns of Sir William Lobjoit who cautioned that the introduction of a category of informal (*voluntary/temporary*) patient would lead to a malingering indigent population entering mental hospitals (cf. Jones, 1972: p.253; The Mental Treatment Act, 1930). A view, not surprisingly, that Szasz (1994) willingly agrees:

> 'The veil that we use to hide the truth of the human condition is psychiatry. If we lift it we rediscover the familiar fundamentals of existence, namely, that some people work and others do not, and that the business of psychiatry is distributing poor relief (concealed as medical care) to adult dependence (whose indolence and dependence are concealed as illness)' (Szasz. 1994: p.149).

At issue here, one might assume, is the role played by psychiatrists in mental health services, psychiatrists who appear damned if they do admit a patient to hospital with a 'diagnosis' of mental illness (informant M) and damned if they don't (informant G). An issue which is clearly underlined by informant G2: (extract: 5.6, below), who claims that the '*crux* [of the definition of mental illness] *is really when people are hospitalised or when they seek psychiatric professional help*' (lines 52-54, below).

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[12]The term severely mentally ill applies to all diagnostic categories of mental illness (see ICD-10 & DSM-IV) and not as might be supposed, psychotic illness. Note also, the unequivocal approbation the medical model receives in the use of the term mentally *ill* in this government sponsored report.

Extract 5.6: Informant G2

45 R: How do you define mental illness?
46 G2: (1.0) Mmm (1.0) mental illness (1.5) is
47 stress on the mental wellbeing that you
48 can't cope with mmm I think we all suffer
49 from mental illness at one stage or
50 another whether it be a bereavement or
51 something you've lost somebody in the
52 family but the crux is really when people
53 are hospitalised or when they seek
54 psychiatric professional help err it's come
55 to a point that they can't cope with it so
56 that's what mental illness is to me - to a
57 point (1.0) they are not able to-

G2, demonstrates very clearly the problem faced by many mental health nurses (workers), including M, above, who try to define mental illness in terms of the social care model - the two, though, mutually exclusive, are fashioned into a workable definition around the axis of medical psychiatry.

At the time of interview G2 was one of only two male nurses working on ward Y - the other being informant M. Once again, the conversation unfolds as a tacit formulation that casts G2 as the willing respondent to the question posed, but unlike M (extracts 5.1-5.3, above) - who was more certain of his position, he is more inclusive in his use of voice and he invites a sense of kinship with others by using the first person plural *we* and the second person plural *you* to describe the alignment he intends by his account in concluding the position he does (lines 47-48 & line 56 above). But note that his alignment to the victims of mental illness is short lived and begins to fracture (or so it would seem) when his pronominal grammar begins to separate him from his patients

(see lines 53, 55 & 57, above)[13].

In common with informant M, above G2 appears to anchor himself firmly to the social care model when he asserts that mental illness is defined in terms of *stress* and a failure to *cope* (lines 47-48 & line 55, above), but he argues that the unfortunate consequence of this experience is that people then engage (presumably because there is no other agency with whom they can) with psychiatric services/psychiatrist - who invariably (indeed must) diagnose their problems in terms of ICD-10 (1992) and/or DSM-IV (1994) diagnostic categories. The first stage of this process, it would appear, is entirely appropriate - normal one might assume, '*we all suffer from mental illness at one stage or another*' (lines 48-50, above), the second, apparently not.

G2's view is reminiscent of Freud's (1915/1917) assertion that 'a healthy person, too, is virtually a neurotic':

> 'If it is reasonable to assume that such [human] conflicts are universal, we are all sick in different degrees. Actually, the difference between anyone and a psychotic may lie in the way he handles his conflicts ... apart from extremes, there is no agreement on the types of behaviour which it is reasonable to call sick' (Freud 1915: p.457).

and, if the force of this were not weighty enough, Jahoda's (1958) equally arch position:

> ' ... we say that all people have mental illness of different degree at different times, and that sometimes some are much worse, or better. Now this is precisely what recent epidemiological studies have demonstrated ... Gone forever is the notion that the mentally ill person is an exception. It is now excepted that most

[13]This is an over-reading of the text at this point, but his self denomination becomes clearer in chapter seven (extracts 7.1-7.4).

people have some degree of mental illness at some time' (Jahoda,1958: p.13).

Szasz (1997: pp. 56-58), in typically abrasive style, is dismissive of the idea that mental illness is a universal to be suffered by all - that suffering, as G2, implies (lines 48-49, above) - is the criterion by which mental illness is defined. He is equally dismissive of the notion that unhappiness of the sort experienced by most people offers anything like a credible definition of mental illness. Or for, for that matter, the behaviours that are consequent on their suffering.

A rather different view was offered by informant M2 (extract. 5.7, below) - a male Staff nurse working for informant G on ward X. Though, a contemporary of G2 (they are similarly aged) M2 voices the more certain view that mental illness is defined in terms of *'psychotic behaviour'* (line 261, below). For him the issue is simply one of volition (an unresolved medico-legal issue since it was *first* muted as a consequence of the Mental Treatment Act, 1930): *'a person's actions are* [either] *controlled by the illness'* (lines 264-265, below), or not. Those who are not controlled by a (mental) illness are either *'normal'* (line 268, below), or they they are *'doing 'what we might call act- acting mad* ..... [they are] *responsible'* (lines 271-273, below).

Extract 5.7: Informant M2

258 R: What would be the strongest
259 indicators to you that somebody was
260 mentally ill?
261 M2: I think psy- psychotic behaviour.
262 R: There's a clear distinction there?
263 M2: There seems to be a clear - mine is
264 basically when a person's actions are
265 controlled by the illness in other words that

266 he doesn't do particularly what he wants to
267 do he seems to - you know he's err doing
268 things that are not normal and doesn't
269 particularly want to do them - whereas
270 another person would be doing what we
271 might call (act- acting) mad - he knows
272 exactly why he's doing it and he's
273 responsible-

Interestingly M2 references no other authority but his own when he claims that mental illness is a psychotic loss of control (lines 263-265, above) - a distinctly medical model orientation/classification, but he appears is less certain of himself when he deploys the pro-term *we* to give a collective, if *muted,* authority to the more controversial view that some patients are defined as mentally ill when, in fact, they are only *'acting mad'* - a sympathy of sorts with the concern expressed by the social care model that medical psychiatry labels people *ill,* when they are not, but from an orientation they would entirely disagree (line 271, above).

There might be a pragmatic utility in M2's position if it allowed the exclusion of all other socially questionable behaviours from the potentially stigmatising category of mental illness, but he doesn't. M2, quite simply means what he says - mental illness is to be interpreted as psychoses, the rest, however they might be defined (ICD-10; DSM-IV classifications or social and/or personal distress) are simply excluded. Mental illness is psychosis[14].

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[14]It is noteworthy, that the 1890 Lunacy Act of (para 341, p.246) defined lunatics (idiot or person of unsound mind) in much the same way that M2 has deployed it here - a catch-all, that attempts to exclude the possibility of error by the measure of *unreason - psychosis*. It wasn't until the passing of the 1930 Mental Treatment Act, that a distinction was drawn between persons of unsound mind (psychotics) and mental illness - where mental illness implies *reason* (para 2(3), p.205) - a paradox lost in history.

But M2's understanding of the term psychosis is deeply flawed if extract (5.8, below) is to be believed, wherein, he clearly uses the term *'cure'* (line 111, below) in the context of psychoses to refer to the complete restoration of mental health, rather than a more imaginative and sublime process of healing. But, to do so is also to imply that psychosis is a distinct entity, rather than the constellation of disorders that are encompassed by this category.

Extract 5.8: Informant M2

108 R:What do you mean by cure curing
109 people?
110 M2:Just that (.) they were ill and it was our
111 job to cure 'em
112 R: Cure 'em using what (.) drugs
113 counselling psychotherapy-?
114 M2: Yeah yeah drugs all that that's the
115 that's what the school told us and you
116 realise that none of that cures anything so
117 why worry I do the job and go home

In fact, both ICD-10; DSM-IV, clearly indicate the complexity inherent in the use of the term psychoses and the transient nature of many of these disorders . A complexity that M2's shorthand clearly over-looks. But more important than this, in one broad sweep, M2 then goes on to dismiss the therapeutic core of both medical psychiatry and person-centred therapy - drugs and/or counselling and/or psychotherapy and most importantly the collectives that espouse their use (see lines 110-11 & 115, above) and substitutes instead a compelling, if mysterious understanding/self definition that is captured in his claim: *'I do the job and go home'* (line 117, above).

It is difficult not to be disconcerted by M2's partial definition of mental illness, cast as

psychosis; exclusion of all other categories of disorder; and dismissal of both physical and psychological treatments; but it is a concern that more properly belongs to institutional psychiatry - which is so obviously pitched between two contrary and unresolvable viewpoints than any individual who might construe its confusion into an acceptable working argument.

Though she is more expansive in her use of the ICD classification - insisting that patients are *'neurotic or psychotic'* (lines 277-278, below) - informant G3 (extract 5.9, below) is equally vague when she argues that some of her patients are not mentally ill, but rather, have what she terms *'relationship problems that have made them unable to cope and depressed and anxious'* (lines 283-285, below) - a softer line than that taken by either informant G or M2 above, but no less inconclusive.

Extract 5.9: Informant G3

272 R: How would you describe mental illness
273 (.) how do you know when somebody is
274 mentally ill?
275 G3: (1.0) Well it depends what mental
276 illness they've got really whether it's
277 depressive illness or - a neurosis or - a
278 psychosis.
279 R: So you recognise those but are there
280 any - are are all of your patients mentally
281 ill?
282 G3: No there's there are patients with
283 relationship problems that have made
284 them unable to cope and depressed and
285 anxious.

The ambiguity inherent in G3's position (a very experienced and competent senior ward Manager/Sister with over twenty years experience) - though unmarked by any

personal reference is glaring - *anxiety* and *depression* that are not contingent on relationship problems are mental illnesses, whereas, those that are, are not! She classifies this group of persons as the '*worried well ... which could perhaps come across as mental illness*' (extract: 5.10: lines 318-320, below; see also chapter 9: conversation 10).

Extract 5.10: Informant G3

317 G3:From the none mentally ill - I suppose -
318 there's lots of worried well isn't there which
319 could perhaps come across as mental
320 illness but no I don't sort of diagnose in
321 the street.

The strain imposed upon G3's, definition is quite simply the result of her juxtaposing (as other of her colleagues are wont to do) two opposing models of *madness*: the social care model, that is, people experience problems in living/coping - but this is not to be construed as mental illness proper - and the medical model, which assumes an underlying disease pathology to explain the disorders it observes - which invariably includes problems in living/coping.

This problem occurs again when informant N, below, a female Staff nurse working on ward X argues a weak distinction between real and contrived mental illness. She begins (like informant G above - her boss) by recruiting the *'text book'* (extract 5.11: lines 142, below) to assert that mental illness is defined in terms of *'losing touch with reality'* (line 145, below; see also M2, above) - psychosis, but very quickly the definition becomes extended to include the *'depressed ..... after somethings happened'* (lines 147-148, below) - who may, or may not, be psychotic. These people, she contends

'*need a bit of help*' (line 151, below).

Extract 5.11: Informant N

139 R: How do you know somebody's mentally
140 ill - you yourself personally?
141 N: Personally - if they show signs of err -
142 you know the err text book sort of stuff
143 that they - you know (1.0) mmm to me you
144 know if they're sort of showing - sort of -
145 they- they're losing touch with reality that's
146 an ( ) mentally ill - or err somebody
147 who's depressed you know after
148 somethings happened to him - that's
149 somebody who's - got an illness in in err
150 that - you know there's something that's
151 happened and they need a bit of help with
152 it.

Summary Position 1

Though the nurses in this topic of talk aligned themselves to either the social care model or medical model of mental health and/or mental disorder the positions they attest are relatively loose alignments which allow a considerable variation in their meaning/understanding of the term mental illness (diagnosis/insanity ascription) - variations which they have severally defined as:

(1) Problems of living/a failure to cope: a person shows signs of suffering, distress and/or disability as a consequence of their chronically disadvantaged life (a non-biological state)
(2) Indigence - deviant/criminal/feckless/irresponsible: a person's (*abnormal*) behaviour is in some way diagnosable and committable
(3) A *normal* state: a person evidences suffering, distress and/or disability as a consequence of the apparently *normal* vicissitudes of life (the Catch 22, paradox; see Joseph Heller, 1961: *Catch 22:* - like Heller's anti-hero Yossarian, to be *mad* is really to be sane; see also Rosenhan, 1973: *On Being Sane in Insane Places*)

(4) The worried-well[15]: a persons anxiety or depression has no discernable social/interpersonal cause (there is an apparent failure to cope with self, rather than with life or others)

(5) Neurosis: a person's anxiety and/or depression has a discernable cause not necessarily attributable to 3 or 4 above

(6) Acting mad: a person asserts (intentionally) that they are mentally ill (when they are not), but are never-the-less diagnosable and committable (*'only a crazy person does crazy things'* : see Szasz, 1997: p.97)

(7) Psychosis - a person's perception, cognition, affect and behaviour are irrational (a biological state)[16]

In this regard, they have managed to capture most of the confusion apparent in medical diagnosis and insanity ascription at this time - a confusion which is as old as time (see Plato's *Phaedrus* 224), and one which Szasz (1997) captures precisely when he concludes:

> 'In examining the idea of mental illness, we must choose between two approaches and be clear about the premises built into each. One approach is to examine mental diseases as if they were bona fide (literal) diseases: in this view the class called *illness* comprises several subclasses, such as, infectious diseases, metabolic diseases, autoimmune diseases - mental diseases. The other approach is to examine mental diseases as if they were metaphorical diseases - that is, not diseases at all but only bearing the names of diseases: in this view, the class called *illness* comprises bodily diseases only - and only bodily diseases are (literal) diseases' (Szasz, 1997: pp.47-48).

Interestingly, though, their *confusion* - or possibly, their commitment to the positions they have construed for themselves and others did not appear sufficient (in all instances) to preclude the possibility that in certain circumstances (pressure of compliance), condition *one* of the social care model might not be achieved - assumption 1 (chapter one, this volume).

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[15]The term worried well is often used to refer to those who persons who worry unduly - who present with mild to moderate anxiety and/or depression.

[16]This ranking is not intended to reflect the order of their appearance in the text, but rather, a rank order in relation to the two models specified.

The Mental Health Patients Position(s)

It was informant G2, above, who claimed that the '*crux* [of the definition of insanity] *is really when people are hospitalised or when they seek psychiatric help*' (extract 5.6: lines 52-54, above) - a definition which might be more appropriately harnessed to define the category of mental illness/psychiatric patient than the category insane person - the two, though, invariably linked, are not necessarily the same thing.

In chapter one (this volume), the legal concept/definition of mental illness and *mental* patient was traced to the Mental Treatment Act (1930) - which was a much delayed and circumspect amendment to the Lunacy Act (1890). The Lunacy Act (1890), it will be remembered, restricted the admission of persons to county asylums to those who were deemed by petition; medical recommendation; and judicial authority to be lunatic, where lunatic was defined as an 'idiot or persons of unsound mind' (Lunacy Act, 1890: para. 341, p.105). Importantly, the category of lunatic has no modern equivalent, but was defined in the Mental Treatment Act (1930: para 2, 3. P.205) as a person 'incapable of expressing himself' - that is, a person who could not reason his/her own affairs.

Essentially, the Lunacy Act (1890) restricted admission/reception to county asylums to those persons who were thought to be psychotic in modern terms. However, the Mental Treatment Act (1930) changed this restrictive and ultimately damaging policy to allow 'Any person who is desirous of voluntary treatment for mental illness and who makes a written application for the purpose of the person in charge, may without a reception

order [founded on petition, medical recommendation and judicial authority] be received as a voluntary patient in an institution within the meaning of the act' (Mental Treatment Act, 1930: para.1(1), 23).

Two categories of patient were thus specified in the act: the mental illness patient and the patient of unsound mind. The distinction between the two, however, was only loosely defined in paragraph 2(3) (ibid: p.205) which states that 'If any person received as afore'said [a voluntary patient having a mental illness] becomes at any time incapable of expressing himself .... shall not be retained as a voluntary patient for a longer period than twenty eight days ... unless in the meantime he has again become capable of expressing himself, or steps have been taken [reception/certification] to deal with him either under the principal Act as a person of unsound mind or under section five of this Act as a person who is likely to benefit by temporary treatment.'

The distinction between the two is one of reason versus unreason and the category mental illness receives no clearer definition than this - a legal tradition that, though surprising, is current to this day (Mental Health Act, 1983. Part 1, para. 1(2)) - one which allows medical psychiatry a wide (though by no means unconstrained) remit to admit as it feels appropriate[17] [18]. Little wonder then, that informant G (extracts 5.4 & 5.5, above) should feel moved to disagree with his medical colleagues about the diagnostic status of patient admitted into his care in a manner that Sir William Lobjoit would

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[17]see The Bournewood Judgement, 1998.

[18]The government is planning a new mental health act and intends to substitute the term *capacity* for *reason* and it is muted that a form of judicial certification will be applied to patients in the community - a vestige of the Lunacy Act, 1890 that has been of the statute book for forty years (DoH. Mental Health Act Reference Group, January, 1999)

approve and for M, not to particularly care (see Jones, 1972: p.253) .

Importantly, Szasz (1997) points out that 'a person becomes a [psychiatric] patient *when* he defines himself, or when others define him, as a patient.'

> ' ... Specifically, for a person to become a psychiatric patient, two circumstances must come together: (1) an individual must make certain claims about himself or others must make claims about him - that is, he must designate himself or be designated by others as mentally ill; (2) a psychiatrist or judge must concur with this claim - that is, he must diagnose or validate the designated person as mentally ill' (Szasz, 1997: p.100).

In doing so, he also defines himself as *sick* - or more precisely - *as if he were sick* (Teresa of Avilla, 1577/Peers, 1946), a collusion with medical psychiatry that legitimates his *sick-role* - his need or dependence on others - and their license to diagnose and treat him.

Sick Role - A Means to an End

Frankenberg (1980: p.199) - after Fabrega (1973) and Kleinman (1978) - makes clear the distinction he sees between a person's experience of *illness* - the subjective experience of symptoms of disease - and *disease*. And he claims that Western curative medicine 'is predicated on the sequence - being *diseased*, feeling *ill*, involving healers in the legitimation and creation of *sickness* as a social state', but that the reverse invariably holds true. People, it would seem, present *as if* sick and the assumption of illness and disease then follow (Szasz's, 1997 point precisely).

That *sickness,* as a descriptive term, can be both crude and imprecise in its use, is evidenced by Burnet's (chapter two) claim that Socrates wished Crito offer a cock to Aesculapius to heal him of the sickness of human life - a claim which referenced no symptoms of bodily illness or disease, but rather, was an allusion to the *sickness* of the Athenian (social) state, one which had brought Socrates to trial and execution. A sickness which finds its ready parallel in modern times, and one which both the antipsychiatry/libertarian psychiatry movement and even the post moderns (see Baudrillard, 1983; Lyotard, 1984 & 1993), have sequestered for their own particular use.

It was Talcot Parsons (1951) who first coined the term 'sick role' to describe the sorts of behaviours that individuals, who suppose themselves to be sick, engage in, in order to facilitate their recovery. For instance they may absent themselves from work, or avoid social contact, or adopt an attitude of helplessness, which in its expression, invites others to care for them, or otherwise be responsible for them. The sick role is a potentially powerful role in a modern welfare state, bringing with it a privileged access to resources often denied to the well.

However, to be sick, at least in Parsonian terms requires a medical/psychiatric diagnosis - or a least the potential for such a diagnosis. A consequence of which is the situated subordination of the *sick* person in medical encounters - medical encounters which invariably privilege the *voice* of the doctor over that of the patient (Silverman, 1987). Importantly - and rather decisively, there is no equivalent to the *sick role* that is acceptable to a welfare cautious society and none that the social care theorists can

mobilise to the care of its client group. Put crudely, sick *benefit* is not an entitlement of those individuals with personal, family, social and/or lifestyle needs.

Whilst all the patients in this series accepted their diagnosis of mental illness/mental disorder as a fact of sorts - or at least, as a convenient (if sometimes crude) shorthand for their current experience of trouble and/or distress, they attributed both its warrant and intention to others. Exemplars of this were informants B; H; L and J below, all of whom demonstrate a marked *resistance* to their medical/psychiatric diagnosis and offer, instead, a description of their *problem state* which is at variance with the informed medical opinion. Typical of these, is informant B (extract 5.12, below). B, is an unemployed, middle aged man with a long history of diagnosed alcoholism and admission for treatment.

Extract 5.12: Informant B

05 R: Why- why were you admitted (.) can you
06 remember?
07 B: Drink problem (.) drinking too much
08 R: Drinking too much?
09 B: Drinking too much (.) yeah
10 R: Who told you you were drinking too
11 much?
12 B: Doctor ((Name omitted))
13 R: Did you think you were err (.) drinking too
14 much
15 B: I was depressed

Despite the fact that his HES diagnosis specified that his admission was due to his chronic alcoholism, B demonstrates a sustained resistance to his psychiatric diagnosis and substitutes instead the diagnosis of depression (extract 5.12: line 15 above & extract 5.13: line 34, below). Note, that his claim to be depressed is one of only two first

person references he makes in a talk that was always *intentionally* argumentative - a commitment to self understanding that is emphatically at odds with informed medical opinion. There is, however, a subtlety in B's positioning which is worthy of further comment.

When asked why he was admitted to hospital (lines 05-06, above) B is both clear and unambiguous - *'drink problem drinking too much'* (line 07, above). When questioned further, he confirms that he was indeed admitted because he was drinking too much (line 09, above), but when asked *'who told you you were drinking too much'* (lines 10-11, above) - an oddly phrased attempt to discern the source of this self denomination (that is repeated almost word for word in extract 5.13: line 26, below), he replies *'Doctor ...'* (line 12, above).

At this point one might assume that B accepts the *diagnosis* of his alcoholism as an accurate reflection of his pre-admission state, but when asked whether *he* thought he was drinking too much (lines 13-14, above) he refuses the position offered - an implied confirmation of his condition - and substitutes, instead, a primary depression as excuse for his *drinking too much*. Note that B does not deny his drink problem, rather, he reconfigures his position - if he has a drink problem it was caused by his depression[19].

B confirms the link between his drinking and his depression (Extract 5.13: lines 16-19,

[19]The concept of 'dual diagnosis' - that a substance misuse serves to mask a severe mental illness, is now well established in psychiatry and B's assertion of depression is probably reasonable. See Beishon (1996).

below), but when asked if he can account for his depression (lines 20-21, below) - the reason for his drinking - he replies *'no'* (line 22, below). In addition, B is apparently unaware of his depression, when he is depressed - (lines 23-25, below) - a not improbable circumstance, if his drinking affords him relief - but one that is also conveniently recondite.

Extract 5.13: Informant B

16 R: You were depressed?
17 B: Yeah (1.5) yeah
18 R: So you err err (.) started drinking yeah?
19 B: Yeah (.)
20 R: Why were err (.) do you know why you
21 were depressed {had err (0.5)
22 B: No} (1.0)
23 R: When you're depressed Ben do you
24 know you're err err depressed?
25 B: No
26 R: Who told you you were depressed?
27 B: Doctor ((name omitted))
28 R: Before that you just had a drink
29 problem?
30 B: I don't have a drink problem ((laughs)).
31 R: You don't?
32 B: No
33 R: Are you depressed?
34 B: Yeah

Asked, *'who told you you were depressed'* (line 26, above), B once again recruits the authority of his psychiatrist and again, it is his psychiatrist who tells him he is depressed - though, this time he accepts the fact this claims. Having now established the validity of his diagnosis of depression - an expert other says that he's depressed - he can effect the final positioning move in this encounter, one which leaves the threat of diagnosis of alcoholism behind and substitutes instead the more acceptable diagnosis of depression.

Remember, it was B (extract 5.12, above) who stated that the reason for his admission was his '*drink problem ...*' (line 07) - repeated again in line (9), but he now says, with great good humour, '*I don't have a drink problem*' (extract 5.13: line 30). In just a few moves B effects a diagnostic *volt face* - he is not the alcoholic he first appeared to be/was diagnosed to be, but rather a depressive who *once* drank. Here the shift in temporal register carried by the present tense assertion that - *'I don't ...*' appears to argue that the problem is now behind him - an emphatic *re*-positioning in relation to a discreditable denomination of past behaviour that is no longer an issue (see also informant L: extracts 5.6 below and informant H: chapter six: extract 6.14 for a similar form of past tense personal accounting).

But even this is questionable. What emerges strongly from this topic of talk (to be repeated in the remaining patient interviews in this chapter and chapters seven and eight to follow) is the situated and highly individuated nature of his accounting when interviewed by a relative stranger.

Taken in its entirety B's conversation functions to deny the contested and, apparently stigmatising mental illness label of alcoholism, and to substitute, instead, the more acceptable diagnosis of depression[20]. But there is also the sense in which B's position argues a resistance to a prevailing normative standard which insists on the uncontrovertible view of *professional* others. In this sense, his account is both appropriate and justifiable - one which Searle (1969/1990) - from an intentionalist-

[20]An equally valid conclusion might argue that B's resistance wasn't an attempt to qualify his diagnostic status in the manner R supposes, but rather resist the questions he posed which he may have thought trite and/or even stupid.

semantics point of view, would argue is commendable, because no belief was ever intended in others.

In a similar way, informant H (extract 5.14, below) uses this topic of talk to refuse the mental illness label of drug addiction that his HES diagnosis has assigned to him, preferring instead the muted diagnostic descriptor/symptom of hallucination as a more acceptable definition of his problem state.

Extract 5.14: Informant H

01 R: Mmm if if you tell me (.) when did you
02 know that you were unwell (1.0) did you
03 have any-?
04 H: It just came on all of a sudden.
05 R: Came on all of a sudden?
06 H: Yeah.
07 R: What?
08 H: I started hallucinating (.) I had a
09 feeling I wasn't well then (.) you know
10 because I started hallucinating
11 R: Did you did you know you were
12 hallucinating?
13 H: No (.) I couldn't say that no.
14 R: No (1.0) did somebody tell you that you
15 were err hallucinating?
16 H: I thought err that err I was in
17 anoth:another world at the time you know
18 (1.0) it was err a very strange err a
19 feeling

H's admission to hospital, unlike B, above was precipitated, not for the first time, by an acute psychotic episode brought on by his frequent *mis*-use of psychoactive drugs. H had a long history of multiple drug use/polysubstance dependence (cf: ICD-10, 1992: F19: pp. 70-83 & DSM-IV, 1994: p 270) which gave rise to an episode of vivid hallucination resulting in a period of quite remarkable violence and aggression. He was

arrested by the local police, admitted to hospital and later that same day compulsorily detained under Section 3, of the *Mental Health Act* 1983 - a detention order which allows for the assessment and treatment of persons who are mentally disordered and who are thought to be a danger to themselves or others, for a period of 28 days. Given the weighty legal implications of this Act, it might be hoped that its criterion for admission is precise in the extreme. Not so. In the *Memorandum on Parts* I to VI, VIII and X of the Mental Health Act 1983(1987) it states:

> 'The Act concerns the 'reception, care and treatment of mentally disordered patients, the management of their property and other related matters (Section 1(1)). The definition of 'mental disorder' is unchanged from the 1959 Act and it 'means mental illness, arrested or incomplete development of mind, psychopathic disorder and any other disorder or disability of mind' (p.4).
>
> 'The term '**mental illness**' is undefined, and its operational definition and usage is a matter of clinical judgement in each case' (original emphasis)(ibid).

What is interesting about H's talk is how he constructs his position from the resources both the questioner and psychiatry provide him - a position which describes his *sick* status, but not his drug addiction. When asked: '*when did you know you were unwell*' (lines 01-02, above) - a highly euphemistic (and soon to be repeated) interpretation of events - H responds by using the pro term, *'it'* (line 04, above) anaphorically, as a questionable trope for something as yet unspoken, but known implicitly to both parties, but, importantly, the *it* that H speaks of is not the period of drug taking that precipitated his psychosis, violent behaviour, arrest and admission to hospital, but, rather, his experience of *hallucination* (lines 08-10, above), which he describes as like being *'in another world at the time'* (lines 16-17, above) and *'it* [being a] *very strange feeling* (lines 18-19, above).

Importantly, neither *unwellness* nor *hallucination* are H's own terms - though the latter might at first appear to be - but are repetitions of words already used in this topic of talk and in another. Tannen (1992: p.98) describes the two forms of repetition H deploys as *synchronic* and *diachronic* repetition: '... repeating one's own words or another's words within a discourse. ... [or] repeating words from a discourse distant in time.' Both of which are used to 'establish [the] coherence and interpersonal involvement' of speakers in dialogue (ibid: p.48).

Extract 5.15: Informant H

20 R: But some one told you that you were
21 err hallucinating yeah?
22 H: Yeah Doctor ((name omitted))
23 R: Until then you were just taking {drugs
24 ((Smiling))?
25 H: Yeah (Laughs)} just taking drugs
26 R: Would you you describe yourself as err
27 err mentally ill ((Name omitted))?
28 H: (Laughs) No I take drugs
29 R: You're a drug addict?
30 H: I take drugs ((irritated))

H reflexively repeats R's cue that he was *'unwell'* (extract 5.14: line 02, above) to describe his psychotic experience and it was his psychiatrist's use of the symptom label, hallucination (extract 5.15: line 22, above) which allows him to extend this apparently neutral description of events even further. The effect of which is two fold, first, he is able to resist the likely claim that his behaviour was criminal or deviant and second, that he is either mentally ill or a drug addict (lines 26-30).

Asked if he would *'describe* [himself] *as mentally ill'* (lines 26-27, above), H is emphatic in his denial, *'no I take drugs'* (line 28, above), he replies - the two are clearly not

construed to be the same thing (line 28, above). *'You're a drug addict'* (line 29, above) R asserts, to which H replies, somewhat irritated, but with an absolute conviction, *'I take drugs'* (line 30, above).

The claim that H's period of hallucination was an *experience* other than mental illness (see Esquirol, 1832: Schneider, 1959; ICD-10, 1992; DSM-IV, 1994) receives some support from Leudar, *et al* (1997), who argue that:

> 'The experience of verbal hallucinations was characterized by the same dialogical structures one finds in ordinary speech and the activities regulated were most frequently mundane. ... All this is consistent with verbal hallucinations being a genus of inner speech. They are of course a rather odd kind of inner speech, because one hears it without speaking and the degree to which it is considered ego-alien is exaggerated' (Leudar, *et al*, 1997: p.896),

A view echoed by Stephens and Graham (1994: p.184) who suggest that verbal hallucinations are simply mis-attributions of inner speech. But, whatever the origins were of H's hallucinatory experience - phenomenological or pathological - it remains an open question as to whether his *drug taking* is a mental illness or not. That he should dispute this claim is entirely consistent with Coulter's (1987) belief that:

> 'Mental illnesses are not, where seriously ratified, first-person avowable states; in fact, it is customary to find them being ardently *disavowed'* (Coulter's, 1987: p. 58).

An interesting variation on this theme of resistance and/or denial of mental illness is found in informant, L (extract 5.16, below) who invites the questioner to make a judgement of her mental state based upon the information she readily provides - information, which taken at face value implies a level of disturbance consistent with

quite profound mental disorder - but one she will not accept.

Informant L, presented as an immediately likeable young woman: assertive, brash and with a quick sense of humour and a great deal of street-wise intelligence. But, she was also a young woman with quite profound, socially *problematic* behaviour. With long periods of hospital admissions behind her, this 24 year old appears to use psychiatry as a prop for a chaotic lifestyle that involves unstable romantic/sexual relationships, frequent alcohol and drug intoxication, aggression and violence, and more disturbingly, self-mutilation and para-suicide. But, whilst psychiatry provides a ready description of her problem state and a refuge from her troubles, L in no way concedes the mental illness title it assigns her.

Extract 5.16: Informant L

17 R: What brought you into hospital Louise?
18 L: Mmm (.) when I first came in I came
19 onto the adolescent unit in the hospital (.)
20 I was (.) suicidal (.) with self-destructive
21 tendencies and drugs drink and they
22 decided that this was the best place for
23 me- my behaviour wasn't socially
24 acceptable (.) so I came in:to ((name of
25 ward omitted)) and I spent four years
26 there

L's start position appears to be a diachronic repetition of what others have told her on some past (and probably often repeated) occasion of talk, and speaks not of the reason for her admission, but, rather the identity she has assumed and psychiatry confirms: '*suicidal ... self destructive tendencies ... drink* [and] *drugs*' (lines 20-21, above) - all medical/technical (and potentially pejorative) terms that give no clear

indication of her nascent problem state. Why was she suicidal, self destructive and using drink and alcohol as she did?

Interestingly, though L speaks in the first person, her commitment to the diagnostic categories she provides appears mute. Her telling of the reason(s) for her first admission gives the impression of a well rehearsed, almost scripted reminiscence of events and betrays no factual assessment of the embedded clauses it contains - did she for instance, truly and utterly believe herself to be suicidal? Whether she did or not others thought she was and it was *'they* ... [this unseen authority who] ... *decided that* [hospital] *was the best place for* [her]' (lines 21-23, above) and that her *'behaviour wasn't socially acceptable'* (lines 23-24, above) - an abdication of personal agency (her age was undoubtedly determinate) that hints more of her duress than any conviction that she was mentally ill.

Extract 5.17: Informant L

R: Did it make you better?
L: Better ((amused))
R: Somebody thought you err err should have been on ((name of the adolescent ward omitted))?
L: I wasn't sick I:I was I was cutting meself more and more and then I got pregnant
R: Why were you admitted to ((name of current ward omitted))?
L: ((Shows deeply scarred and recently wounded arms)) Same thing (1.0)
R: Are you are you err err trying to {kill yourself or or-
L: ((Irritated))} I do it (.) to feel better
R: (1.0) Are are you mentally ill Louise err err do you
L: ((Reveals more scars on abdomen and neck)) You tell me

45 R: D:do you think the hospital is the place
46 for you?
47 L: Where else is there?

L's resistance to the diagnostic categories psychiatry provides emerges rather more clearly in this next extract (5.17: lines 27 and 28, above), when she refuses the position offered by R - a claim (it would appear) that hospitals make you better. Her response is a subtle reflexive repetition of the word *'better'* (line 28, above) - better she asks, from what? The inference that she was in some way sick is not lost on L and when she is pressed a little further she responds with an assertive: *'I wasn't sick'* (line 32, above) and a declarative: *'I:I was I was cutting meself more and more and then I got pregnant'* (lines 32-33, above).

Though L's pregnancy is an important disclosure at this time, it is her self mutilating behaviour that provides the reason for her admission to hospital, but this is not to be construed as evidence of her apparent mental illness, but rather, something else besides. When asked if she was *'trying to kill* [herself]' (lines 38-39, above) - a possible (and indeed likely) outcome of her self mutilating behaviour, she replies that she does it *'to feel better'* (line 40, above), an indirect, but none-the-less definitive assertion that she was not an intentional suicide. Note how L uses the phrase to *'feel better'* in this instance, but not in the former - her admission to and treatment in hospital. Whatever L *feels better* from, it isn't a *sickness* as psychiatry conventionally defines it.

Importantly, L's self-mutilating behaviour ceased for a period of time coincidental with her pregnancy and the early infancy of her daughter, but resumed in quite dramatic

fashion when her relationship with the child's father came to an end. It was the end of this relationship which precipitated her most recent admission to hospital - now into its second year. Though, L, is highly dependent upon both social services (her daughter is in care) and psychiatry to alleviate her problems, she is clear in her own mind that, '*cutting*' herself is not to be confused with mental illness - what ever others might think, she isn't mentally ill. When asked, if her *'self destructive behaviour ... mental illness'*, she is sure it isn't - *'no'* she answers (extract 5.18: lines 67-68 & 71 below).

Extract 5.18: Informant L

66 ..... you use the term self-
67 destructive behaviour {(.) is that a mental
68 illness by your
69 Yeah}
70 definition?
71 L: No.

In similar fashion informant J (extract 5.19), below begins the interview with an apparent acceptance of her *mental*-illness label, but again, this was a misunderstanding she was wont to correct.

Extract 5.19: Informant J

01 R: You're a day patient Jenny is that right?
02 J: Yes
03 R: How long have you been coming in?
04 J: I've been- just over three weeks now
05 (1.5) do you want me to {say anything
06 more
07 R: If you} if you you would?
08 J: I'm agoraphobic and doctor ((Name
09 omitted)) and my GP wants me in for the
10 groups and so I can get used to travelling
11 to a from here that's why I'm here

J, is a thirty something, housewife with a long standing, if poorly treated agoraphobia. She had refused in-patient treatment (a resistance in itself) for several years and had only recently agreed to attend the ward as an out patient. Having been in 'therapy' before J readily agreed to the interview/conversation and showed signs of having *learned* something of the form of this sort of transaction from her previous encounters with psychiatry - note, for instance, how quickly J takes the initiative when she asks '*do you want me to say anything more*' (lines 05-06, above)) - a reversal of the referents that usually discriminate interviewer from interviewee in this type of situated *quasi* professional encounter.

Having, reconfigured her position and taken charge (as it were) J then offered a forthright, if marginal account of her diagnosis and treatment prescription (lines 8-11 8-11, above). In doing so, she readily confirmed that she had been receiving psychiatric help/treatment for *two years* (extract 5.20: line 14, below) and that her agoraphobia had been diagnosed by her GP some time before that (line 17, below). Asked what did she understand by her agoraphobia she offered a cryptic, but essentially accurate description of it in terms of: it's '*a fear of being out of the house ... I get anxious and upset shaking a lot ... even my hair's falling out now*' (lines 21-24, below) and when it was suggested that she '*sounded as if she had read a book*' (lines 25-26, below) she was appeared both pleased and amused (line 27, below).

Extract 5.20: Informant J

12 R: You've been seeing doctor ((ibid)) in
13 outpatients for some time Jenny yeah?
14 J: Yes for about two years

15 R: Was it doctor ((ibid)) who diagnosed
16 your agoraphobia?
17 J: No:o my GP ((Name of GP omitted))
18 R: What do you understand by
19 agoraphobia- Jenny do you know what it
20 it is what it what it all means?
21 J: Ye::s (.) a fear of going- being being
22 out of the house I get anxious and upset
23 shaking a lot (.) even my hair's falling out
24 now
25 R: ((Laughs)) Sounds like you've read a
26 book?
27 J: ((Laughs))

However, when asked: '*does it matter that someone's stuck a label on you and called you mentally ill*' (lines 28-30, below) - a less than tactful response to her candour (and one that appeared to unsettle her[21]), J refuses to *concede* that her undeniable agoraphobia is indeed a *mental illness*. Interestingly, though her response at first appears to be an odd conjunction of disparate clauses she, does in fact, manages to say three things really quite well: first, she confirms her illness status, *'I don't want to be ill'* (extract 5.21: line 31, below), but not her mental illness status (line 38, below) and, in so doing, also declares her lack of personal agency in this regard (cf: Szasz, 1997: pp. 60-61); second, she signals that she is a victim apparently no less deserving than someone with *'a heart disease'* (lines 31-32) - the metaphor she deploys is really quite powerful and should not be underestimated; third, she confirms her desire to *'get better'* (line 32).

[21]Brown and Levinson (1992) describe the sort of threat implicit in this remark as *'face-threatening'* and, wherein, face refers to an individual's *'self-esteem'* (ibid: p.2) - a feature of talk that emerges several times in chapters nine and ten.

Extract 5.21: Informant J

R: Does it does it matter that someone's stuck a label on you and called you mentally ill?
J: I don't want to be ill but if I had a heart disease I'd still want to get better
R: So the label the diagnosis just pins it down say's what's wrong with you
J: Yes
R: Do you- would you describe your agoraphobia as a mental illness?
J: No
R:How would you describe it
J: Agoraphobia.
R: A fear of going out
J: Yes

With a simple brevity, J has positioned herself as ill and no less wanting and/or deserving of care than anyone else - though, it is clear she does not mean mentally ill, in the sense that R has used the term. Asked if she *'would ... describe* [her] *agoraphobia as a mental illness'* (lines 36-37, above) she offers a categorical *'no'* (line 38, above) and argues a secular status for her agoraphobia, free it would appear, from any association with mental illness, but one that merits comparison with serious physical illness. Others, it would seem (R is clearly implicated here) might call her agoraphobia mental illness, but she does not (lines 36-42).

Summary Position 2

In what are highly situated and individuated contexts of talk the patients in this series showed a marked resistance to the attribution of their mental illness labels and did much to intentionally *re*-position themselves in relation to the diagnostic categories psychiatry (and R) were wont to give them, but they did so, whilst apparently colluding

with medical psychiatry for purposes that were not entirely clear - but to a degree which implicated the *sick-role* benefit they accrued from this. Importantly, though, when they spoke they spoke only for themselves and there was no instance when their use of the first person singular *I* became the plural *we*.

There was, however, a tension between their *personal* identity (if only marginally expressed in the text) and their situated *social* identity, which clearly signalled a potential for misunderstanding. A tension, it would seem, that does much to undermine the aspirations of social care theorists and the person-centred approach to care they posit. Mental health clients do not necessarily construe a complementary view of their troubles(s) and/or distress - assumption 3 (chapter one, this volume). A feature of their understanding that carries into the next chapter (six) when the topic of talk considers the *system/culture* of care.

Chapter 6: The Discursive Position(s) of Mental Health Nurses and Mental Health Patients/Clients in Talk Framed by the Topic the System/Culture of Care

> (6.1) Plato: '... let those who have been made what they are only from want of understanding, and not from malice or an evil nature, be placed by a judge in the Sophronisterion, and ordered to suffer imprisonment during a period of not less than five years. And in the meantime let them have no intercourse with other citizens except with the nocturnal council and with them let them converse with a view to improvement of their souls' health. And when the time of their imprisonment has expired, if any of them be of sound mind let him be restored to sane company, but if not, and if he be condemned a second time, let him be punished with death' (Laws: 908e-909/Taylor, 1996: p.1464).

Introduction

This second analysis describes/interprets participants' *self* and *other* positions in talk framed by the topic: *The System/Culture of Care*. A system/culture of care that is riven by a history not always complementary to its current purpose and one which is invariably challenged by the incommiscible mix of patients it serves[1]; the discursive medical and or social interpretative repertoires (theories/storylines) of its staff (cf. Alaszewski, 1986); and the control it must inevitably exert through both policy and legislation (Mental Health Act's, 1983 &1995).

The mental health nurses in this topic of talk were loath to admit that there was a system/culture of care to speak of (and, indeed, some nurses refused to speak of it in

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[1]Acute institutional mental health care does not discriminate its choice of patients beyond that which is defined (and not always so - mental illness having no legal definition, Mental Health Act, 1983) by HES (ICD-10 & DSM-IV) classification. A mix of patients that is captured, in part, by the differences observed between informant H (chapter five: extracts 5.14 & 5.15) and informant J (chapter five: extracts 5.19, 5.20 & 5.21) - see also same this chapter).

any substantive way), however, the majority of nurses argued that their work demanded an acceptable degree of patient control which, though muted in its expression, was both varied and illuminating in its tone and one that signalled an asymmetry of power and self understanding that militated against the *empowerment* and civil *rights* of patients in their care.

Two positions did emerge, however, to dominate this account: the first was a damning indictment of nursing colleagues and the system/culture of care they represented by informant M (extracts 6.1-6.4); the second spoke of the essential dishonesty of the system/culture and focused rather personally on the social care position espoused by informant M (informant G: extracts 6.5-6.8).

In contrast the patient group acknowledged the need for the control of professional *others* and argued a sympathy and understanding for the nursing staff that was largely unexpected and, more intriguing than this, an antipathy towards one another that was surprising, but it was also a perspective that emphasised the uniqueness of their personal experience of acute institutional mental health care - one that emerged in chapter five of this volume.

The Mental Health Nurses Position(s)

Informant M: (extract 6.1, below) adopts a relatively arch and unequivocal social care model position (see also chapter five, extracts 5.1-5.3, this volume) when he claims that the system is a place for the *'benefit of the people who work there'* (extract 6.1: lines

60-63), but not, as it transpires, for him - an *I - they* distinction he is wont to conjure in all of his talk.

Extract 6.1: Informant M

R: When you talk about the system what
what do you mean by the system?
M: The system.
R: The system?
M: I suppose I think that the system is
mmm the old definition of an institution
designed for the plea- pl::place for the
benefit for the people who work there - it
strikes me very much that the system is
err is built err- you can talk about patients
first ((Reference to the Patients Charter))
and stuff like that but I see little or no
evidence of that - I think most most of the
people - seems to me that most of (1.0)
most of the relatively senior people in the
system accept that it is there for their
benefit and their existence and that that
the the patients cannon fodder.

It is interesting to note that M almost said that the system was *'designed for the plea-*[sure] (rather than just the benefit) *of the people who work there'* (line 63, above) - a slip of the tongue no doubt - but one that signals, in a quite powerful way, the tenor of criticism to follow. A criticism that M uses to create the space/position from which the therapeutic relationship he espouses (and the social care model *it* describes) can work (see also chapter seven: extracts 7.11-7.17 & chapter eight: Conversation one: extracts 8.1-8.14, this volume). But can it work in the *'Empire of the Selfsame*[2] - that is, in a system of care so old in its attitudes. Cixous & Clément (1986) would argue that it can't,

[2]It will be remembered that this is the very powerful term that Cixous & Clément (1986) use to describe the enduring domination of social and/or institutional practices and wherein powerful logocentric (often phallocentric) discourses control the individual (see chapter one, this volume).

that in such a system, the *giving* of the *Gift* always carries a cost to the receiver greater than the gift given:

Having suggested that the system benefits the *'people who work there',* rather more than the patients it cares for, M goes on to dismiss the Patient Charter[3] (line 66, above) and implicates those in charge, stating that, it *'seems to me that most of the relatively senior people in the system accept that it* [the system] *is there for their benefit and their existence'* (lines 69-72). Interestingly (and rather, oddly given the pecuniary benefit he derives from his work), M excludes himself from this category of senior person - though, he holds the title of Manager/Charge nurse.

M reinforces his exclusion when he confirms the existence of a culture (extract. 6.2: line 118, below) and the fact that he stands *'outside the culture'* (line 120, below). If this were not enough, M uses a very powerful metaphor to drive his point/his position home - the patients he says, are *'cannon fodder'* (line 73, above) - a term generally deployed to refer to the expendable human material of warfare, but in this instance recruited to position patients as the detritus of a partisan system of care, of which, he is intellectually, if not physically, set apart.

M's perception of the *system's* view of the mental health patient is not unique (see Foucault 1961; 1977/1991; 1992; Szasz 1962; 1973; 1994; 1997; and Goffman 1961/1986; 1990) - the social care model's critique at its fulsome best, but it is certainly

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[3]The Patient Charter (1997) is a HMSO publication that specifies the rights of patients and the obligations of staff in mental health services. The right that M alludes to is the right to be consulted with regard to all aspects of care. Meeting Charter standards is always cited as evidence of good-practice.

at odds with the Code of Practice for Mental Health (1993) and the Mental Health Act (1983), which insist that patients admitted to psychiatric hospitals are always:

> 'Treated or cared for in such a way that promotes to the greatest practicable degree, their self determination and personal responsibility consistent with their needs and wishes' (The Code of Practice for Mental Health: p.2)[4].

If the system of care is as M describes it to be - and he clearly believes it is - it is emphatically at odds with the standards of care and *self determination* expected[5]. But, M says more, and argues that the culture is an *'echo of the medical model almost in that the patient are irritants to be tolerated in the search for one's pay packets'* (lines 122-125, below).

Extract 6.2: Informant M

113 R: If- would you would you say that the
114 hospital has a culture you talk about the
115 institution and you talk about the system -
116 the system the institution - is there a
117 culture that you could describe?
118 M: I think there's a culture - it sounds a bit
119 arrogant really when you talk err talk like
120 this but err I'm outside the culture - I think
121 the culture consists of mmm I suppose an
122 echo of the medical model almost in that
123 the patients are irritants err to be tolerated
124 in the in the in the search for one's pay
125 packets- I am very commonly aware of the
126 very low levels of tolerance and
127 misunderstanding about the motivations of
128 patients in here and that when their

[4]The inherent ambiguity in this statement is obvious, but the moral/ethical intention is clear with respect to the patient's right to self-determination - condition two of the social care model.

[5]Remember here that the majority of patients (90+%: HES 1997) in any mental institution are informal patients enjoying the same civil rights as any other person.

129 behaviour gets difficult for the nurse to
130 tolerate then err exclusion becomes the
131 err answer

Importantly, the culture M speaks of is not an intellectual formulation referenced by any medical/psychiatric theory or legal definition, but rather, is a culture defined in terms of the observed practices of his colleagues, who appear slaves to the *echo* of this once repressive system of care[6] - a system that he claims no membership (line 20, above). To make his point, M remarks, that he is *'commonly aware of the very low levels of tolerance and misunderstanding about the motivations of patients in* [the hospital] *and that when the behaviour gets difficult for the nurse to tolerate then exclusion becomes the answer'* (lines 125-131, above).

The idea that the medical model is in some way intrinsically bad has a considerable backing. Not least from Goffman (1961/1986) who talks of the *'vicissitudes of the tinkering trades'* (ibid: 281-336) - by tinkering trades he means those persons who provide a (*personal service occupation*) whether *'perfunctory* or *expert'* - not least of whom are doctors

> 'Our giving up our bodies to the medical server, and his rational empirical treatment of them, is surely one of the high points of the service complex. Interestingly enough, the gradual establishment of the body as a serviceable possession - a kind of physicochemical machine - is often cited as a triumph of the secular scientific spirit ...' (Goffman, 1961/1986: p.297).

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[6]The dominance of the physician in the State control of asylum's was first established with the passing of the County Asylums Act (1808) and the Madhouse Act (1828), both of which sought to ensure the humane treatment of patients through the proper regulation of a central standard. All subsequent legislation has reinforced their role in this regard, notably the Lunatics Act (1845); the Lunacy Regulation Act (1853); the Lunacy Act (1890); the Mental Health Act (1959); and, most recently, the Mental Health Act (1983).

Similarly, Foucault (1991) talks of the micro politics of medical power and how it dominates others by its institutionalised disciplinary practices - its *surveillance* and control of the body through inscription and medical meaning (ibid: p.93). Symptoms in medical psychiatry, though amorphous, are rendered specifics of disease by the sign they pretend. To *drink too much*; to *hallucinate*; to *cut* oneself; or *fear* the society of ones fellow man/woman is to incur the signifying meaning of the sign - alcoholic, drug addict, personality disorder, or agoraphobic (see informants B; H; L: & J, chapter five). All of which may have advantage to the individual, but not without cost to self:

> 'Medical examinations threaten [the] embodied self with untoward intimacies. The accoutrements of propriety are stripped away: I appear in nothing but my body. What follows has the structure of a transgression, an infringement, but one in which I am complicit. I disclose my body to the other, the stranger, the physician. To deflect this threat to the embodied self, medicine constitutes a separate realm in which the body as a lodgement of the self is transformed into the body as object of scrutiny: persons become patients' (Young, 1993: p.152).

It is this peculiarly impersonal treatment of the body which is the source of criticism of medicine in general and psychiatry in particular. Already stigmatised by their *illness* psychiatric patients are removed, either by choice or circumstance, from their place of domicile to hospitals which have a legislative mandate (Mental Health Act, 1983 & 1995) to control/constrain their behaviour to a degree which is often inconsistent with their sense of personal agency. It is this that M complains about, the fact that patient's expressive behaviour is seen as inappropriate rather than a symptom of their trouble and or distress (lines 125-132 above). The culture he says, *'is quite intolerant ... old fashioned really - it still lingers back you know twenty years ago'* (extract 6.3: line 147 & lines 149-151 below) - a formulation, that, if it wasn't already clear, he repudiates and distances himself from.

In the following extract (6.3) M makes clear the *old fashioned* distinction he sees existing between patients and staff and he uses a simple (though possibly misleading) metaphor to do so: the privilege accorded to *'staff cups* [in relation to] *patient cups'* (line 153, below).

Extract 6.3: Informant M

146 ..... the culture
147 seems to me to be quite intolerant really.
148 R: A culture of intolerance?
149 M: Yeah and of err of err of an old
150 fashioned really - it still lingers back you
151 know twenty years ago when err you know
152 - the culture is to do with the the tea tray
153 isn't it staff cups patient cups - its evident
154 every where you go - I can see it in the
155 hospital here-

His image has a familiar resonance and is one that speaks of the sort of sharing that is common-place in many social/institutional settings. Who for instance, would question the identity of the last person to use crockery held in common stock in a faculty common room. To do so, is to invite comment and possibly even censure - despite the many good reasons to the contrary.

But can his argument carry to the social mix of a mental hospital? M clearly believes it can, and he argues that when these barriers are broken down, *'rapid progress* [can be] *made'* (extract 6.4: lines 162-163, below). Taken at face value, he has a point, how can a therapeutic relationship/collaboration be developed if artificial barriers exist to prevent it? But, in reality, his argument appears less certain. Importantly, he takes no account of the many valid assumptions that determine the paired social identities that constitute

the position of both mental patients and mental nurse - not least, the spectre of social class - see particularly informant J2 (extract 6.17, below).

Extract 6.4: Informant M

and I::I think that when it's broken down
rapid progress is made - it becomes a kind
of err -this collaboration between the err
clients and staff rather this err this notion
that the patients often believe that we've
got a magical answer for their problems -
yet we're still many times still prepared to
continue or encourage that belief which
seems entirely ludicrous to me - I can't
accept that at all and the only - in my - in
my own work it is collaboration that leads
me where I want to go.

But this was never his intention. What is now revealed is the space/position promised by his earlier argument - that is, that there is likely to be greater trust and understanding when the category patient is transformed into the category client (line 165, above). Patients, it appears, *'often believe that* we've *got a magical answer for their problems'* (lines 166-168, above) and, rather more importantly, that *'we're still many times still prepared to continue or encourage that belief'* (lines 168-170) - an asymmetrical positioning in terms of power and supposed knowledge that is only traduced when these roles are collapsed to reveal a partnership of equals. Collaboration, he claims, *'leads me where I want to go'* (line 173). Note, here M's use of the first person singular in this last statement - his personal commitment is undeniable and his sincerity entirely plausible.

Note, in passing, that M introduced the pro-term *we* in (lines 166 & 168, above) to

suggest a collusion with others he had previously disabused, but he does so (or so it would appear) to draw attention to this apparent fallacy, rather than any personal commitment to it - 'to what he says, rather than, 'what he does' (Mühlhäusler and Harré, 1990: pp.173-175; cf. Torode, 1976: p. 93)[7].

In contrast, to M informant G argues that the psychiatric hospital functions as a refuge, a place of last resort, where, as Szasz's (1994: Part 1) is wont to describe it: society discards its unwanted, indigent population (see extract 6.8: lines 210-211, below for this particular reference)[8]. Viewed from this perspective the psychiatric hospital, as a system of care, does little more than provide a form of 'secular poor relief' - it is, in effect, a workhouse [9].

Extract 6.5: Informant G

R: It sounds like there is a real difference
between staff and patients err a them and
us is that- is that {err what-
G: There is} (1.0) you can pretend there
isn't but there is no one here meets up
with patients if they dont's have to err we
all do a job some just think that they're
different
R: Some of the staff- some of the staff
think they're different err err in what way

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[7]This is a good example of the fact that pronouns should not be read out of context - that they are not of themselves, an adequate explanation of *voice* and that their analysis/interpretation should be anchored to the things said - the story told.

[8]The reader's forebearance is invited with regard to this particular reference (which occurs again in the next paragraph) - the text of which, lies some distance from its first mention - importantly, though, the sequencing of these extracts drives a particular point and shift in the order of talk was not thought to be appropriate.

[9] See The Vagrancy Act, 1597; Poor Law, 1601; Vagrancy Act, 1714; Vagrancy Act, 1744 for a colourful interpretation of rogues, vagabonds and other idle and disorderly persons that G possibly alludes to).

172 G: ((Laughs)) You've met them
173 R: ((Smiles) Have I?
174 G: ((informant M)) he's one
175 R: ((informant M) ((laughs))

Like M, though, G also acknowledges the difference between patients and staff (extract. 6.5: lines 165-169, above), but unlike him, he sees this as a consequence of their personal disposition: *'no one* [he says] *meets up with patient if they don't have to'* - and rather more conclusively, *'we all do a job some just think that they're different'* (lines 166-167, above). Note, that he uses the integrative *'we'* to emphasise the *all* inclusive nature of his position and then, by way of emphasis, adds a second clause which suggests that those who think otherwise are less than honest: the job he concludes is to provide a refuge for patients, a place where they might *rest up'* (see extract 6.8: lines 208-211, below), but some staff [not to say M] believe themselves to be different - different, it would appear, in the sense that they think they can do more than he would contend is possible. The implication of their collective self deception is clear and one that G is at pains to avoid.

To do so, G makes a direct attack on the dishonesty he feels implicit in M's position (extract 6.6: lines 176-183, below) and, by so-doing, he disavows the social care model he espouses (extract 6.7: lines 184-196, below). M, he says, *'goes on about caring and therapeutic relationships and patient rights'* (lines 176-178 below), but this is *'only a front'* (in reality) he behaves no better than anyone else *'in a rough house'*[10] (lines 179-180 below). He concludes by suggesting that his approach (M's) is alright, *'if you spend*

[10]This is a *very* old fashioned term used by *some* mental health nurses to refer to a physically violent episode of patient's behaviour. Interestingly, G casts himself as a credible witness to this event and invites his addressee to believe it undermines M's position.

all day talking to women .. [with] .. *little girls who want their hand holding'* (lines 180-183 below)[11], rather than, one must suppose, the difficult male patients that populate his ward.

Extract 6.6: Informant G

176 G: ((M) he goes on about caring
177 and therapeutic relationships and patients
178 rights but that's only a front err err I've
179 seen the way he behaves in a rough
180 house alright if you're- if you spend all
181 day talking to women from ((name of ward
182 omitted)) little girls who want their {hand
183 holding

This is a barbed attack on M, but one that emphasises the central problem at the heart of the mental health services and the therapeutic intention it assumes: the classification of patients and the degree of *control* that is required to manage their individual needs. G makes clear that he has no time for the counselling role that M assumes for himself (extract 6.7: lines 184-196, below), but this is also a metaphor for the dishonesty he feels is implicit in a system which appears to vaunt a social care model approach: *'its what management like'*[12], he says (line 190, below), whilst ignoring the incorrigible/intractable nature of many of the patients it/he has to manage on a daily basis. Speaking of his own patients he asserts (probably with some degree of accuracy) that *'no amount of talk is goin' to get* [them] *sorted'* (lines 195-196 below).

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[11] M, it will be remembered, is the Manager/Charge nurse of ward Y, an all female ward.

[12]Management, as it is used here, is a vague term that captures no precise identity - rather, it appears to be an attitude of implicit threat conjured by the system/culture of care - see also informant G3 extract (6.10, below).

Extract 6.7: Informant G

184 R: Sounds} err sounds like you don't have
185 much time for counselling and err that
186 sort of thing?
187 G: No (1.5) ((laughs)) err you want me to
188 say why?
189 R: Yeah
190 G: Its its what management like and the
191 doctors- err the easy stuff gets a high
192 profile and ((M)) gets a posh
193 office but err err it's talk that goes round in
194 circles he couldn't work on ((name of
196 ward omitted)) err no amount of talk is
197 goin' to get the men on here {sorted-

When asked, what would [get them sorted] (extract 6.8: line 198, below) he replies, *'If the world were a better place'* (lines 199-200, below) and argues a pragmatic, if pecuniary picture of patients in need of 'relief' (lines 200-207, below). Once again, G aligns himself, if not by direct quote or reference, to the position taken up by Szasz (1994) who has argued consistently that the modern day mental hospital functions in a rather dishonest way to provide a form of poor law relief (see/compare with the Poor Law Act, 1601):

> 'Society's responses to poverty, unemployment, lawlessness, and craziness have thus merged in a vast quasi-therapeutic bureaucracy whose basic mandate is storing the unwanted' (Szasz, 1994: p.26)

Both M and G are tossed on the horns of a dilemma of some magnitude, one that has haunted the provision of mental illness services since the modern era of psychiatric care and treatment began - the distinction that is to be made between *madness, badness*

and *sadness*[13] [14], and the apparently increasingly elastic boundary of psychiatric diagnosis and service provision (The Lunacy Act, 1890 emphasised the legal control of the insane and the Mental Treatment Act, 1930 emphasised their medical control - neither of which sits comfortably with the other) - capturing this, Scull (1993) quotes Sedgwick (1972) and says that:

> 'The future belongs to illness ..., as the range of conditions subject to medical *control* and intervention is expanded, generating pressures to redefine various behaviours into medical and thus *controllable* pathologies' (Scull, 1993: p.392, in Sedgwick, 1972: p.220 - my emphasis).

Extract 6.8: Informant G

198 R: What would}?
199 G: ((Laughs)) If the world were a better
200 place maybe ((laughs)) (1.0) the men on
201 here don't want to talk they want
202 somebody to pay their rent buy their beer
203 and smokes that's all (1.5) there's no
204 talking them better (.) when they're in
205 trouble they come in here and when err
206 err the social have sorted them out they
207 want to go home
208 R: Sounds like all they want is asylum- a
209 place to rest up?
210 G: Yeah- what society doesn't want ends
211 up in {((name of hospital omitted))

It is clear from the preceding texts that both informant M (extracts 6.1-7.4) and informant G (extracts 6.5- 6.8, above) have strong reservations about the system/culture of care

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[13]This is an unfortunate euphemism, but it is much used and manages to capture the essence of the problem.

[14]Though, it is possible to slightly over-read the government's vision for *Modernising Mental Health Services*, 1999, there is a hint that their policy is beginning to blur this distinction: its intention, it says,'is to focus upon all those of working age who have mental health and associated social care needs, whether or not they have other disabilities, or additional problems of a medical, social, or behavioural kind' (ibid: p.9)

in which they work - though for very different reasons. For M the system is pernicious and apparently hostile to the *collaborative* work he wishes to do - a system he emphatically refutes, whilst for G, the system is simply self deceptive about its real function, as a 'warehouse' for society's indigent - a return in thinking, one might suppose, to Plato's Sophronisterion.

The paradox that besets them both is real and hinges on the apparently unreconcilable demands for untrammelled personal freedom and the demands of the state (through its many institutions) for something approximating universal conformity. Here, Hegel's (1892-6/1968 & 1979) conception of a *universal* subject(ivity) in conflict with an *individual* subject(ivity) is evident (see Habermas, 1994: p.40). In essence, Hegel claims that the *universal* subject is the embodiment of the state (cast as objective reason/ normality), whereas the *individual* subject is a singularity - an individual citizen of the state. Inevitably, when conflict arises between these two figures of self consciousness - as it surely must, 'it is the concrete absolute of the state [which always] receives precedence' (Holub, 1991: p.154; see Plato's *Republic*).

Problematic for psychiatry (and the mental health nurse) is the extent to which it is thought to collude with the state in the control and suppression of the individual and the 'indefinite criteria [it] employ[s] to identify and define mental illness' (Scull, 1993: p.391) as evidence of an *unreasonable* contradiction or resistance to its ideologies, rather than contributing to their freedom through its generosity, love, commitment and/or benevolence - the *Gift* relationship. Foucault (1977/1991b) is in no doubt that psychiatry does in fact collude in the suppression and control of the individual in what he famously

terms the *carceral* society wherein:

> ' ... the supervision of normality was firmly encased in a medicine or psychiatry that provided it with a sort of 'scientificity'' ... in this ... 'it was supported by a judicial apparatus which directly or indirectly, gave it legal justification. Thus, in the shelter of these two considerable protectors, and, indeed, acting as a link between them, or a place of exchange, a carefully worked out technique for the supervision of norms has continued to develop right up to the present day' (Foucault, 1977/1991b: p.296)

The issue of control so explicit in Foucault's position is developed in the following five texts of talk (extracts 7.9-7.13, below) and demonstrates something of the demand for *universal* conformity that has always been at the heart of the mental health institution. Historically, conformity was ensured by threat and/or violence, but this gave way in the early 1800s, to what was to become known as, the *moral* treatment of the insane (cf. Pinel's *Nosographie Philosophique*: 1798; Tuke's, *Descriptions of the Retreat: An Institution Near York for Insane Persons of the Society of Friends*: 1813) - or, as it really was, the better management of the insane.

Two factors became central to the *moral* treatment of the insane and both shed some light on the positions taken up by M and G: the first requires the classification of patients at the point of admission (diagnosis), and the second a ward system sensitive to their very particular needs (system/culture of care). It is the ward system that creates, 'an intimate tie between the patient's position in this classificatory system and his behaviour,' Scull (1993: p.170). In essence the ward system was developed to ensure that the most troublesome patients were properly located within the system of care - in effect, G has the most troublesome male patients, whilst M enjoys the privilege of (apparently) more manageable women. The effect of which was noted by Goffman

(1961/1986), who observed that:

> 'Whatever the level of the new patient misbehaviour, then, a ward can be found for him in which this conduct is routinely dealt with and to a degree allowed. In effect, by accepting the life conditions on these wards, the patient is allowed to continue his misbehaviour, except that now he does not particularly bother anyone by it, since it is routinely handled, if not accepted, on the ward' (Goffman, 1961/1986: p.361).

That the system/culture of care is, as Goffman is wont to describe it - one which argues for the *Proper* management of patients through forms of coercive control is conceded by the remaining nurses in this topic of talk. Interestingly, though, none of these nurses was willing to acknowledge a system/culture of care in any appreciable way - though, they implicitly acknowledged *its* control over them (see informants G2: extract 6.9; G3: extract 6.10 & M2: extract 6.12, below).

Asked to say something about control (extract 6.9: line 219) informant, G2 offered a pragmatic, if ultimately paternal view of the control he exerts over his patients when he stated that he tries to *'keep away from controlling people as much as possible'* (lines 220-221 below), but finds that, *'in running an actual ward then an element of control has to come into it'* (lines 221-222). His position, it would appear, is determined not by his personal disposition to control - he says it isn't, but by an organisational (not to say moral) imperative, which apparently insists that the needs of the many take precedence over the needs of the few. Note, that in this instance of talk he uses (as he is wont to do, see chapter five: extract 5.56) the second person plural of the pro-term *you* to capture the institutional/moral force of his argument and conjure the solidarity with others he intends - a sort of, we all do it, sense of position (lines 225 & 227,

below).

Extract 6.9: Informant G2

219 R: In your job you direct people?
220 G2:I try and keep away from controlling
221 people as much as possible but in running
222 an actual ward then an element of control
223 has to come into it it's much the same as
224 being a parent of three or four children in
225 order for all to have fair play you have to
226 have some sort of controlling (1.0)
227 atmosphere or a (1.0) you have to
228 exercise control over them otherwise one
229 wouldn't have fair play over the other.

G2's position in relation to the patients he cares for is compelling and one that he defines in terms of a parent-child relationship (line 223-224, above; see Berne, 1964 for the possible consequences of this complex form of *transactional positioning*). The analogy he makes between the family and the institution, though appearing benign, does much to characterise his working relationship with his patients, in whom he conceives a potential for *disobedience*, in the absence of what he describes as a *'controlling atmosphere'* (lines 226-226, above). But, he is emphatic: *'you have to exercise control over them'* (lines 227-228, above). Note here how G2 uses the person deixis *them* (intended or otherwise) to open up a relative distance between the position he espouses and patients he manages - mental patients, one must conclude, are a category quite clearly set apart from mental health nurses (this point is driven home in his later talk - see chapter seven (extracts, 7.1-7.3).

What he actually means by controlling atmosphere is unexplicated, but it is reasonable to assume that he is referencing, though somewhat obliquely, the rules and/or

regulations of the ward and/or the institution - the normative standard that is to be upheld: the system/culture of care. The indication that the individual is sacrificed to the group is evident - without the exercise of control, *'one wouldn't have fair play over the other'* (line 228-229, above). But what is the nature of the rules and regulations he alludes to?

It is interesting, that no where, accept in legislation (Mental Health Act, 1983, and then only in respect of certain categories of detained patient) does it state what a patient can or cannot do whilst in hospital, rather, there is a tacit assumption of their compliance, which is defined in terms of their willingness to be treated, rather than any censure or sanction that might otherwise be imposed - and this would be true of any type of hospital admission - one is usefully reminded here of the debate concerning the status of the *informal* patient that was developed in chapter one this volume - which recognised the fudge this really is.

The implicit nature of these rules and regulations emerges in extract (6.10), below, when informant G3 positions herself as the instrument of management - *'They'* (the hospital) rather than she, *'want a smooth running ship ... they want* [she says] *us to control the patient'* (lines 463-466, below), but interestingly, *they* don't provide *'orders about control'* (line 467, below). Importantly, G3 posits that there is an unseen controlling hand exerting a pressure of responsibility on the collective (of nurses) she variously refers to as, *'us'* and *'we'* (lines 465-466, below) - though undoubtedly true, it is also device, she (and others) might use to militate any blame or criticism that might attach

to this type of 'dirty work' or 'shit work' (Emerson & Pollner, 1975)[15].

G3, also offers, a useful reminder of what Bean (1986: p.5) refers to as: *'coactus voluit'* - the limited, or otherwise, no choice options persons have when they engage with the institutional practices of a medically/legally dominated system/culture of care - not least, it would seem, when engaged with mental health nurses.

Extract 6.10: Informant G3

458 R: Part of the supervision would be to
459 control as well do you think - does the
460 hospital want you to control patients the
461 lives of patients - order and control of
462 patients?
463 G3: (1.5) They ((management)) want a
464 smooth running ship I suppose - don't they
465 so in that way they want us to control the
466 patients - there's (1.5) we don't have
467 many sort of (1.0) orders about control.

Asked, *'what if the staff lost control and the patient had control'* (extract 6.11: lines 468-469, below) an intriguing question to say the least, G3 raises two interesting points - none of which speaks of the sanctions her senior managers might impose upon her: one, the result would depend on which group of clients were in (lines 471-474, below), an implicit recognition of variation in the type of patient that does much to mirror the concerns of informant G (see particularly extract 5.4 & 6.5-6.8) and more importantly, the fascinating observation that, *'they* [the patient] *have control over a large part of the ward* (lines 474-478 ,below) - though, what part, is unclear. An observation which is entirely reminiscent of Weider's (1974a/1974b) study of the *'Code'* of behaviour that

[15]This theme of 'dirty work' or 'shit work' is developed later - see informant H, extract (6.14, below).

influenced the lives of narcotic felons in a half-way house hostel. An under-life, not always apparent to staff, but never-the-less powerful in determining the staff-client relationship and the behaviour that accrues from this.

Extract 6.11: Informant G3

R: What if what if the staff lost control and the patients had control - can you imagine that sort of scenario?
G3: Well it depends on which - who's in doesn't it really which clients are in what group of patients you've got in at the time - as what would happen (1.0) I suppose they do have - con- control over a large part of the ward really don't they of - they're here twentyfour hours a day seven days a week we're not.

A singular instance of the potential power of this underlife and the discrimination this suggests (extract 6.12, below) is described most dramatically by M2 below, who tells the story of a patient who *'we* [the nurses and it would appear some *patients] wanted removed and discharged'* (lines 196-197 below), but whose discharge was resisted by the consultant - a not unusual circumstance - that later, led to his being subject to a *'good pasting'* (line 201, below) at the hands of fellow patients. The effect of which was to see him discharged the following day.

Extract 6.12: Informant M2

R: You mention power - do you think there are issues of power on a {ward like this
M2: Oh yeah oh definitely definitely}
R: How would you describe it?
M2: I could give a very good example if you want {an example

193 Yeah}
194 we had a guy who was admitted by one of
195 the consultants who was abusing drugs
196 while still on the ward and we wanted him
197 removed and discharged he was actually
198 informal when the consultant refused to do
199 so and four of the patients from here
200 actually grabbed hold of him and took him
201 outside and gave him a good pasting and
202 he was moved the next day for his own
203 {safety - I think that's power there.

M2, though, tending to be something of a maverick respondent (see also chapter five: extracts 5.7 & 5.8, this volume), gives no indication of disapproving the action taken by the patients - did he collude with them? Rather his forthright description of events (lines 198-203 above) gives every indication of a story well told for the outcome it intended - which was probably to shock, amaze and/or impress the researcher? The effect of this event, though, was two-fold: one, the patient was discharged home as the nurses had requested, and two, the consultant had to concede the necessity to do so - his position of authority.

M2's position is interesting - he was, with out doubt, emphatically opposed to the position of the consultant, who aligned himself with a patient he spent relatively little time with[16], but he is also arguing again, it would seem, the space he created for himself in chapter five (extract 5.8), in which, it will be remembered, he set himself apart from the treatments/therapies espoused by both the medical model and social care model and suggested, instead, a variant of these, captured by his enigmatic, but

[16]Consultant 'episodes' (HES) are measured in minutes rather than hours and it is unlikely that the patient referred to saw his doctor more than once or twice a week - a position of understanding that is singularly different from that of nurses who work eight to twelve hour shifts.

wholly unrevealing belief, that, *'I just do my job and go home'* (line 117). The sense that the system/culture of care fails to satisfy M2's meaning/understanding of his role is clear, but what job he assumes for himself, if not custodian or therapist, is equally, unclear.

The power of this *under-life* was famously described by Goffman (1961/1986) who noted various instances of solidarity and camaraderie - or *'collective secondary adjustments'* (ibid: p.93) among inmates at Central Hospital - a camaraderie which brought a number of patients into a partnership in order to work-the-system. But in order to work-the-system effectively, as Goffman describes it, you 'must have an intimate knowledge of it' - and rather more importantly, the *complicity* of staff.

If the event described by M2 is true - and there is no reason to doubt that it wasn't - it was probably an exception to the rule, the outcome of which was more fortuitous for M2 than he would possibly admit. He does however, hint at something not altogether obvious (and not expressed in the text) - the possibility that staff and patients might collude with one another against a system/culture of care they both disagree - one that is dominated by the power of medical psychiatry - a view that emerges again, albeit, in a slightly different form, in extract (6.14, below).

For the moment, though, a muted variation of the theme of control and collusion is given by informant N below, who says with complete candour that, *'we* [the nurses] *advise them ... knowing that they'll agree with that advice'* (extract. 6.13: lines 190-192, below). A pragmatic observation that speaks more of the asymmetry of the parent-child

relationship described by informant G2 above, than the *therapeutic* relationship that M would want to espouse.

Extract 6.13: Informant N

185 R: Just say} something about that power
186 then - is it exercised do you think by the
187 nurses - doesn't matter where it comes
188 from - do you think nurses exercise power
189 over their patients?
190 N: Mmm I think we advise them
191 sometimes - knowing that they'll agree
192 with that advice.

A parent/child relationship that some patients encourage because the yield for them is greater than it might otherwise be, if they were to adopt a more vigorous assertion of their *rights* (see Harré & van Langenghove 1991; Berne, 1964). Importantly, one of the central tenets of the social care model rests on the assumption that clients wish to assert their *rights*, or can be encouraged to do so, when in fact the opposite might sometimes be true.

Summary Position 1

The complexity of this institutional mental health service is apparent in the accounts of informant M and informant G who both find fault with the system/culture of care, but from quite different perspectives. M gives strong voice to a social care model approach, which argues a libertarian and emancipatory view of the client - which sets him apart from the system/culture of care other senior nursing colleagues espouse for themselves. In contrast, G argues two things, it would seem: one, a more discrete and focused

admission policy in keeping with his understanding of the *'text book'* categories he claims and, two, for more honesty in the provision of care, which he feels absent from the system.

In both, though, there is very clear evidence of a *self* denomination that is at odds with the acute institutional mental health service they work in, and both, it would seem, give testimony to the fact that mental health nurses do not construe a *system/culture* of care that will *empower* their clients and emphasise their civil rights - condition two of the social care model, rather, the opposite is probably true (if not in all cases, certainly in some). And, if it wasn't explicit in chapter five, their collective position clearly undermines - assumption 1(chapter one, this volume),

Though, they would not/could not be explicit about the system/culture in which they worked, informants G2; G3; M2 and N all conveyed something of the complexity of positioning that is likely to arise when the issue of control (of themselves and others) is discussed in institutional mental health services, and they did so to a degree which renders the accounts of their patients all the more plausible. One which reinforces the view that institutional mental health care is a complex field of self and other positions in which the idealised therapeutic relationship is difficult, if not impossible to achieve (see chapters eight and nine, of this volume, which clearly shows that the contrary is true - a paradox, not entirely understood).

The Mental Health Patients Position(s)

That control (and sometimes even restraint) is practised is witnessed by informant H below, who adopts a surprisingly pragmatic, not to say sympathetic view of nursing staff, when he describes how they *'coped'* with his disturbed behaviour when he was first admitted (see extract. 6.14: lines 514-520, below). He begins his account with an almost apologetic, *'I don't feel ashamed but ...'* (line 513 below), wherein the conditional relevance of this first utterance serves only to further complement the behaviour of the staff referenced in the second, which he clearly deemed appropriate in the circumstance.

Extract 6.14: Informant H

508 R: Okay going back to when you were first
509 admitted mmm (1.0) can you remember how
510 staff treated you then when you when you were
511 hallucinated and
512 admitted to the-?
513 H: Well I feel- I don't feel ashamed but I: I think
514 the staff coped with me very well because I was
515 very stressed up and very high and very anxious
516 and (.) on the go all the time and kicking and
517 punching and (.) things like that so (.) I:I felt that
518 the staff did (.) the staff coping with me at the
519 time not me coping with the staff.
520 R: Right ((Laughs))
521 H:You know what I mean 'cos I was really poorly
522 you know and I was kicking out and misbehaving
523 and (.) so it's how the staff coped with me not
524 how I coped with them
525 R: How did they cope with you can you remember
526 H: (1.5) They grabbed me and held me down
527 ((Laughs)) couldn't do anything else could they
528 R: Grabbed you
529 H: Yeah
530 R: The staff were were stopping you (.) you know
531 sort of preventing you err- I don't know injuring

532 yourself or running away?
533 H: Yeah that's when they put me on a
534 section-

Note, that H continues to use a medical free-hand[17] to describe his behaviour (see chapter 5: extract 5.14 &5.15, this volume) which he portrays in terms of being, *'very stressed up'* and *'very anxious'* (line 515, above) and *'really poorly'* (line 522, above), which, though, an important reminder of the distress *he* was experiencing at the time of his admission, also works to qualify the aggressive and violent behaviour he displayed when he was, *'kicking and punching and things like that'* (lines 516-517, above) and *misbehaving'* (line 523, above). His acceptance of the need for nurses to physically restrain him (lines 527-528, above) is apparent when he acknowledges that the *'staff* [had a job] *coping with* [him] *at the time* [rather than him] *coping with the staff'* (lines 518-519, above)[18]. He says *'they grabbed* [him] *and held* [him] *down* [they] *couldn't do anything else could they'*, he says with complete candour.

The end result of H's aggressively psychotic behaviour was his compulsory detention in hospital for treatment subject to Section 3 of the Mental Health Act (1983), a fact he acknowledges with equanimity when he says: *'that's when they put me on a section'* (lines 533-534, above). This is an interesting remark because it does two things: one, it draws to a close the commentary on his past behaviour - which he clearly implies is now at an end (see also informant B: chapter five extracts 5.12 & 5.13 and informant

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[17]By medical free-hand is meant the commonplace usage of such terms and does not necessarily imply a medically qualified referent.

[18]The staff he speaks of are undoubtedly nurses - doctors would not involve themselves in this activity and no other staff are asked to do so. To this end, all mental health nurses receive training in control and restraint - sometimes euphemistically called, 'care and responsibility' and/or 'none aversive physical control.'

L: extracts 5.16 & 5.17 for a similar example of *re*-positioning in relation to a discreditable denomination of past behaviour) and brings into focus another alignment - that is, his alignment to those others he describes as *'they'*. In this instance, it is absolutely the case that the *'they'* he refers to, is in fact, his consultant psychiatrist construed as the plurality of physicians he/she leads - and it is he/she alone, who did impose his detention under Section 3 of the Act[19].

It is interesting formulation, because it suggests (and no more than that) an affiliation (if not collusion) with nursing staff that is possibly absent from his alignment to medical staff - note, that he apparently harbours no ill will towards the nurses (lines 526-527, above)[20], but appears to acknowledge the power exercised over him by this medico-legal complex - here, it is useful to be reminded of the circumstances of his forced admission to hospital - his arrest and detention by the police (chapter five, this volume). To this extent, he hints again at the sort of camaraderie between nurses and patients that was suggested by informant M2 (extract 6.12, above).

To be compulsorily detained in a mental hospital as H was, is without doubt, the most important legal sanction/control that can be imposed upon a person in the United Kingdom outside of the criminal justice system. However, the dubious status of this legal activity in a caring profession is not only recognised by patients, who are subject

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[19]The Mental Health Act 1983 will only allow designated medical practitioners to detain patients under compulsory section and these are referred to in the Act, as Responsible Medical Officers (RMO's). These doctors are always consultant psychiatrists and not, as might be thought, other medically qualified persons. Interestingly, Registered Mental Nurses (regardless of seniority) have a limited right to detain patients under Section 5(c) of the Act, a right not given to other physicians.

[20]This is not true and it becomes clear in chapter seven (extracts 7.18 & 7.19) that their relationship is mutually, disingenuous.

to its constraining influence, but also by those nursing staff who are *forced* to exercise its power and authority[21]. Pilgrim & Rogers (1994), referencing work done by Emerson and Pollner (1975) describe this work as 'dirty work' or 'shit work' and they argue that it was:

> 'negatively accounted for by workers who preferred the morally superior role of being benign therapists. The dirty work conception derives from earlier work done by Hughes (1971), who sees it as an aspect of all professional activity entailing a practitioner being obliged to 'play a role of which he thinks he ought to be a little ashamed of morally' (Pilgrim & Rogers,1994: p.94).

The therapeutic role of the nurse is, it would seem, inevitably compromised by an imperative forced upon them by others - not least, the system/culture of care in which they work, which implicates them (more than any other) in the control and restraint of patients.

The extent to which the *no-choice* option might apply (to both nurses and patients) can be judged by informant L, below who asserts that, *'you can't beat ... [the system]'* (extract 6.15: line 115, below) - an implication of its strength and indefatigability that is only challenge by her resolve not to be beaten by it: *'you can't let the system beat you you can't beat it you can play along with it (.) you can work at it'* (lines 118-121). Here, (for the sake of argument) it is tempting to assume that her frequent use of the pronominal *'you'* is an inclusive plural referent pointing to a solidarity that might include nurses, but it is (I think) more properly read as a sort of *formal* talk - the need she felt to objectify her remarks and make them more serious (Mühlhäusler & Harré, 1990:

[21]What choices, one might now suppose, was available to informant M, in the *'rough house'* described by informant G (extract 6.6: lines 179-180, above) - none at all, if he was to retain his job?

ch.6).

Extract 6.15: Informant L

114 R :You know the system pretty well
115 L: Yeah { you can't beat it.
116 Mmm}
117 R: You can't beat the system ?
118 L: You can't beat the system (.) you can't
119 let the system beat you you can't beat it
120 you can play along with it (.) you can work
121 at it.
122 R: Tell me what you mean by that?
123 L: Well if:if you try an' beat the system you
124 think you're clever you think you can do it
125 all better than them and get away with
126 everything and mmm and it's impossible

Asked to say what she means by the system (line 122, above), L is vague - the system she describes is not captured by any precise definition or even characterisation, but rather emerges as a construct supported by the poles of her personal experience: *'if you try and beat the system you think you're clever you think you can do it all better than them and get away with everything and mmm and it's impossible you can't'* (lines 123-127, above. Whether the system she talks of is the hospital, or the social care apparatus in which her life is nested, is hard to say, but that she experiences it as a tangible (controlling) force is undeniable.

Importantly, though she believes the system to be unbeatable and she positions herself in an apparent space that lies somewhere between the arch resistance of some, and unacceptable defeat of others. By defeat she appears to mean passivity and/or dependence (extract 6.16: lines 150-157, below) - though the possibility of her meaning/understanding something else is implied by her enigmatic and ultimately

elusive remark, *'letting <u>them</u> take on another person'* (lines 155- 156, below). By resistance she appears to mean, rule breaking and challenging behaviour of a type that informant G2 above, is want to speak of (lines 165-172, below).

Extract 6.16: Informant L

L : Mmm (1.5) when you're actually doing nothing for yourself (1.0) when you're doing <u>absolutely</u> nothing (.) just sit back and let everybody do everything for yourself- for you (.) your not helping yourself you're only letting the system beat you- you're letting <u>them</u> take on another person (.) you know instead of working with them.
R: What sort of advice would you give to err err shall we say a newly admitted (.) mmm patient (.) who needs to understand the system (.) shall we say another seventeen year old girl {(.) with your {experience-?
Yeah}
L: I:I've had to do that (.) (seems strange) ((Laughs)) just (.) basically outlining what goes on in the ward and what you can and can't get away with (.) you know (.) what you are supposed to do (.) or expected to do (1.0) mmm things like you don't go out drinking and (.) you know you help all you can (.) you have a loyalty (.) you <u>don't</u> turn on staff (.) you know totally- t:that's the o:only thing I would (inform you about on the ward) is that you don't turn on the staff (.) you know they're here to help you not sort of (.) hinder you or anything.

It is in this space that the opportunity for self expression is created, one which allows rule breaking of a sort (lines 167-168, above); cooperation (lines 168-172); loyalty (line 172, above); and a regard for staff that is both genuine and caring - *'you <u>don't</u>'*, she says with perfect emphasis, *'turn on the staff ... they're her to help you'* (lines 175-177).

She explains that by turning on staff she means being aggressive towards them, a circumstance not unfamiliar to nursing staff in mental health services and one that sits uncomfortably with all *caring* agencies, but one she disavows. Not because she concedes the possibility of sanctions, but rather because of the concern she feels for them.

L, is instructive for a number of reasons, not least because she signals a diversity of patient reaction to the experience of an essentially oppressive system/culture of care, a reaction which is characterised by defeat or resistance. Something of the defeat and resistance she speaks of is captured by informant J2 below - a self sufficient elderly gentleman, who mourns the fact that many of the men on his ward have made *'a haven of the place'* (extract 6.17: lines 207-209, below), apparently, because, they know no better (206-211, below) - a view that the spirit of Sir William Lobjoit would heartily approve.

It is their acceptance of psychiatric hospital life that is the measure of (their) defeat and by inversion, the measure of his own resistance - and superiority (note his position in relation to: *'a lot of these chaps',* line 206, below), a resistance which he politely expresses as a desire to go home, *'you'll be glad to go back to you own home',* he is asked (lines 215-216, below), *'oh absolutely'* (line 217, below) he replies with alacrity and emphasis.

Extract 6.17: Informant J2

201 R: Is there a down side to being in a
202 psychiatric hospital do you think?

J2:(1.0) It all depends I think the way you feel and way you think {(.) like
Yeah}
see a lot of these chaps here are quite happy here {(.) they've made a haven
Yes}
of the place you know (.) they get their three meals a day they probably wouldn't get at home but (1.0) not to me I don't look at it that way like you know I'm grateful for what's happened to me and what they've done for me here but (1.0).
R: You'll be glad to go (.) back to your own home?
Oh absolutely

The position that J2 takes up is interesting, because by suggesting that it is his proximity to other patients that defines the, *'down side'* (line 201, above) of the psychiatric hospital, he raises an important issue: the social relationships that obtains between in-patients. Dohrenwend & Dohrenwend (1969) are among many social theorists who emphasize the inverse relationship found between social class and psychological symptoms. Simply stated, more people from the lower social classes suffer from mental disorders, and are subsequently admitted to psychiatric hospitals, than are people from the middle or upper classes - in this sense, the system/culture of care is marked by the inferiority of its class membership.

To this one might also add the practice of merging an apparently indigent (none mentally ill) population with a mentally ill population - the effect of which has been to force an incommiscible meld of people (patients) into a single psychiatric frame of reference (cf. Szasz, 1994: pp.25-26). Prior (1993) observing the system/ culture of care in mental health care points out that:

> 'The in-patient world was not, of course, defined solely and simply in relation to the staff world. Indeed, in-patients proved able to construct and participate in a social world of their own design' (Prior, 1993: p.165).

However, whilst this social world might offer friendship and constructive activity to many it could prove to be a world of isolation and threat to others - a point not lost on informant G2 (extract 6.9, above). But, the effect of this social mix is a rarely considered factor in the social milieu of the psychiatric hospital - patients, it would seem, are expected to cope with one another.

The difficulty that some patients have in relating to other patients is evidenced by informant J, below, the agoraphobic lady (who believes herself ill, rather than mentally ill - chapter five: extract 5.1, this volume) attending hospital as a day patient, who conceded that she: *'wouldn't stay in* [hospital]', because there are patients who *'upset'* her: noisy patients, who apparently, *'can't help it'* (extract. 6.18: lines 72-74, below), and, significantly, male patients, who visit from the adjacent ward - the ward managed by informant G. above - (lines 75-77, below).

Extract 6.18: Informant J

66 R: Is there is there anything you don't like
67 about the place?
68 J: No I don't think so
69 R: Sorry to sound morbid but but if you
70 were really ill would you want to be
71 admitted (.) to stay in?
72 J: No no:o I wouldn't stay in I I know a lot
73 can't help it but- the the noise is upsetting
74 sometimes ((Name of patient omitted))
75 shouts a lot and and the men from
76 ((Name of adjacent male ward)) come
77 over sometimes I don't- it wouldn't be the

78 same if I had to stay in
79 R: The place is alright in small doses
80 J: ((Smiles/tense)) Yes in small doses

In this potentially unhappy mix of patients, informant J only made friend with *'patients in* [her own] *group'*(extract. 6.19: lines 405-406, below) - by which she meant patients in her own therapy groups, all of whom were women diagnosed as neurotic, or having an eating disorder - a discrimination that she also extended to the nursing staff - (see line 409, below)

Extract 6.19: Informant J

405 J: I've made friends with patients in my
406 groups but not with anyone else that's me
407 being different (.) that's me making choices
408 about myself and who I mix with (.) I don't
409 talk to all the nurses and not all the nurses
410 talk to me

Summary Position 2

The system/culture of care described by the patients in this topic of talk is undeniably complex and contradictory. Variously, they have acknowledged: the need for control (and even restraint) by nurses; the need for freedom and autonomy - whilst recognising the futility of resistance and defeat; an allegiance to and concern for nursing staff; an antipathy towards other patients and a class consciousness; and a desire for discharge whilst acknowledging the need for the friendship and support of other like minded persons. Interestingly, the concerns expressed by patients in this study find a ready parallel with Beadsmoore, Moore, Muijen, Shepher, Warren, Moore & Wolf (1998) recent survey of *the quality of care in acute psychiatric wards* - in which they concluded:

> 'Although patients valued the respite quality of acute wards, they least liked the lack of freedom which accompanied it, identifying rigid ward regimes, strict routines and being told what to do, as examples. Attitudes and availability of nurses was the second most common dislike. This was referred to by one in five patients, nearly as many people as those who thought the staff the best part of their stay. They referred to nurses as being rude, speaking in a disrespectful manner, and spending most of their time in offices. Likewise, while many patients appreciated being with others in a similar situation, some found this the least liked part of their stay. These people were concerned that other patients seemed threatening or harassing' (Beadsmoore, Moore, Muijen, Shepher, Warren, Moore & Wolf, 1998: p.37).

It is, or so it would appear to be, an artificial and contrived world which does much to challenge the assumptions of many caring mental health professional, not least mental health nurses, who would presume a social milieu in their hospitals and wards which accords with the best intentions of Main's, (1946) conception of *'The hospital as a therapeutic community'*, one which argued an:

> 'attempt to use the hospital not as an organisation run by doctors in the interests in their own greater technical efficiency, but as a community with the immediate aim of the full participation of all its members in its daily life' (Main, 1946: p.67).

And, it is one that once again challenges the assumption (3: chapter one, this volume) that mental health clients can construe a *system/culture* of care in which they are *empowered* to exercise their civil rights - which, it will be remembered, is condition two of the social care model (Rogers, 1957; 1975).

Chapter 7: The Discursive Position(s) of Mental Health Nurses and Mental Health Patients/Clients in Talk Framed by the Topic Relationships

> (7.1) '... Is it true, then, as we were just now saying, that desire is the cause of friendship, and that whatever desires is friendly to that which it desires, and friendly at the time of its feeling desire' (Plato's Lysis: 221d/Wright: p.166)

Introduction

This third analysis describes and interprets participants' *self* and *other* positions in talk framed by the topic: *Relationships*. In both chapter six and chapter seven something of the situated construction of mental illness (insanity ascription) and the system/culture of care in which it is most actively expressed was explored. Both chapters demonstrated significant variations in the construction and function of informants' accounts of mental illness (insanity ascription) and the system/culture of care in which they work, to a degree which suggests that the achievement of a therapeutic relationship is something to be hoped for, rather than necessarily assumed.

It will be remembered from the introductory chapter that (Fiedler, 1950b: p.443) argued that the 'goodness of therapy is a function of the goodness of the therapeutic relationship' - a position most ardently espoused by social care theorists', but one that is strongly implied in the *Syllabus of Training* for Mental Health Nurse (1982). However, the extent to which a therapeutic relationship, with its emphasis on *congruence* (genuineness/authenticity), *unconditional positive regard* (warmth and respect) and *empathic* understanding, is achieved by nurses and, indeed, warranted by their

patients, is an open question and one that is explored in the following texts of talk (cf. Rogers, 1957; 1975).

Inevitably (given previous accounts), the majority of nurses in this topic of talk adopted a disappointing (if predictably) *Proper* view of their relationship with patients, rather that the idealised *Therapeutic Relationship* they might otherwise have achieved in circumstances of care where interpersonal therapies (therapeutic conversations) are proximate to, and dependent upon the relationships they realise. They were, in essence, disinclined to conceive that their relationship with patients was anything more than an exigency of their work and there was, in fact, only one example of a nurse (informant M) favouring any patient with anything like, *congruence*, *unconditional positive regard* and *empathic* understanding.

Similarly, the majority of patients in this topic of talk believed that the friendship of nurses was largely pretended and would disabuse any assumption that their friendship was to be taken for granted. However, there were two exceptions, both of whom acknowledge their regard for the nurses who cared for them - though, it must be said, one of these (informant J: extracts 7.23 & 7.24, below) was more discriminating than might have been supposed.

The Mental Health Nurses Position(s)

In the previous chapter six, informant G2 (chapter six: extract 6.9), in common with other nurses, described the system/culture of care in which he works in terms of the need to

maintain control and he drew a parallel between the *ward* and the *family* in this regard. G2's use of the family as a descriptive metaphor is a powerful one for two reasons: first, he reminds us of the essential asymmetry of the parent child relationship in matters of morality and/or normative standards of behaviour and wherein, the former invariably assumes a rectitude and responsibility over the latter, grounded in their self conscious understanding of the context of their talk and/or experience; and second, because he reminds us of the potential even in this near *perfect* alignment of related individuals has for both harmony and discord and that discord is probably the more likely consequence in interactions between strangers than the harmony that might be hoped for, or otherwise achieved between relatives and/or friends.

It will be remembered that Rogers (1962) made much of the *positive* aspects of *parenting* believing that children (and clients) exposed to unconditional positive regard grow *strong* and *sure* in themselves, whilst those who are not, are haunted by their own self-doubt.

> 'I am coming to believe that children brought up by parents who would like them "if" are never quite right. They grow up assuming their parents are right and that they are wrong; that somehow or other they are at fault; and even worse, very frequently they feel they are stupid, inadequate, inferior' (Rogers, 1962: p.421).

That there are at least two ways to *do* parenting is in no doubt, but that G2 and other nurses in this series should choose the latter view of this, is, it must be said, a source of some concern. In the following account G2 describes a relationship with his patients which pivots on the axis of their submission and/or compliance to the *normative* standards of behaviour he (or, more likely, the hospital is wont to describe - see chapter

six, this volume) - a so called, 'would like them *if* ' relationship. It transpires that those who resist (his) control, are the ones who dislike being in hospital and those who dislike being in hospital are disliked because of it (extract 7.1: lines 251-263, below). It is a fatalistic sweep and one that was previously described by informant M (chapter six extract 6.1 & 6.2) who, it will be remembered, bemoaned the fact that the motivations and/or behaviours of patients is generally misunderstood by the staff who care for them - if not by him (see also extracts 7.11 - 7.17, below for a description of how complex and problematic empathy can be).

The conversation unfolds in three parts: part one describes the response of patients to control (extract 7.1: lines 251-263, below); part two reveals the grievance felt by some patients towards staff centred on that loss of control and the threat this imposes on the nurse-patient relationship (extract 7.2: lines 264-276, below); and part three, records G2's dislike of patients who resent their admission to hospital (extract 7.3: lines 277-290, below). G2 takes it as a given that control is both desirable and appropriate and describes two categories of response to this control in terms of those patients who are *willing to take it on and [those] people who aren't'* (lines 255-256, below). Not surprisingly, it is those who resist (his) control who experience the most difficulty and in whom staff find least *'popular'* (lines 261-263, below).

Not surprisingly, given his previous talk in this series (see chapter 5: extract 5.6 & chapter six: extract 6.9), G2 is positioned as the willing respondent to the question posed - though, clearly answering some quite personal questions occasioned by this encounter. Interestingly, in this instance, he appears to speak more for himself than he

has done before, though, once again, he is apt to inveigle the support of absent others (nurses) in making clear his understanding of the things he describes (see extract 7.2: lines 268-276, below).

Extract 7.1: Informant G2

251 R: What's the response then of the
252 patients to this sort of control do you
253 think?
254 G2:It varies from person to person some
255 people are willing to take it on and some
256 people (aren't).
257 R: So they expect it some people?
258 G2: Yes.
259 R: And others presumably resist it?
260 G2: Yes.
261 R: What about those people who resist it -
262 how- are they popular with the staff or -
263 G2: Not always no, no.

Asked if he thinks the patients like the staff (lines 264-265, below) - a not improbable hope in a caring profession - he responds that *'he would like to think so, but thinking about it a lot of patients have many a grievance against staff'* (extract 7.2: lines 266-268, below). Grievances, which hinge on their admission to hospital and their *de facto* loss of control (lines 274-276, below).

Extract 7.2: Informant G2

264 R: Do you think the patients like you - not
265 you personally but you as staff?
266 G2: I would like to think so - but thinking
267 about it a lot of patients have many a
268 grievance against us.
269 R: What sort of grievances would those be
270 do you think?
271 G2:Emmm(1.0) I think the fact that they've

272 had to come here and sort of put their put
273 their lives in our hands I suppose you
274 could say mmm it's because they have
275 lost control over themselves- I think that's
276 the main grievance.

But, despite the insight this affords him, G2 appears not to understand the circular nature of the impasse this logocentric, 'selfsame' positioning intends, or the debilitating effects of the power and authority this necessarily assumes - power, which Giddens (1991) argues should be distributed to the benefit of all.

> 'Power within social systems which enjoy some continuity over time and space presumes regularized relations of autonomy and dependence between actors or collectivities in contexts of social interaction. But all forms of dependence offer some resources whereby those who are subordinate can influence the activities of their superiors. This is what I call the *dialectic of control* in social systems' (Giddens, 1991: p.16) .

The *dialectic of control* is profoundly important, not only to the wellbeing of the individual, but also to the social/relational system of which he/she is a part, but there is a sense in which the mentally disordered person in G2's experience is confounded by a system of care which assumes that their resistance to care (as an assertion of personal agency) is evidence of some personal deficit.

The relationship that G2 posits ignores the *dialectic of control* and describes a *Proper* relationship that Cixous and Clément (1986) argue demands a *tithe* cast in terms of an individuals' submission to the *selfsame* dominant order of things, rather than the mutually satisfying *gift* of reciprocity that is a feature of everyday interpersonal encounters - not to say the therapeutic relationship that might otherwise be conceived in these circumstances.

Graumann (1995: p.18) insists that reciprocity 'is a *moral principle* rather than a technical term' - one that 'presupposes mutuality which, in turn, is based on certain kinds of commonality' of experience and understanding that is absent from G2's account - and, indeed, all other nurses account in this series. In essence, reciprocity is simply the recognition of a person's warrant to speak from the position ascribed to him/her by a particular moral order of talk.

Mental health patients should in any sensible relationship have the right to speak and dissent if they so choose, and do so without threat to the relationship their position describes - that it may not, must pose a considerable threat to the therapeutic relationship that social care theorists and nurse education intends (see *Syllabus of Training* for Registered Mental Nurses, 1982: p.1).

Not surprisingly, the inbuilt asymmetry of the *Proper* relationship that G2's position describes has the potential to generate antipathy in both *master* and *slave* (Hegel, 1979) - not least because of the 'dialectical' impasse this inevitably invites. Little wonder then, that G2 acknowledges that, though he would hope it were different, the patients have good reason to dislike him and the staff (extract 7.2: lines 266-268, above). But, more telling than this, he is equally sure that the staff don't always like the patients (extract 7.3: lines 278-279, below), an unfortunate (if ultimately human) reaction to a diverse and often incommiscible mix of patient, but one that does much to undermine the therapeutic intention some of his colleagues intend.

Asked if the staff resent the patients, or find them troublesome, G confirms with absolute

candour, that *'yes... they are* [troublesome]' and that he (and note that he speaks emphatically for himself), *'dislikes an awful lot of people that come in here'* (lines 283-286, below). And those he dislikes are those who are unhappy in hospital (line 288-289, below) - a hospital that informant M (extract 6.1: lines 60-63) described as working for the *'benefit of the people who work there'* and a system that informant L (extract 7.15: lines 123-127) argues can't be beaten - reason enough, one might suppose, to dislike both the thought and the reality of their circumstance.

Extract 7.3: Informant G2

277 R: Do you think the staff like the patients?
278 G2:No not all of them no (.) but I feel that's
279 human nature.
280 R: Is there any resentment do you think
281 directed towards patients (.) do staff find
282 them troublesome?
283 G2:(1.0) Yes (.) I mean they are (.) I mean
284 I'd be lying if I felt that that I liked
285 everybody that came in here (.) I dislike an
286 awful lot of people that come in here (.)
287 mmm usually people who - how can I say
288 (.) dislike being dislike the fact that they
289 are in a psychiatric hospital and they have
290 to sort of be in a psychiatric hospital.

If compliance is one feature of the *tithe* to be paid by patients in the *Proper* relationship, a second is the limitation imposed by nurses on the friendships they might reasonably expect and/or assume. Arguably, informant G2's relationship with his patients appears more structural than personal and something of his regret is captured in lines 264- 268 (above), but this is not the case for informant M2 below, whose own feelings can only be gauged by the apparent credulity he observes in his patients who believe him their friend.

Extract 7.4: Informant M2

105 R: Just explaining that err the relationship
106 I- do you see patients to be(.) your friends
107 are you friendly with patients?
108 M2: Up to a point

Asked if he saw the patients as *'friends'* (lines 106-107, above) - a not improbable circumstance, given the very wide margin this simple term allows[1] - he replies, *'up to a point'* (line 108, above), but continues by describing a relationship that is cloaked in the disingenuous position he construes for himself in both institutional and social encounters. He acknowledges *that 'some of them* [patients] *think I'm friendly with them'* (lines 119-120, below) and that, *'a lot of people* [patients] *call* [him] *friend '* (line 121, below), but he disavows that this is so, with a conclusive, *'no they're not my friends'* (lines 126-127, below), even though, his behaviour might suggest otherwise (lines 122-126, below).

Extract 7.5: Informant M2

119 M2:I think some of them think I'm friendly
120 with them I wouldn't particularly say I am
121 friendly a lot of people call me friend but I
122 don't ever like to say I'm not I've met
123 people out there and I talk to them I'll meet
124 somebody when I'm shopping I'll speak to
125 them I meet somebody in the pub I'll
126 speak to them but no they're not my
127 friends.

M2 offers a remarkably arch and uncompromising personal view - he speaks for no one, but himself of his (lack of) relationship with patients, one which admits no personal

[1]The definition of friendship implies no more than one of the following: 'one attached to another by esteem, respect and affection; an intimate associate; a supporter' (cf. The Modern University Dictionary, 1955).

feelings for those people he is charged to *care* for. But, if M2's austerity is a little surprising, it is no less formidable than the unequivocal position taken up by G: extract 7.6, below, his senior manager - an argumentative man who invariably casts his personal avowals in the first person singular so as not to be misunderstood (see chapter five: extracts 5.4-5.5 & chapter six: extracts 6.5-6.8).

To begin, G is asked, '[does he] *make friends with* [patients] *whilst they're in [hospital]*' (extract 7.6: lines 107-108, below), G replies (not at all untypically: extracts 7.5 & 7.6) that his relationship with patients is *'professional'* (line 109, below). Pressed to describe his relationship further, he is emphatic, *'no'* (line 115, below), he doesn't, *'like anyone in particular'* (lines 111-1 14, below), and no, he doesn't acknowledge the possibility of friendship outside of the hospital. Finally, sensing something of the trajectory of R's questioning, he signals his aversion to the social-care position with the enigmatic suggestion, that he *'know*[s] *what* [R] *mean*[s]' (line 115) and that he, [doesn't] *work like that its a job'* (lines 116, below).

Extract 7.6: Informant G

105 R: ((Laughs)) Fair enough err mmm let me
106 ask you (.) What's your relationship with
107 patients (.) do you make friends with them
108 whilst they're in here?
109 G: Mmm It's a professional relationship
110 (1.0) is that what you mean
111 R: Mmm err I was thinking more- do you
112 like them like anyone in particular are they
113 the sort of people you would make friends
114 with if they weren't in hospital?
115 G: No I know what you- I know what you
116 mean but but I don't work like that it's a job

G's position, is consistent with his view that in the context of his own work, medical diagnosis is (or appears to be) a social expedience, rather than a clinical fact, one which inappropriately admits an indigent, sometimes criminal population into his care (see chapter six: extracts 6.4, 6.5). Little wonder, then, that whilst G readily admits that he does, *'feel sorry for* [the patients]' in his charge *'feeling sorry for them doesn't make 'em better'* (extract 7.7: line 119-120, below).

Extract 7.7: Informant G

118 R: Do you feel sorry for them
119 G: Yeah I feel sorry for 'em but feeling
120 sorry for them doesn't make 'em better
121 R: What about the so called therapeutic
122 relationship?
123 G: What about it
124 R: How can it work if you're not genuine
125 G: Who said I'm not ((irritated))
126 R: What I'm trying to say is err err how
127 close can you get to err err can you have
128 a therapeutic relationship if you're not
129 friends with the patients- don't like them
130 G: I didn't say I didn't like 'em I I err keep
131 a distance (1.0) the women like to pretend
132 that the patients are the same as us but
133 that's just them playing nurse I mean look
134 around ((name of ward omitted)) they're
135 chronics- they' re all in here vagrants ex
136 cons we've even got a sex offender who's
137 going to be their friend
138 R: It err It err err sounds to me like you
139 don't like them very much?
140 G: I don't like or dislike anyone I I err try to
141 be fair (.) do the job ((irritated)).

Something of G's sensitivity to the social care position, and the therapeutic alliance this implies, emerges when he is asked to comment on *'the so-called therapeutic relationship'* (lines 121-122, above) - a relationship he would understand, if not necessarily avow. To which he reflexively replies, *'what about it'* (line 123, above), an

apparent stall that R tries to correct by defining the therapeutic relationship in terms of *genuineness* (line 124, above) - a term which derives from Rogers (1957: p.96) notion of congruence.

The implication that G is in some way not genuine (authentic in his behaviour) is not lost on him and he responds to this apparently condescending personal denomination with a vigorous and accusatory, *'who said I'm not'* (line 125, above). A not unreasonable response, one might suppose, given that he probably believes that his relationship with patients is *genuine* in the terms he would describe - rather than that which the social care model would espouse. It will be remembered that in extract 7.7: lines 195-196, G asserted that, *'no amount of talk is goin' to get the men on here sorted'* - which is not to suggest that other forms of intervention won't.

R's clumsy conjunction of three potentially disparate concepts: therapeutic relationship, friendship and liking (lines, 126-129, above) does little to define the concept of closeness that he introduces in line 127, but it does produce an effect which has G arguing that: contrary to extract (7.6: line 15, above), he *'didn't say I didn't like 'em* [but that he] *keep*[s] *a distance'* (extract 7.7: lines 130-131, above) - a relational distance, one must assume, but most importantly, the relationship he implies is construed as some form of feminine misconception or failing - the women (a category description he clearly disapproves) he says, *like to pretend that the patients are the same as us but that's just them playing nurse'* (lines 131-133, above).

Once again, G draws a parallel between feminine and masculine positioning (extract 7.6: lines 180-183), which argues that therapeutic talk of the sort assumed by social care

theorists, is limited in its scope to, *'little girls who want their hand holding'* (ibid: line 183) and not, as might be supposed, the patients in his care, the indigent and criminal (extract 7.7: lines 133-137, above) - to whom, he tries *'be fair* [to] *do the job'* (lines 140-141, above).

G adopts an altogether *Proper* view of his relationship with patients, one that is apparently free of personal likes or dislikes, but it would be altogether inappropriate to assume that it is anything less than the professional relationship he clearly intends it to be in, *'do*[ing] *the job'* he does (line 141, above).

In both G and M2's accounts there appears to be a singular lack of *connectedness*[2] in the sense that Goffman (1971: p.63) is wont to describe with the patients they manage - one, which lacks any credible warmth on their part and one which undermines the self definition *(autonomy)* and/or human rights *(empowerment)* of the patients with whom they daily interact[3]. Their commitment to co-operate is, in all probability, luke warm and consistent with their narrow definition of mental illness (extracts 5.4, 5.5, 5.7 & 5.8) and the system/culture of care in which they work (extracts 6.5, 6.6, 6.7, 6.8 & 6.12), both of which are marked by *theories* of deviance and social control (cf. Alaszewski, 1986; Scull 1993)

So far informant accounts have been restricted to an all male perspective - an altogether

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[2]By *connectedness* Goffman means reciprocity/mutuality of relationship and the worth this conveys from one to another.

[3]It is useful to be reminded of the aggressive and often violent behaviour of the patients they manage and the impositions placed on them both by the Mental Health Act (1983) in respect of some of them. None of which commend a social care model approach.

phallocentric view that Cixous & Clément (1986) would argue is the essence of the *Selfsame*, but G3 below, offers a female perspective, which once again argues the limitations imposed on relationships in mental health institutions - though, once again, positioning herself from the distal references she makes. Asked, if '*close friendships* [are] *encouraged between staff and patients*' (extract 7.8: lines 155-156, below), she replies in the negative (line 157, below) and qualifies her position in terms of the need to: *'maintain a professional relationship with the patients and not become over involved'* (lines 158-159, below) - a concern that is also expressed by informant N: extract (7.10 below).

Extract 7.8: Informant G3

154 R: For instance - I mean as an example
155 mmm - are close friendships encouraged
156 in the hospital between staff and patients?
157 G3:Not friendships friendships as such no
158 they need to maintain a professional
159 relationship with the patients and not
160 become over involved.
161 R: What about romantic involvement with
162 patients?
163 G3: Well they'd need to be nuts to be
164 involved ( ).

It is interesting that R uses G3's concern not to become overly involved with patients as a prompt to question the possibility of *'romantic involvement'* (lines 161-162), a not improbable leap of imagination that acknowledges the complexity of therapeutic relationships that foster feelings of trust, intimacy and regard, whilst, recognising the possibility of sexual impropriety that might be its unintended consequence. Importantly, the Mental Health Act (1983) and Sexual Offences Act (1956) make clear the limitations of any sexual relationship allowable between mentally disordered patients

(including informal patients whose volition is unimpaired) and staff - a tension, which is captured in the UKCC's *Code of Professional Conduct* (1992), which states that the nurse must:

> 'Avoid any abuse of your privileged relationship with patients and clients and of the privileged access allowed to their *person*, property, residence or workplace' (UKCC's *Code of Professional Conduct*, 1992: para.8; my emphasis).

The extent to which sexual impropriety (however this might be construed) is a feature of counselling/psychotherapy is largely unknown, but Ussher (1991) cites studies (though somewhat dated) which suggest that sexual encounters between *patients* and therapists is not uncommon:

> '... up to 15 per cent of therapists *admit* to such activities, and over 50 per cent engage their patients in physical contact which they deem 'non-erotic', such as kissing, hugging and touching (Kardener *et al*, 1973; Holroyd and Brodski, 1977). These are not isolated incidents, for of those therapists who admit to having had sexual relationships with their patients, over 80 per cent have done so with more than one woman patient; and many have done so repeatedly, the *average* being twenty-nine times (Holroyd and Brodski, 1977). The question of the boundaries between what is and is not erotic is debatable, and kissing or touching patients may be deemed abusive. But what is outstanding is the high percentage of therapists who actually own up to sex with their patients. Is this merely the honest few?' (Ussher, 1991: p.180)

Little wonder that G3 considers that anyone romantically[4] involved with a patient would *'need to be nuts'* (lines 163-164, above). In an interesting response to R's question, *'how close can you get to patients'* (extract 7.9: lines 165-166, below), G3 co-authors *a* completion with R which *agrees* that psychotherapy, is a very *'shared activity'* (line 168, below) - a reciprocity and prescient understanding of the relative importance of the issue

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[4]The dictionary definition of *romantic* does not specify a sexual relationship, but allows that feelings of love, passion, nobility and ideal might also figure - which might be construed as the empathic focus of person-centred therapy by those with a want to do so.

at hand and one she readily confirms with the statement that *'cuddling and holding isn't really encouraged'*[5] (lines 174-175, below).

However, she concedes an important qualification, that, *'if somebody was very ill'* (line 176, below), cuddling of the sort described, would be allowable (lines 177-178, below). What she means by *very ill* remains unexplicated, but it makes possible her statement that *'we do sometimes hold and touch hands'*. A form of contact, which is open to variable interpretation, but appearing now to signal an unvoiced sensitivity and/or concern for the person in distress.

Extract 7.9: Informant G3

165 R: From that really mmm - how close can
166 you get to patients given that
167 psychotherapy can be a {very-
168 G3: Shared} activity-
169 R: Tense shared activity touching and
170 holding patients cuddling and being very
171 close to patients whether members of the
172 same sex or not (.) the opposite sex (.) is
173 that encouraged do you think?
174 G3:Cuddling and and holding isn't really
175 encouraged as such - err it isn't (1.0) I
176 mean if we've got somebody very ill and
177 needs a cuddle - I mean yes I suppose we
178 do sometimes hold and touch hands and-
179 R: Would you be concerned about -
180 you've got a number of male staff on the
181 {ward or one-
182 G3: I've} only got ((G2))
183 R: Would you be concerned if if a young
184 male-
185 G3:Yes if they left themselves open and (.)
186 R: compromised-

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[5]Ellis & Beattie (1993: pp. 29-31) describes a typology of the function of touching in situations/ relations which would not preclude the use of *therapeutic* touch, but one which clearly sets limits on the relationships intended.

187 R: Were to get too close to the patient?
188 G3: Yes.

Not surprisingly G3 has reservations about the propriety of 'cuddling' in the context of care and acknowledges her concern that her *one* male staff nurse (informant G2) is not *'compromised'* - as R is wont to put it (line 186, above). Most tellingly, that he doesn't get *'too close to the patients'* in his charge (lines 187-188). Arguably G2 (in common with other male nurses) manages his relationships with patients with an eye to the charges that might be made against him - charges that informant M (extracts 7.11, 7.15, 7.17 & 7.18, below) is only too well aware.

The boundaries imposed upon nurse-patient relationship is clearly an issue of concern for all nurses and informant N (extract 7.10) extends this concern further, when she acknowledges the need to refuse the entreaties of patients for a friendship beyond the confines of the hospital and/or therapy. A limitation in *care*, which argues that the dependent relationship which occurs as a consequence of admission and/or therapy cannot reasonably continue beyond the margins of the hospital.

Asked about *'relationships with patients'* (line 641, below) she admits that patients do make overtures to staff: that *'there are some staff that get ... invited to patients homes'* (lines 642-644, below), but that she knows that this sort of behaviour has *'been frowned on'* (line 645, below) - though without proof, she suspects that those who have done so, have been warned (lines 645-647, below).

Extract 7.10: Informant N

641 R: What about relationships with patients?

642 N: (1.0) Mmm (.) I don't know - there are
643 some staff that get err - you know - like
644 invited to patient's home and that and I
645 know that's sort of been frowned on I don't
646 know if they've actually been warned
647 about it but it's all you know- keep your
648 distance from them because they are
649 patients after all ((Softly)).
650 R: So you think generally the feeling would
651 be don't get too close to patients?
652 N: Yeah.

Though, N refers to no particular rule - it is probably an implicit formulation that grasps the sensitivity of the action concerned, it is self evident that not, *'get*[ting] *too close to patients'* is a convention that is known by most, if not all, nurses: *'it's all you know-'* she says, *keep your distance from them because they are patients after all'* (lines 647-649, above). Hence, it would seem, her drift from the first person singular *I*, to the inclusive second person plural *you*.

It is certainly a convention that informant M below knows all too well and he describes this as a *'common extreme'* of behaviour (line 490, below) . That, when *'a staff member takes on board a patient in a personalised sort of way ... it's recognised* [and] *danger bells ring ... and the necessary avoiding action is taken'* - though by who, he doesn't say (lines 494-496, below).

Once again - as he has done throughout this conversation (chapters five & six), M speaks for himself and marks almost every utterance he makes with the pronominal *I* - some slippage does, however, occur, not unnaturally, given the import he intends by his talk in extracts (7.13: line 620 & extract 7.15: lines 701 & 710) when he objectifies his account with an impersonal, though, possibly inclusive, *'you'*.

Extract 7.11: Informant M

I suppose the most common extreme of that is when a staff member might take on board a patient in a personalised sort of way - that's happened on a few occasions and and as soon as it's recognised danger bells ring and the necessary avoiding action is taken.
R: What sort of personal involvement are you talking about?
M: (1.5) Mmm perhaps (1.0) visiting the patient out of out of work hours perhaps making their home phone number available - spending perhaps what was perceived as an unusual amount of time with a single patient and that kind of thing.
R: So there is a line to be drawn between the staff on the one hand and the patients on the other in the hospital?
M: Well well err I think I've said that before haven't - to my mind the line is crystal clear.

M offers three examples of *'taking on board a patient in a personalised way'*: *'visiting patients out of work hours'*; giving them your *'home phone number'*; or , rather more inportantly for him as it transpires, spending more than an *'unusual amount of time with a single patient'* (lines 499-504, above). He concludes, if it were not already clear, that the *'line'* to be drawn between the staff on the one hand and the patients on the other in the hospital' is *'crystal clear'* (lines 509-510, above) - which reinforces the point he made earlier about *staff cups* and *patient cups* (chapter six: extract 6.3: line 153, this volume).

But how, one might ask can a man who appears to align himself so closely to the social care model cope with such restrictions? The answer is simple, he ignores the

convention[6], but acknowledges the consequence of others misinterpreting his behaviour. In the following extracts M describes in a very open way his approach to therapy in a manner that is admirable in terms of his personal commitment, but naive in its expectation. It is also revealing of the organisation and mangement of *this*, and probably all other mental health hospitals.

M makes a clear distinction between the general run of hospital patients and those he is *'working with'* (extract 7.12: lines 573-579) - by which he mean personalising his relationship with patients (extract 7.17, below). Though he offers a rather broad definition of what it is to work with clients (lines 587-606) he concludes that it is a *collaborative* relationship based upon a mutuality and reciprocity of understanding (lines 595 & 603). To this end, he says he goes *'out of* [his] *way to ... depower* [and] *deskill* [him]*self'* (lines 605-606, below) - *'to get down to their level'* (lines 606-607, below).

Though he says it in his own way M captures much of what Giddens (1994) means by idea of a *Pure* relationship - a relationship, free from the 'external conditions of social and economic life' and one which 'exists [only] for its own sake' (ibid: pp.89-90), but in doing so he also signals the problems that might ensue from such an *idealised* relationship (see extract 7.14, below) - when the intentions of one party are not wholly understood by an other.

> 'In a pure relationship, the individual does not simply 'recognise the other' and in the responses of that other find his self-identity affirmed. Rather ... self-identity is negotiated through linked processes of self exploration and the development

[6]By convention is meant the propriety of mental health nurses not getting 'too close' to patients/clients in their care.

of intimacy with the other' (Giddens, 1994: p.97).

Extract 7.12: Informant M

M: No I mean - I suppose I play a mixed game here really in - I've no doubt that I play the same game that they do with the majority of patients and I think that I would have to differentiate between two sets of patients really the ones that are on the wards that I'm working with ((this is a reference to M's work as a psychotherapist)) and I use use that term loosely-
R: I I presume that working with some one is-
M: you know what I mean (1.0) if I'm working with some one it means that I've actually spent a significant amount of time with them - that they understand who I am what I am what I potentially can do what I can't do (.) and I understand why they're here about their family background whats the matter with them what their expectation is of what I can do or may do with them and the only approach is is a collaborative one(.) I can't (.) I learned that I couldn't make any progress whatsoever if I maintained the belief that I had something that I could give to a patient and they believed that I had something they wanted and I was about to give it to them -It's - I simply found it didn't work and so from the very beginning any patient that I am working with it's a collaboration right from the beginning - in fact I think I go out of my way to depower deskill depower myself - to almost come down to err to their level

Asked if the patients he *works with* accept the position he assumes (or indeed wishes to assume in relation to them - line 608, below) - a not improbable point of concern when assumptions of paired social identities are challenged in this way (see Goodenough,

1969; Levinson, 1988; Warner. 1937), he answers in the affirmative, but implies that some of his client's probably don't (line 609, below). Importantly, he concludes that those who do accept his position do so, because he is willing to abdicate *'power'* (line 612, above) and encourage *'openness'* and *'equality'* in their relationship (lines 621-624, above).

Extract 7.13: Informant M

608 R: Do do patients accept that?
609 M: Most I think do.
610 R: How do you do that?
611 M: ((Laughs)) Gosh (1.0) I think err I throw
612 away a lot of my err power (1.0) I I ask
613 them to - I ask them a question they ask
614 me a question - If I'm asking them where
615 they come from then I think they have
616 every right to know where I come from if I
617 ask them if they're married I think they
618 have every right to know if I'm married or
619 how long I've worked here or what my
620 intentions are etc I think that if you
621 encourage openness and information
623 between two people then some degree of
624 equality exists right from the beginning.

It is interesting that M concedes that he *'plays a mixed game'* with his patients/clients (extract 7.12: lines 573-574) - a discrimination which might support informant G's view that M (and probably all other social care theorists) is not entirely honest in his relationship with patients, that he operates a double standard that is most clearly exposed in his response to a *'rough house'* (extract 6.6: lines 178-180). A charge, it will be remembered, that G used to emphasise the dishonesty of a hospital management that vaunts the social care model at the expense of the work he apparently does (extract 7.7: lines 190-197).

Asked if there are *'behaviours that challenge* [him] *personally'* - a not improbable circumstance in the complex field of mental health work (extract 7.14: lines 671-672, below), M is unequivocal - *'no'*, he replies, there are none (line 674, below) and he supports his claim with a narrative of such insouciance that it probably borders on the reckless (extracts 7.15-7.19, below).

Extract 7.14: Informant M

671 R: Are there any behaviours that
672 challenge you personally any patient
673 behaviours?
674 M: Not really no.
675 R: What sort of thing would challenge
676 you?
677 M: ((Sighs)) (0.5) Well I'm particularly- at
678 the moment being sexually harassed by a
679 female patient and I can't even pretend
680 that it's difficult for me now - it's irritating
681 but not not difficult in an embarrassing sort
682 of way (.) I think my biggest problem is in
683 letting go of people who I have worked
684 with over a period of time - when the when
685 the therapeutic value of the sessions have
686 ceased and they still they have some
687 feelings (.) some kind of human contact is
688 required they want to to know me and to
689 be with me still and I think it's quite diff- I
690 find that the most difficult part in saying (.)
691 you know I can't see any point in err you
692 continuing to come here ( ) will that
693 do?

Describing his *'sexual harassment by a female patient'* (lines 678-679, above) M acknowledges (albeit indirectly) that the therapy he engaged in with this client demanded of him *'some kind of human contact'* (line 687, above) - intimacy, one might suppose, but that this human contact was withdrawn when the *'therapeutic value of the sessions* [had] *ceased'* (lines 684-686, above) - his decision apparently. This, not

unnaturally, left his client with *'feelings'* for him which he felt unable or unwilling to reciprocate (lines 687-688, above).

The transference effect experienced by this particular client (and it could not be anything else in the context M describes) appears more intense than is usually experienced by clients in these circumstances, but it is interesting that M has chosen to resist it, rather than explore it (lines 682-693, above). Though transference is strictly speaking a psycho-analytic *tool* (see Freud 1949 & 1973), it is implicitly a part of *Person-Centred* therapy:

> 'It is impossible to discuss structuring the therapeutic process and the therapist's use of time, depth and mutuality, without describing those essential prerequisites, namely the patient's emotional impact on the therapist and the therapist's impact on the patient (Cox, 1987: p. 119).

In effect, there can be no therapy without emotion (transference/counter transference) and managing its expression - modifying and changing it, is crucial to the 'dynamic flow of therapy' (Cox, 1987: p.121). However, whilst colleagues appear guarded to avoid any undue emotional involvement with patients, M has encouraged it, but not without recognition of the consequences to himself.

Interestingly, the consequences that M fears are not those described by his current interaction with this particular client - he is clear that whilst he finds it *'irritating'* (line 680, above), *'its not difficult in an embarrassing sort of way'* (lines 681-682, above), but, rather, the reaction of his colleagues, whom he fears will interpret *his* behaviour inappropriately (extract 7.16: lines 726-736, below).

In fact, his description of events appears to signal this particular concern from the beginning: asked, if there are any *'behaviours that challenge* [him] *personally'*, he responds, as previously indicated, with a relatively unequivocal, *'no'*, but when pressed, modifies his reply to indicate that, '*at the moment* [I'm] *being sexually harassed by a female patient'* (lines 677-679, above) - a quite profound statement that he trails like a feint merely to describe the *problem* he encounters when he has to *'let go of people'* when *his* work is complete (lines 683-693, above) - a problem encountered by all person-centred therapists:

> 'Unless the psychotherapeutic relationship has a predetermined duration, the adequate negotiation of the ending of an 'open-ended' psychotherapy demands finesse in the appropriate structuring of time, depth and mutuality. 'Ripeness is all'. But for many patients in whom separation anxiety is a prominent feature, the prospect of the termination of formal sustained therapeutic sessions is menacing' (Cox, 1987: p.274)

Extract 7.15: Informant M

694 R: Yeah yeah okay can you control those
695 things?
696 M: Yeah ( ) How do I control it? (1.5)
697 R: Are there any sanctions that you use?
698 M: (1.0) ((Laughs)) Oh God (1.0) well I say
699 no I (1.0) but -this this particular patient is
700 not only err not only sexual but violent as
701 well so one minute she'll punch you and
702 the next minute she's trying to pull your
703 shirt out and get her hand down your
704 trousers mmm - so I feel quite justified in
705 pushing that patient away when she's
706 invading my personal space or pulling my
707 trousers or punching me on the nose - I
708 feel quite justified in err err retaliating
709 against her and pushing her away and
710 then you get into whole difficult area how
711 far can a professional person go in err
712 pushing shoving resisting it's a very
713 difficult balance.

R, though, is less concerned with M's problem in terminating his relationship with this particular client than how he manages to control her behaviour, which appears to be a dilemma of considerable moral and legal proportions. Asked, *'if there are any sanctions* [he] *can use'* (extract 7.15: line 697, above) to *control* her behaviour, he responds with an honest, if somewhat blithe, *'I say no'* (lines 697-698, above). However, giving a more expansive description of her sexual harassment - which now includes episodes of violently assaultive behaviour (lines 699-704, above) M is able to reason a justification for *'retaliating'* in the manner he describes, though with a hesitation that suggests something of his underlying concern (line 708)[7].

The idea that a member of staff might retaliate when provoked by a patient is unusual to say the least, but M's position is consistent with his belief, that when the barriers between staff and patients are broken down, *'rapid progress is made'* (extract 6.4: lines 162-163). Given that this lady's behaviour doesn't hint at a more disturbing *pathology*, he probably feels his behaviour is reasonable within the context of their *relationship* - a relationship he argued previously is based upon their *'equality'* (extract 7.13: line 624) - a relationship clearly qualified and supported by the social care model (cf. Rogers, 1957; 1975).

Though he identifies closely with the social care theorist's position M is conscious of the risks he runs and it begs the question, *'how do colleagues react'* (lines 724-725, below)

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[7]A recent report in *Mental Health Nursing* (1998: pp. 4-5) concludes that 'nurses working in mental health continue to feature prominently in cases of alleged professional misconduct considered by the UKCC ... the most common reasons for removal from the register [of nurses] or formal caution were physical or verbal abuse of patients and clients.' Importantly, this article also reports that men who, are in the minority in the nursing workforce, are over-represented at professional conduct hearings.

to his particular approach, which is the extreme opposite of theirs (extract 7.16: lines 724-725, below). Not surprisingly he concedes that his *'biggest dread is that colleagues think that* [he's] *encouraged this patient* [overtly sexual] *behaviour'* (lines 730-733, below) - that it is something more than an extreme expression of a positive transference effect, which possibly, ought to have been better managed by him.

Extract 7.16: Informant M

724 R: How do colleagues react to this sort of
725 thing?
726 M: (1.5) Mmm- I think the biggest
727 problem can occur if the people who
728 worked with me interpret interpret what is
729 happening in a different way than I do I
730 think in this case I err my biggest dread is
731 err - is that my colleagues think that I 've
732 encouraged this err patient in her
733 behaviour.
734 R: Is there a danger that they might
735 believe that?
736 M: Oh yes.

M's concern about this particular patient becomes more animated in this final extract of talk (7.17) and does much to qualify the potential for relationships that is allowable between nurses and patients in mental health services. His want to break down barriers is laudable, and all the more so when one considers the arch positions adopted by one or two of his colleagues - M2 and G, most notably. But the risks he runs, both personally and professionally are real and do much to emphasise the caution of informants like G3 (extract 7.8, above) who regards the possibility of a romantic attachment with a patient with professional alarm - a view shared by patient informant M3 (extract 7.26, below) and a circumstance that other patients would probably find inconceivable (extract 7.18 & 7.19, below)

Extract 7.17: Informant M

737 R: You you imply or or maybe I'm
738 misinterpreting this you you don't accept
739 the rule that separates patients from staff
740 and you want to cross that barrier and
741 engage with patients in a way that other
742 staff would find difficult?
743 M: Yes I err yes I think err my behaviour is
744 frequently in danger of misinterpretation
745 like with this patient now who is sexually
746 attracted towards me (.) mmm and initially
747 mmm she didn't display this kind of
748 behaviour she was frightened err
749 essentially and I just spent quite a a lot of
750 time with her (.) I took her out a lot I've
751 been to church with her mmm which
752 seemed relevant at the time mmm and I
753 was very supportive and err quite physical
754 with her - there was a lot of touching in
756 those early stages mmm holding her and
757 err caring for her which I err - I suppose
758 I'm afraid in a way now that this has
759 happened that people will misinterpret my
760 behaviour or critically or cruelly say that
761 err you know I got what I deserved-

M's response to his client's initial *fear* (extract 7.17: line 748, above) was to do something that appears genuinely caring - he chose to spend more time with her. A reasonable response one might suppose to human distress and suffering, but one that also signals the beginning of *person-centred* therapy: his wont to 'come into a direct personal encounter with his client, meeting [her] on a person-to-person basis (Rogers, 1962: p.417) - to be congruent with her.

To achieve this M was prepared to put himself out, as it were: to even go '*to church*' with her, which, he believed *'relevant at the time'* (lines 750-752, above) - a commitment to her which is both powerful in its expression and regrettable in its final

consequence. From '[spending] *quite a lot of time with her'* (lines 749-750, above), his relationship developed to become, as he describes it, *'quite physical'* (lines 753-754, above) - a physicality which included. *'a lot of touching ... holding ... and caring'* (lines 754-757, above). All of which, he now concedes was, and continues to be, open to misinterpretation (759-761, above; see particularly extract 7.9, above). A conviction of potential impropriety that is clearly trailed by the ever increasing hesitation (voiced pause) that has now crept into his account (lines 743, 746, 747, 748, 751, 752, 753, 756, 757 & 761, above)[8].

There is no suggestion that the relationship that M intended with his client was anything other than proper, but that it was conceived to be more than this by his client and is now a source of concern to both him and (possibly) his colleagues - who clearly figure in his thinking (extract 8.16: lines 726-733 & extract, 8.17: lines 757-761), is clearly the case. Though the detail of this particular *therapeutic* relationship is a sketch that hints at more than it tells, it does much to support the position taken up by other nurses in this series who were constant in their wish to maintain a professional distance - one which privileges their dominant position and limits their personal involvement with the people in their care.

Summary Position 1

The limitations imposed by the majority of nurses on their relationship with patients is

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[8]The use of pause is complex, but suggest that a speaker is taking 'time to think [and a] time to plan and may be suggestive of the emotional and/or cognitive difficult they are experiencing (Ellis & Beattie, 1993: pp.118-119)

all too apparent and is as much a product of their own self-other definition, as it is the moral imperative of the caring service in which they work. It is, however, a limitation that concedes no significant difference in the patients they nurse - their ability to exercise informed consent (their personal agency), and is one that emphasises the asymmetry of the power and authority that exists in this (and probably all other) institutional mental health settings; the control this is wont to exert and the restrictions on friendship this necessarily implies. Interpersonal mutual regard, it would seem, is not a priority of this particular caring service.

All-in-all, their accounts suggest that mental health nurses cannot construe a *relationship* that is *congruent*, *unconditionally positive* and *empathic* towards their clients - condition three of person-centred therapy and assumption 1 (chapter one, this volume).

M's account is particularly instructive because it describes in a salutary way the difficulty he experienced in a relationship (one assumes) he negotiated with the best possible motives, but over which he eventually lost control. It is also an account that articulates in a very important way the limits of the therapeutic relationship - a relationship that is always constrained by time, place and the propriety of the situated social identities of the persons involved.

The Mental Health Patients Position(s)

There emerged in the preceding two chapters a sense that in the contrived social world

of the modern day mental hospital, patients (possibly more so than the nurses who care for them) have a pragmatic understanding of the position(s) they must necessarily assume in relation to staff in order to maintain the *fiction* of their social identity[9]. This view is reinforced in the first three accounts of the following series, all of which variously describe, the pretended nature of the relationship that obtains between nurses and patients and the need to demonstrate this artifice for the rewards that can accrue in circumstances that are perceived to be little different from the rest of life.

It is a pragmatic view of the life world of psychiatry that informant H readily confirms in the context of his relationships with nursing staff. H, it will be remembered was compulsorily detained in hospital due to his drug addiction and violently assaultive behaviour. However, whilst he denied the former (preferring instead the muted diagnostic descriptor of his *psychotic* hallucination) he readily conceded the latter and, more-over, the challenge that this had presented to nursing staff (chapter six: extracts 6.14 - 6.15, this volume). H's start position is to describe his relationship with nursing staff as *'friendly'* (extract 7.18: line 147, below) - remember that he bore them no ill-will for the control and restraint they had exercised over him (see chapter six: extract 6.14), but by degrees this is reflexively decomposed to reveal his less than certain feeling towards them.

Extract 7.18: Informant H

145 R: How would you describe your

[9]Goffman's (1961/1986) essay's: *'the inmate world* 'and *'the staff world'* and his description of the process of *mortification of the self* offer a vivid insight into the contrived social world of the *asylum* - and *fiction* of social reality this supports.

146 relationships with the nurse- nurses?
147 H: Friendly.
148 R: Friendly?
149 H: Yeah friendly yeah ((Laughs)) (.) nice
150 friendly atmosphere.
151 R: It's a good atmosphere on the ward?
152 H: Yeah (.) well as good as it could be
153 ((Laughs)) I'm not goin' to say anythin'
154 else am I ((Laughs))
155 R: No.
156 H: No (1.0).

R's repetition of H's assertion that his relationship with staff is, as he describes it, *friendly* (line 148, above), signals the beginning of a decline in what is, and probably always was, a tenuous regard for the nursing staff: *'yeah friendly'*, he replies with a laugh (line 149, above), *'nice friendly atmosphere'* (lines 149-150, above). It's interesting that H extends this apparent qualification of his relationship with staff by referencing the anonymous atmosphere on the ward, rather than the quality of the persons to which the initial question alludes. This pragmatic elision appears to allow a second qualification which is pregnant with unspoken criticism: the atmosphere, he says is, *'as good as it could be'* (line 152, above). Note, that his utterances so far have not been marked for person, but at line (153, above) he adopts the first person referent *I* to qualify his position with a telling: *'I'm not goin' to say anythin' else am I'* (line 153, above).

Asked if the staff would be *'the sort of people* [he] *would mix with outside* [the hospital]' (extract 7.19: lines 157-159, below), H replies with a deliberate and prolonged stress, *'n::oo'*, they are not the sort of people he would mix with. He confirms his position with a *illustrative* shrug and an assertion, that, *'we just play at friends'* (line 162, below). It is interesting that H now uses an inclusive *we* (a reference not used by patients in

these conversations before) to emphasise the collective he feels he speaks for.

Extract 7.19: Informant H

157 R: Would you- err are they the sort of
158 people you would mix with outside (.) the
159 nurses I mean?
160 H: N::oo
161 R: Why's that (1.0)?
162 H: ((Shrugs)) we just play at friends don't
163 we.
164 R: Do you?
165 H: Yeah
166 R: Do they play at friends the nurses I
167 mean?
168 H: Yeah (.) course that's their job isn't it
169 what they're paid to do (.) be nice
170 R: It's play actin' then (.) not genuine?
171 H: Yeah (1.0)

A collective that R clearly believes implicate the nurses as much as anyone else (lines 166-167, above) - a generalisation that H readily confirms (when pressed) by announcing that the nurses are playing at friends, that it's, *'their job ... what they're paid to do ...* [to] *be nice'* (lines 168-169, above). Asked if their behaviour might be perceived as, *'play actin'* [and] *not* [as some might hope or suppose] *genuine'* (line 170, above), H replies with an affirmative, if cryptic, *'yeah'* (line 170, above).

H's account suggests (and no more than that at this time) that he and the nurses with whom he interacts collude in a deception they probably abjure, but agree for the sake of their mutual convenience - a convenience that many would regard as a *commonplace* feature of everyday social life. But, one that is surely an anathema to any social care theorist who conceives the possibility of a shared conception of his/her clients reality through the absolute sincerity of their *therapeutic* relationship - a hope that informant B,

a middle aged man with a history of alcoholism and/or depression, would probably wish to disabuse them of.

The tentative start to this extract of conversation (extract 7.20: lines 135-149, below) is worth recording for two reasons: one, because it describes something of the difficulty R experienced when attempting to broach a sensitive issue with patients not entirely confident of his motives; and two, because it produced a response of surprising and prescient candour, one which, was to assert that the best advice that B would give to a friend wanting to know something about the hospital to which he is to be admitted (line 148, below), is that, *'it's alright as long as you get on with the staff'* (lines 150-151, below) - the pronominal *'you'* in this instance could be read as inclusive or merely objectifying.

Extract 7.20: Informant B

135 R: If you're going to tell a friend a friend
136 who's going to come into hospital a close
137 friend a:nd he he told you ( ) he said
138 I've got to go into ((Name of hospital
139 omitted)) yeah.
140 B: Yeah
141 R: Err what would you say to him?
142 B: What for.
143 R: It doesn't matter he's- it's- I don't know
144 it could be anything but somebody's told
145 him his GP his doctor told him you've got
146 to come into hospital (.) so he comes to
147 you and says hey ((name of patient
148 omitted)) what's it like up there what
149 would you say?
150 B: Say it's alright as long as you get on
151 with the staff.
152 R: Yeah (1.0) you've got to get on with the
153 staff have you?
154 B: Yeah.

155 R: What happens if you don't get on with
156 the staff?
157 B: (1.0) You won't go far will you (.) you
158 don't get on with the staff you won't go too
159 far.
160 R: You won't go too far?
161 B: No.

A view which resonates with Goffman's (1961/1986) notion that there are four possible alignments patients can adopt in relation to the institution: first, they can 'withdraw' and ignore everyone other than themselves; second, they can 'challenge' the system/culture care by a constant refusal to co-operate; third, they can 'maximise their satisfaction' with the institution by making minimal positive comparisons between *it* and the 'outside world'; or four, they can, by a process of 'conversion' '... take over the official or staff view of [themselves] and [try] to act out the role of the perfect inmate' (Goffman. 1961/1986: p.63) - in essence, be as the staff would want you to be!

There is something of this conversion process in both informant H and B's accounts of their relationship with staff: a relationship which insists that they 'appear-the-friend' of, or at least 'get-on-with', the staff to ensure they accrue all of the benefits of their hospitalisation. Asked, *'what happens if you don't get on with the staff'* (lines 155-156, above), B replies with what seems to be an apocalyptic, *'you won't go far will you ... you don't get on with the staff you won't go too far'* (lines 157-159).

Interestingly, the benefit that B identifies is the opportunity to speak to staff: *'well'* he says, *if you don't get on with them you won't get no one to talk to will you ... to hear about your problems'* (extract 7.21: lines 162-164, below). A conditional that was clearly expressed in G2's account in extract 7.3 above (lines 283-290), but one that does much

to undermines the possibility of a therapeutic relationship in circumstances so apparently contrived. Indeed, it must represent the worst of all possible beginnings for the counselling/psychotherapeutic relationship this supposes and its effect must be judged by Rogers (1962: p.421) belief that the: *'I* would like them *if'* relationship, is always damaging to the persons concerned.

Extract 7.21: Informant B

161 R: In what way?
162 B: Well if you don't get on with them you
163 won't get no one to talk to will you (.) to
164 hear about your problems.
165 R: Right so you need them to talk too?
166 B: Yeah

Informant J2, will be remembered as the elderly man whose comments revealed him irritated by a system/culture of care that allowed other patients to *'make a haven of the place'* for themselves, and a man anxious for his early discharge (see chapter six: extract 6.17: lines 207-208 & 215-217). Not surprisingly, he viewed his relationship with staff in a similarly uncompromising way - though forced to do so by talk that was clearly urging a response. Asked, *'would he describe the nurses as his friends someone he would trust'* (extract 7.22: lines 214-215), he replied with an understated - and unmarked for person, *'they're alright'* (line 216, below) - a not entirely convincing affirmation of his regard for them, but one that he was unwilling to advance without further prompt.

Extract 7.22: Informant J2

214 R: Would you describe the nurses as your
215 friends someone you would trust?

216 J2: They're alright.
217 R: Do you mind that they control your life
218 whilst your in hospital?
219 J2: What do you mean?
220 R: Well they tell you when to get up (.)
221 when to go to bed (.) that sort of thing?
222 J2: Yeah
223 R: Does that cause a problem (1.0) can
224 you be friends with someone giving you
225 orders?
226 J2: It's no different here than anywhere else
227 you have to get on with people whether
228 you like them or not
229 R: Do you like them (.) the staff
230 J2: I couldn't say one way or the other

Though, J2 expressed himself *'grateful'* for the care he had received whilst in hospital (extract 7.17: lines 212-214), his wish to reassert his independence was both obvious and understandable. Asked, if he minded *'that* [the staff] *controlled* [his] *life whilst* [he was] *in hospital'* (lines 217-218, above) - a topic shift that is contrived more out of intuition than any statement he has so far made - he prevaricates and feigns not to understand its intended import without further explanation (lines 219 -222, above).

But, the intuition that this was an issue of concern for him is confirmed in the next two-part exchange, one which, rather oddly, asks him if he could *'be friends with someone giving* [him] *orders'*, to which he replies, *'its no different here than anywhere else you have to get on with people whether you like them or not'* (lines 226-228). It is the second stressed clause which holds the clue to his disposition, one which argues a need to 'get on with people', rather than to like or otherwise dislike them. It is a pragmatic response, one which is both recondite in its evasion and singular in its determination to avoid an unwanted *im*position (cf. Davies & Harré, 1990; Harré & van Langenghove 1991; and also Brown & Levinson, 1992, for an account of the impositions of others as a 'face-

threatening-act').

Does he like the staff, he is asked (line 229, above), to which he replies *'I couldn't say one way or the other'* (line 230, above), an epithet of unquestionable politeness that it is hard not to conclude that: *no*, he doesn't particularly like the staff. Little wonder, one might suppose, given the previous accounts of G and M2 above, in whose care J2 currently resides.

Informant J, an anorexic lady ill disposed to her mental illness label, is similarly polite in her wish to avoid any unwanted *im*position that might further threaten her self-esteem (see chapter five: extract 5.21). Asked to confirm that she never *'wan*[ted] *to come into hospital'* (extract 7.23: lines 178-179, below), J has *no* hesitation in agreeing that this was the case and that she was persuaded do so by her community nurse and, most importantly, by informants M and G3, who both co-manage the ward she attends. That they were able achieve this is certainly testimony to the positive impact they all had upon her at this time and one she readily admits (lines 185-187, below)[10]. Note, Rs enthusiastic, but no less crude attempt to construe the nurses she speaks of in the best possible light - a cueing that Goffman (1973: p.102) would recognise as 'tactfully avoiding the administrative facts of [her] situation' (lines 188-189, below).

Extract 7.23: Informant J

178 R: But but you didn't want to come into
179 hospital no

[10] It will be remembered that J had been treated as an outpatient for two years prior to her day-patient admission and one might suppose that her condition had warranted her admission prior to this time (extract 5.20: lines 12-14).

180 J: No
181 R: What err persuaded you
182 J: ((Laughs)) ((Name of the community
183 nurse)) she brought me in to ((Name of
184 ward)) to speak to ((Name of Ward
185 Sister/G3 and Charge Nurse/M)) and they
186 persuaded me to try coming as a day
187 patient
188 R: One up for the nurses hey
189 J: Yes
190 R: Do you get on well with the nurses err
191 err have they made you feel different
192 about the hospital
193 J: Yes they're very caring very patient with
194 me

Interestingly, though, it emerges that her relationship with nurses cannot be generalised beyond this particular group - all of whom she claims are, *'very caring* [and] *very patient with me'* (lines 192-193, above) - a personal denomination which signals something of the exclusive view she takes of her relationship with staff on the ward. Asked (oddly, as it now appears), which of these three nurses she would choose to be her friend (extract 7.24: lines 234-238, below) she concedes that it would be her community nurse and reinforces her choice by claiming that she is, *'more like a friend than a nurse'* (lines 243-244, below). A qualification that speaks of the discrimination that she (and probably most others) make between these apparently complementary social identities - to put it simply, nurses cannot suppose the friendship of their patients/clients as a matter of right (see chapter six: extract 6.19).

Extract 7.24: Informant J

234 R: Its putting you on the spot I know but if
235 err err circumstances were different would
236 you choose ((names of Charge
237 Nurses M & G3 omitted)) or ((Community
338 nurse)) to be your friends

239 J: Yes ((Name of community nurse
240 omitted)
241 R: She sounds like a good friend is is that
242 what she is do you think a good friend
243 J: Yes yes she is she's more like a friend
244 than a nurse
245 R: Do you like all of the nurses on ((Name
246 of ward omitted))
247 J: I mostly work with ((name of Charge
248 Nurses/M & G3 omitted)) but I
249 haven't met anyone that I thought I
250 wouldn't like
251 R: No
252 J: No

The discrimination that J makes in her relationship with nurses, emerges more forcibly when she is asked if she, *'likes all of the nurses on the ward* '(lines 245-246, above) - given, that *liking* implies no more than *approving* of these various individuals - J is unwilling to confirm this and asserts, instead, that she *'mostly works with M and G3*' - an interesting diachronic formulation that is a sort of counselling speak not much heard anywhere else (lines 247-248, above). Her response is interesting, in-as-much-as, the first clause appears to betray a partiality that hints at her disapproval, but the second offers a repair that works to deflect any slight to others this might imply: *'but I haven't met anyone that I thought I wouldn't like'* she says (lines 248-250, above). A play on words, one might think, which, whilst clever in its construction, does little to confirm her claim[11].

If J doubts her friendship with nurses, informant L (extract 7.25, below) does not, and she confirms that she has made *'strong friendships with the staff'* whilst she has been in hospital (lines 313-317, below). Asked how she would *' describe* [her] *relationship generally with nurses'* (lines 318-319, below), L experiences a moment of confusion,

[11]An alternative reading of the text would suggest that J is being distinctly honesty in the face of some very leading questions - an honesty that argues no more than the limitation of her experience.

believing the question relates to *general* nurses[12] - a confusion, which though unexplicated in this context of talk, might be explained by her experience of *general* nurses caring for her self inflicted injuries, a care that many concede falls short of the care received by victims of accidental injury[13].

However, when corrected (lines 322-323, below) L offers a thoughtful reflection of her relationship with staff, one that first admits that she, 'get[s] *a bit paranoid with them sometimes* ... *think*[ing] *they're watching* [her]' (lines 324-327, below) - a not surprising reaction given her predilection for self wounding behaviour (extracts 5.16 - 5.18).

Extract 7.25: Informant L

313 R: In the six years that you've- been
314 coming into hospital mmm would you say
315 you you've made strong friendships with
316 the members of staff?
317 L: Yeah.
318 R: Right (.) how do you describe your
319 relationships generally with nurses?
320 L: Mmm what with (.) general nurses is
321 that what you mean (can't think exactly)?
322 R: No as a general sort of (.) feeling about
323 nurses?
324 L: Mmm I get a bit paranoid ((Laughs))
325 about them sometimes you know (.) I think
326 you know (.) they're watching me (.) what
327 I'm doing and that (.) do they really care
328 are they really or is it just a job and
329 (.) you know I get very doubt- doubting
330 times like that (1.0) but I actually know
331 they- up here especially they are they

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[12]The term general nurse is a common reference to a Registered General Nurses (RGN) - a nurse who is qualified to work in general medicine, surgery, etc. and one who is clearly distinguished, from the Registered Mental Nurse, who is qualified to work in psychiatric medicine.

[13]The evidence suggests that people who self injure are often labelled as 'attention seeking' or 'manipulative' and are blamed rather than supported in their distress (Favazza ,1996) Favazza, in particular, offers ample evidence that this is so and evidence that clinicians are all too often punitive in their treatment of such patients.

332 genuinely do care {(.) you know (.) and we
333 stay
334 Yeah}
335 friends (.) outside the hosp- (.) I live in
336 ((Name of town omitted)) you know and
337 we stay friends outside of the hospital
338 which is nice (1.0) you know so when you
339 do come back in at least you know
340 someone (.) you know that sort of-.
341 Right

It is in the context of this experience of being watched that L asks: *'do* [the nurses] *really care ... or is it just a job'* (lines 327- 328, above) - a heart rending appeal that speaks of the importance of this relationship to her, and one she admits she has sometimes doubted (lines 328-330, above), but one she concludes is genuine: *'they genuinely do care'*, she says (lines 330-332, above).

Importantly, L believes that her friendship with nurses is not bounded by the hospital, but rather extends in time and space, to include the town in which she lives and her frequent returns to hospital. A view that is quite different from any other informant account in this topic of talk, and one which does much to argue for the possibility of a therapeutic relationship not constrained by any threat and/or derision from others (see Informant M: extracts 7.11-7.18, above).

But, this is a singular account and one that informant M3 - a single lady with a long history of psychiatric *illness* and admission to hospital, who has not featured in this discussion so, is want to disabuse (extract 7.26: lines 472-479, below). Returning, to the theme of romantic relationships (as an erstwhile measure of social normality) M3 is asked how the hospital would react to such a thing developing between a male member

of staff and female patient (lines 446-450, below). Interestingly, she claims not to know how they would react (line 451, below) - an entirely reasonable admission of ignorance, that denies her knowledge of any rule which prohibits this possibility occurring.

Extract 7.26: Informant M3

446 R ... if (.) romantic relations were to
447 develop on the ward between say a male
448 member of staff and a female err patient
449 how do you think the hospital would react
450 to it?
451 M3: (1.0) I don't know.
452 R: I mean if you're trying to create a normal
453 environment with normal things going on
454 (.) you know what I mean-?
455 M3: Yeah (1.0).
456 R: Is there a difference between the staff
457 and patients?
458 M3: I think in that- in in err yes I think you
459 know- I think it's something you've got to
460 be wary of and I wouldn't imagine- you
461 know I suppose it could happen but it's
462 not the best of circumstances you know
463 for err err- especially if somebody on the
464 staff who is well (.) you know if they fall
465 for somebody who's not well I mean err
466 you know in some way they must realise
467 it's the wrong time in anybody's life to
468 form a relationship but then again I:I don't
469 suppose you can help it happening can
470 you.
471 R: That would seem a reasonable I
472 suppose mmm what about friendships
473 then have you developed friendships with
474 the staff whilst you've been here?
476 M3: Not with the staff-
478 R: Not with staff?
479 M3: No

However, having apparently closed this particular line of enquiry, she is prompted to reconsider the matter further, when she is asked: 'is *there a difference between the*

staff and patients' (lines 456-457, above) - and she does so with a pragmatism that is steeped in the issues involved. Her first inclination, however, is to answer the question directly and she begins with a hesitant, *'I think in that-'* (line 458, above), which then trails into a brief voiced pause which signals a self correction that shifts the *topic* of talk away from the presumed difference between these two identities, to a resumption of talk about romantic relationships, but without any reference to the same.

The topic emerges as an anaphora cloaked in her cautious acknowledgement of the risks involved: *'its something you've got to be wary of'* (lines 459-460, above), she intones, credulous still of it ever actually happening - again, the pronominal *'you'* appears to be object, rather than integrative in its form. But, she concedes that it might happen, in a sequence that begins with a desultory, *'I wouldn't imagine-'*, that she repairs with a rather more conclusive, *'you know I suppose it could happen'* (line 460-461, above).(lines 461-463, above). However, her caution is self evident and she admits (if it wasn't already obvious) that hospital is *'not the best of circumstances'* for it to occur.

There then follows a sequence which lifts the problem of nurse patient/client relationships from the rarefied atmosphere of Freudian *conceptions of transference* and *counter-transference*, to the issue of volition, a state of being, which has vexed medico/legal experts since the *Lunacy Act* (1890). M3 makes three points all of which narrow to the problem of informed consent: one, staff are presumed to be mentally well; two, patients/clients are not; three, staff should know better (lines 463-468, above - and she says, with prescient understanding of the problem, that staff, must *'realise it's the*

wrong time in anybody's life to form a relationship' (lines 466-468, above).

However, in a final sage comment M3 concedes that people probably can't *'help it happening'* (lines 468-470, above) - a view which does little to mitigate the actions of staff, but one that has merit in pointing to the unpredictability of this and other relationships. In short, it is difficult to legislate for the feelings of individuals and people will like and dislike as they so choose, despite the wants of social care theorists/person-centred therapist's and/or national bodies mandated to describe curriculum content of mental health nurses.

In a final word, one that has coloured the position taken up by the majority of nurses and patients in this topic of talk, M3 is unequivocal in her belief that she has not made friends with any staff whilst in hospital (lines 472-479, above.

Summary Position 2

With the exception of informant L and, in part, informant J, the patients in this topic of talk expressed a reserve in their account of their relationships with nurses, which does little more than mirror the wont of the majority of nurses to maintain a *Proper* relationship with them. It is a *impasse* of some magnitude - that, should it find expression in the conversational therapies that are so much a feature of mental health care, can do little for the outcome these talks intend - an idea, though, that is altogether disabused in the series of therapeutic talks to follow (chapters eight and nine of this volume). Importantly, and in contrast to the nurses in this series of conversations, the patients always talked

for themselves, rather than for a collective - an emphasis on their subjectivity that underpins the basic rationale of person-centred therapy (condition three of the social care model).

Once again, though, an essential condition of the therapeutic relationship - the relationship intended by the proximity of carers to cared for, is compromised by the disposition of both nurses and patients towards one another. A disposition which speaks more of strangers than does of friends. In effect, mental health patients/clients do not construe a *relationship* with mental health nurses that is a compliment to person-centred they intend by their practice - assumption 3 (chapter one, this volume).

PART THREE: A THERAPEUTIC WAY WITH WORDS: EXPLORING THE INTERIOR OF THE BEGINNINGS OF THERAPEUTIC TALK

Chapter 8: The Discursive Positions of Mental Health Nurses/Therapists and their Clients in Therapeutic Talk - Incompatible Positions and Resistance

> (8.1) Socrates: The story about Thales is a good illustration, Theodorus: how he was looking upwards in the course of his astronomical investigations, and fell into a pothole, and a thracian serving-girl with a nice sense of humour teased him for being concerned with knowing about what was up in the sky and not knowing what was right in front of him at his feet' (Plato's Theaetetus 174a/Waterfield, 1987: pp.69-70)

Introduction

This fourth analysis (and the fifth to follow in chapter nine) describes and interprets participants' *self* and *other* positions at a *beginning* in an ongoing series of therapeutic talks (person-centred counselling/psychotherapy). It will be remembered from chapter one of this volume that the social care model posits that the *debilitating* effects of both medical diagnosis and admission to hospital - the incarnation of a misconstrued discourse of deviance and social control - the 'Empire of the Selfsame' (Cixous & Clément's1986; cf. Main, 1946; Rogers, 1951, 1957 & 1975), can be militated by the therapeutic relationship it describes - a relationship that signals a concern for client autonomy, empowerment, and the essential legitimacy of their version of reality - their *subjectivity*.

However, in chapter two of this volume, it was argued that Grice's (1957; 1975) and Searle's (1969/1990; 1994) subject centred paradigms of intentionality (the ontic-logos of person-centred therapy) are representational models of communication that take no

account of hearers as contributors to speaker meaning/understanding - that in effect, subjectivity stands prior to the language and the context in which it is used. In contrast, it was argued that Habermas's (1991) intersubjectivist paradigm of communicative action posits an inevitable, if sometimes unintended, complicity between speakers and hearers in the realisation of the meanings/understanding they intend. In effect, whether, they agree it or not, person-centred therapists actively contribute to their clients' meaning/ understanding.

Surprisingly, given the relative freedom to position themselves and others as they might in talk that was never meant to be consensual (or disputational), chapters five, six and seven, of this volume, suggest that mental health nurses and mental health patients/clients are not disposed to agree conditions one, two, or three of the social care model, but rather align themselves in a less than certain appreciation of the person-centred therapy this model intends. Given that this is the case, it becomes even more pressing to ask whether mental health nurses can abandon the constraints imposed upon them by the medical model - carceral society, and work as counsellors/ psychotherapists as they have been encouraged to do, by government wont (Ministry of Health, 1968); professional imperatives (ENB, 1982 & 1989b) and social policy (Duggan, 1997).

That they can, is evidenced in the therapeutic talks to follow (see also chapter nine, this volume) - all of which insist, in a very awkward fashion, the subjectivity of the client - that is, their truth, their right and their sincerity. However, despite the *tacit* positions of social identity these conversations describe (counsellor/counsellee) participants in the

first five conversations in this series are never able to agree a mutually compatible position in relation to one another and are cast as adversaries in form of talk that is always constrained by the polite conventions of person-centred therapy. In essence, all of these conversations appear to be conversations about conversations the counsellor/psychotherapist would like to have with their client - if only their clients would not resist[1].

Conversation One: Discordant Positions

The orientation to subjectivity which is emphasised by person-centred therapy is neatly captured in the first moments of this conversation between informant M - who, it will be remembered, was the nurse who most closely aligned himself to the social care model of mental illness (extracts 5.1-5.3; 6.1-6.4; 7.11-7.17) and informant S, a depressed, middle-aged housewife/school teacher (extract 8.1, below). Ignoring all other possibilities, and there was at least one (see lines 72-73, below), M asks S, *'where* [she is] *at now'* (line 71, below), a question which , though, oddly phrased, she clearly understands is a probe designed to allow him entry into what Rogers (1975: p.4) refers to as her, *'private perceptual world'* - and one which might also hint at her experience of this form of circumstantial opening[2].

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[1]The idea that resistance is an unconscious, transferential experience, is much disputed and Rennie, (1994: p.45) reports, after (Rorty, 1976a), that 'when interviewees were given an opportunity to report on their subjective experience of an hour of therapy, it was evident that they were *persons* in interaction with this other person, the counsellor.' Similarly, Greenson (1967) observed that resistance in psychoanalysis is not entirely unconscious, but describes a real relationship, one in which, the client might resist treatment because they object to the analyst in some way (see Liotti, 1989; Strean, 1985).

[2]There is an opening preamble to this conversation that is concerned with the mechanics of the tape recording - in consequence the therapeutic talk begins at line 68.

It is a legitimate probe that Patterson (1974: p.104) argues avoids the possibility of any undue interrogation of the client and one that Nelson-Jones (1991: p.222) insists, is used to establish the clients' 'internal frame of reference' (position of meaning/understanding), without which, he says, the counsellor 'may never understand the clients' perceptual world or subjective reality and hence will not have the information base from which to make the client feel empathically understood.' It is an approach, which, though, variable in its expression, is a constant theme throughout this series of conversations.

In this instance, though, it is a non-specific probe that S is emphatically unwilling to accept and she counters his move with an exasperated audible token and an apparent request that he doesn't bother *('buzz')* her with what might be construed as his haughty counselling tones, but rather, that he *'ask* [her] *a proper question'* (lines 69-70, below). M responds by asking her to reflexively compare how she *'feel*[s]' today, with how she felt *'yesterday'* (lines 72-73, below) - an oblique construction, but one that clearly signals his understanding of the retroactive premise this conversation is meant to unfold (see Marková, 1990: p.137).

Extract 8.1: Informants M & S

68 M:Where are you at now?
69 S:Aaaah don't buzz me (.) ask me a
70 proper question (.) I don't understand
71 that.
72 M:Do you feel as well as you did
73 yesterday?

S's response is interesting because it functions as a second order act of deliberate self

positioning, one which turns the topic of talk away from the self disclosure M was urging upon her, and one which now insists that he address the topic of talk they both know is implicit in their encounter, her emotional state - an argumentative response that is consistent throughout her talk. A topic she contends is made all the more salient by her non-verbal communication - which, she clearly believes, M has failed to address in any adequate way (see extract 8.4: lines 96-97).

Her response to M's second question is an unequivocal, *'no'* (extract 8.2: line 74, below) - she doesn't feel better than she did yesterday. Pressed to say more with a question that appears to declare some mild surprise on his part, M (line 75, below), S admits that she hasn't been feeling well since *'tea time yesterday'* (line 76, below) - a decline in her mood state, the severity of which, is announced by her feeling less than *'heroic'* - an allusion to her usual stoicism, which later becomes meaningful (see extract 8.3: lines 80-89, below).

Extract 8.2: Informants M & S

74 S:No.
75 M:When did you start not to feel so well?
76 S:Tea time yesterday (.) I was just sitting
77 there (.) didn't feel that heroic.

Asked how she felt when she woke this morning (extract 8.3: lines 78-79, below), S offers a two-part account: first, she reveals the depth of her distress, in terms of her, *'feeling flat'* and not seeing *'much point* [in] *getting up'* (lines 81-83, below) and second, her fortitude in adversity (lines 84-89, below) - which, when compared with her relative collapse during the previous evening (lines 76-77, above) - gives some measure to how she was feeling then, and how she is feeling now. A point that M ignores when he

refuses the turn of talk invited by her substantive pause (line 89, below)[3]. S answers his apparent indifference to her feelings by concluding, that if he wants to know more, *'he is going to have to work'* for it, that she is, in fact, *'not in the gabbling mood '* (lines 91-92, below).

Extract 8.3: Informants M & S

78 M:What did you feel like when you woke
79 up this morning?
80 S:Tired (.) my head aches (.) I've had a
81 headache since I woke up (.) I just feel
82 flat (.) I'd say there wasn't much point
83 getting up (.) I haven't felt that for a while
84 (.) but I got up and put some washing in
85 the washing machine and did all my
86 ironing and things (.) kept busy as I do
87 when I'm at home and feel like that (.) fill
88 the hours so I don't have to do anything
89 about it (1.0) that's it (.) go on ask me
90 another question (.) come on (.) you're
91 going to have to work today (.) I'm not in
92 the gabbling mood today (.) I'm afraid.
93 M:We were talking (.) I said a bit to you
94 about that yesterday (.) didn't I (.) about
95 styles?

M responds to this relatively fierce injunction (to modify his approach) by attempting to shift the topic of talk away from S's immediate concern about her feelings, to something he has previously referred to as *'styles'* (lines 93-95, above) - note here, M's use of the integrative *'we'* (line 93, above), a first and only occasion he invites her collusion in this way (muted though it is), in what is, a predominantly first person/second person

[3]Some caution is invited in describing this and any other significant pause in this series as a turn invitation, rather than a moment of silence that is adjudged by person centred counsellors to be important in, 'allowing the client to delve deeper into what [he/]she is trying to convey' (Nelson-Jones, 1992: p.28).

construction of talk, that simply fails to agree a compatible perspective[4]. But, once again, S refuses the position offered - a reminiscence of their prior talk, and asks instead, that: *'surely* [he] *can see* [she's] *not the same as yesterday'* (extract 8.4: lines 96-97, below) - by which she appears to mean, she is possibly worse than she was yesterday - a fact he has so far ignored and she insists is addressed before she moves on to any other business.

Extract 8.4: Informants M & S

96 S:Yeah (.) well (.) surely you can see I'm
97 not the same as yesterday?
98 M: I can see that you are the same as you
99 were yesterday.
100 S:I am the same?

Though there positions in relation to one another are clearly antagonistic M, is not easily drawn into the collusion S is urging on him and he refuses to validate her claim of apparent emotional relapse and instead he offers a first person avowal that insists she is, in fact, *'the same as yesterday'* (lines 98-99, above) - a position which suggests (and no more than that) that S has failed in some way to address the topic of *'styles'*, which he thought relevant in their previous days talk (extract 8.3: lines 93-95, above), and which she does nothing to deny with her self-reflexive paraphrasing of his questionable opinion: *'I am the same',* she asks (line 100, above).

Extract 8.5: Informants M & S

101 M:Yes (.) nothing's changed (.) has it
102 then?
103 S:well (.) I don't feel as good as I did

[4]M, it would seem, is equally unwilling to sacrifice his subjectivity to S's - a position he maintains throughout.

104 yesterday.
105 M:So (.) whats goin' on?

Had it been M's intention to move the conversation forward from the previous day's talk - and it might be supposed that it was - he has been stalled by S's refusal to self disclose beyond her immediate concerns and he is forced to change his tack. But he does so with a subtlety that is almost lost: *'nothing's changed'*, he asserts, but this is not a reference to S's current mood state, but rather a reference to her *'world'* - which he believes hasn't changed since yesterday (extract 8.6: lines 107-108, below). S, responds with a clarification that, first agrees that nothing has changed, then, second, and more importantly, that *she* has - the point she has been urging upon him all along (lines 103-104, above).

By incremental adjustment the topic of talk is re-negotiated, albeit in a biased and highly marginal manner, until M is forced to make the first proactive move in search of new information: *'so* [he asks] *what's goinin' on*'? (line 105, above). To which S replies with apparent indignation - *'why didn't you ask how I was'* (line 106, below) - a hedge it would seem which once again appears to resist the trajectory M wishes to pursue. M responds by asserting more clearly his understanding that [her] *world hasn't changed since yesterday'* (lines 107-108, below), only to be countered by S's belief that it has (lines 109-110, below).

Extract 8.6: Informants M & S

106 S:Why didn't you ask how I was?
107 M:The world hasn't changed since
108 yesterday, has it?
109 S:Why are you asking me (.) my world
110 has changed.

M's failure to immediately empathise with S's current mood state is self evident and it points to a difficulty that is consequent on any conversation that is, or hopes to be, resourced from *within* the subjectivity of an other, rather than from *without* - a conversation that begins by refusing that meaning/understanding is both situated and co-authored/co-sponsored by participants in their talk.

In this sense, it points to a recurring difficulty in this series of therapeutic talks, namely, the reliability of clients' self report/disclosure and the part played by the counsellor/ psychotherapist in the construction of its meaning/understanding. There appears to be a tacit assumption in these opening moments (and in the conversations to follow in chapter nine) that the diorama of the clients' subjectivity is in some way separate from its social production (Gergen 1988).

S's refusal to self disclose in the manner M was urging upon her (extract 8.1: line 68, above) is an eloquent testimony to the position she conceives he must play in the story she is invited to tell - a story replete with possibility, but one that is inevitably a 'temporary construction of what seems most appropriate from the perspective of the narrator at that time' (Gergen, 1988: 102).

Interestingly, S's resistance to M, is not a rejection of the situated identities their positions describe - client/counsellor, but rather the trajectory of his talk which apparently assumes an improvement in her mental state she has no intention of

agreeing[5]. In this instance her wont is to talk about herself from the vantage of her own understanding, rather than from his, an orientation to talk that insists that the prelude to any further discussion is a recapitulation of her problem state and the distressed identity this necessarily assumes.

Problematic, throughout the early stages of this encounter it would seem, is M's assumption that he could choose the focus of their talk without regard to the constraints imposed upon him by the 'involvement obligation' (counsellor) invited by their therapeutic encounter, rather than the everyday conversation this talk might otherwise have implied. Speaking of this, that is, the 'social control' of conversations, Goffman (1972) remarks that the:

> '... major obligation of the individual *qua* interactant is balanced by his right to expect that others present will make some effort to stir up their sympathies and place them at his command. These two tendencies, that of the speaker to scale down his expression and that of the listeners to scale up their interests, each in the light of the other's capacities and demands, form the bridge that people build to one another, allowing them to meet in a moment of talk in a communion of reciprocally sustained involvement. It is this spark, not the more obvious kinds of love, that lights up the world' (Goffman, 1972: pp.116-117)

That S was unwilling or, indeed, unable to progress the conversation in the reciprocal manner Goffman supposed, was self evident throughout extracts (8.1-8.6, above) and this remained the case until M offered a repair that conceded both her understanding and her self interests, rather than what appears to be his own - *'what* [he asks her] *is the problem'* (extract 8.7: line 262, below). His mood, though, is sceptical and S's

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[5]Rennie (1994: p.46) suggests that client resistance of the type this describes is relatively commonplace an is an objection to a 'particular counsellor *intervention* ..*strategy* and/or *approach* and reflects the fact that people as clients in counselling, know what they are experiencing.

inquisitive and emphatic *'sorry'* (line 263, below) more properly describes her surprise at his apparent naïvety, than it does, the regret it might otherwise pretend (see extract 8.13, below).

Extract 8.7: Informants M & S

262 M:What's the problem?
263 S:Sorry?
264 M:What's the problem?
265 S:Problem is (.) I'm here and I shouldn't
266 be.
267 M:Because?
268 S:I'm depressed.

But, M is unmoved and he repeats verbatim his call for the proofs he demands (line 264, above). In this instance, his repetition captures something of what Tannen (1992: p.54) has described as, 'yessing' or 'buttering someone up by hypocritically displaying continual automatic agreement' with the position they assume. Interestingly, S's first move to explain herself is a curious inversion of the facts which conflates the detail of her *problem* into a self censure that is a criticism of her admission to and subsequent stay in hospital: *'I'm here and I shouldn't be',* she declares (lines 265-266, above; see extract 8.13: lines 313-314, below).

Pressed to say more with a form of 'yessing' that offers no apology for its temerity (line 267, above), S concedes that her admission to hospital - fateful, though this was, is a consequence of her depression (lines 268, above) - a fact, it must be supposed, well known to M. Asked to explain herself further (extract 8.8: 269, below) S proffers a story that, in all probability, M has heard before (lines 270-277, below), and one which he appears to have little or no sympathy - if his mild, but unmistakable mockery, is to

be believed in the avowal that declares his position of understanding and the end of his resistance to the position she has assumed - hereafter, his position is one of benign, if unconvinced, facilitator (lines 278-279, below).

Extract 8.8: Informants M & S

269 M:What does that mean?
270 S:What does depressed mean(.) I can't
271 cope with life outside this place (.) can't
272 go shopping (.) would probably drop my
273 son on his head if I had to spend any time
274 alone in the house with him and his sister
275 while he was screaming (.) can't work (.)
276 can't cope with cooking shopping
277 anything like that.
278 M:So there's not a great deal that you
279 can do really?

M's alignment to S is both tantalising and indulgent in its circularity and captures something of the dilemma that bedevils person-centred counsellor's/psychotherapist's, who, not wishing to do injury to their client's account (their right, their truth and their sincerity) are forced into a form of ritualised politeness that precludes the sort of direct confrontation of the facts that is commonplace in other forms of talk (cf. Goffman,1972: p.139). However, this is not to say, that counsellors/psychotherapists don't ever confront their clients - they (probably) do, but they do so, in a manner that tries always to limit their own self revealing understanding of the facts under description to a minimum (cf. Carkhuff, 1969, Vol 2: pp.92-95; Berensen, Mitchell & Laney, 1968: pp.111-13; Nelson-Jones, 1991: p. 313)[6] [7].

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[6]Interestingly and rather intriguingly, Berenson, Mitchell & Laney (1968: pp.111-113) point to the fact that unskilled counsellors more frequently confront than do skilled counsellors.

[7]It is important to concede that this is an idealised view of confrontation in person-centred therapy and it may, or may not, always hold true. Masson (1993: pp.229-247), particularly, is loath to believe that therapists are as discreet as Rogers (1957) was wont to believe. In contrast to the idealised view Heron

Importantly, extract (8.8, above) changes the form of S's story from the, so-far, circumstantial allusion to her admission, depression and somatic state (see extract 8.4, above) to something infinitely more tangible - her inability to cope with her domestic and working life, both of which appear fraught with unresolved personal difficulties. But, this is a spore that she has clearly trailed before and one that is doomed to disappoint her interlocutor in its inconclusion (see extract 8.14: line 323, below).

Extract (8.9) below, begins with S confirming her inability to cope - her distressed identity, with an emphasis that repeats the reference she previously made to her sons screaming (extract 8.8: lines 272-275, above). M, responds to this particular focus with a peremptory *'sometimes'* (line 291, below) which once again captures something of the projected nature of his inquiry and the retrospective premise on which it is so clearly built - one which appears to argue a limit to the negative impression S is want to give of her self and the facts she describes.

Extract 8.9: Informants M & S

290 S:Yeah I can't cope with him screaming.
291 M:Sometimes?
292 S:Mm quite a lot of the time.

There, then follows a moment of what appears to be prophetic confusion when S implies a greater ability to cope than she would want to admit (line 292, above & extract 8.10: lines 293-294, below) - an impression she quickly corrects with an utterance that clearly signals the importance of the contradiction she had buried in her initial self assessment

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(1989) offers a comprehensive (if inordinately complex) idea of how prescription, information giving and confrontation might be achieved without hurt to the client.

of the problem she claims (see extract 8.7: lines 265-266, above) - in hospital she can *cope*, but at home she can't, a circumstance she clearly mourns, if she can't control (lines 295-297, below).

Extract 8.10: Informants M & S

293 M:You can't cope a lot of the time or you
294 can?
295 S:Well here fair enough here (.) where I
296 know if I do need help (.) that's fine I can
297 run for help.
298 M:But the prospect of being on your own.

It is an important contrast and one which she develops to include her husband (extract 8.11: lines 299-301, below) and rather more emphatically, her work as a school teacher, the idea of which now appals her - *'Christ I couldn't do it'*, she remarks (lines 304-308, below). A timely reminder, one might suppose, of Alaszewski's (1986; cf. Main, 1946) belief that mental hospitals can afford some patients a meaningful social construction that is otherwise absent in their life.

Extract 8.11: Informants M & S

299 S:At home with ((name of husband and
300 children omitted)) is just not something I
301 relish the thought of.
302 M:What were the other things (0.5) work.
303 you couldn't work.
304 S:No way couldn't even walk through the
305 doors let alone face twenty-four kids or
306 whatever it is (.) twenty eight I think is the
307 biggest class I had (.) Christ I couldn't do
308 it.

That S can't cope at home and/or school and derives some comfort and/or benefit from

her admission and stay in hospital is fairly certain, but why she can't cope in either of these situations remains as obscure now as when this conversation began and, presumably, when all others concluded[8]. It is an enigma that might have been answered (whole or in part) when M asked S to explain, *'so what's this all about then'* (extract 8.12: line 309, below), wherein, his use of the proximal, indexical *this,* appears to reference, *this* particular construction of talk, rather than the repeated story line he had just heard.

Extract 8.12: Informants M & S

309 M:No So what's this all about then.
310 S: I don't know- what do you mean?
311 M:You somehow feel that you should be
312 able to do all these things-

However, had it been M's intention to explore the specifics of *this* construction of talk, rather than any other, it was lost when S responded to his question with an understandable, if ultimately perverse, request to know what he meant (line 310, above). This appears to be a pivotal moment in their conversation, but one that collapses immediately under an elision that clearly signals a return to the storyline that was always her preferred option - her recent emotional decline (extract 8.13: lines 313-321 & 319-321, below; see extracts 8.2, 8.3 & 8.4, above).

Extract 8.13: Informants M & S

313 S:Well no (.) I can't (.) well I've done it
314 before so hopefully I'll be able to do it
315 again (.) but when and how (.) that's the
316 problem?
317 M:Yeah (.) which is a hole you don't want

[8]It is useful to be reminded that this conversation is one of several therapeutic encounters M and S have been engaged in.

318 to be in (0.5) and {you're getting-
319 S:Yeah} and I started climbing out last
320 night (.) yesterday and I hit a slippery
321 patch and went down the bottom again.

Proof, if proof were needed, that their talk is momentarily stalled by this seemingly inconclusive repetition of a story already told emerges more powerfully in this final extract (extract 8.14, below), when, M agrees, though, with less than good grace, the relapse that S has been urging him to accept and with it the self denomination of distress this is want to invite (line 322, below). But, his equivocation is thinly veiled and she responds to his 'yessing' with a riposte that confirms that he has, indeed, *'heard it all before'* (line 323, below) and, in doing so, she adds fuel to his position of mocking sarcasm which is captured in his contiguous statement of disbelief: *yeah yeah yeah'* (line 324, below).

Extract 8.14: Informants M & S

322 M:Ok yeah yeah.
323 S:Yeah, yeah you've heard it all before.
324 M:Yeah yeah yeah.

The discordant position of M and S's to one another is apparent throughout this conversation - M, it would seem, wants to move on and talk about other things (styles one might presume), and S doesn't. In doing so, S not only asserts her distressed identity, but also her control of a conversation that is fixed by the diorama of her understanding, rather than the *reciprocity of perspective* M had assumed to be possible (see Schutz, 1963). That M didn't believe S's *collapse* of the last twenty four hours was self evident, that he could do little about it, was equally true (see extract 8.14: lines 322-324, above).

Problematic, it would seem, is S's katathymic thinking - which is cleary not receptive to the talk M intended in this encounter, but it is also true that M has laboured under a convention that Patton (1984) has described as, 'keeping the client talking', one which assumes that:

> 'Whoever claims to be using counselling techniques - and any list of techniques will do - finds that he or she has accepted the major responsibility in the encounter for making happen the kind of conversation intended by the list. By using counselling techniques, counsellors are attempting to ensure that conversation happens in the first place. ... The use of counselling techniques is a demonstration of this obligation' (Patton, 1984: p.449)

In the next conversation between informants A2 and M3, the counsellor is once again cast as the disbelieving facilitator of a talk that is more disjunctive than it is discordant - disjunctive, in that the prospect of their future harmony appears less certain than it was for M and S, but it is a talk, no less than conversation one above, in which the obligation to make it happen rests entirely with A2.

In this second conversation, the counsellor, A2 thinks he knows that M3 is not the schizophrenic he claims to be, whilst M3 offers *evidence* that he is, or, if not, a position of self understanding worthy of psychiatries comment. Their talk, however, like conversation one above, appears constrained by those polite conventions of person-centred therapy which insist that there is no overt disagreement and/or untimely ending to their encounter - that, in effect, the position assumed by the client cannot be disagreed.

Conversation Two: Disjunctive Positions

In this talk a different, more passive form of resistance emerges between informant A2, a male staff nurse and M3, a young man in his early twenties, thought to be assuming a schizophrenic illness for the purpose of admission to hospital. In this instance M3's resistance appears to be no more than a complement to, or an artifact of, the counsellor's failure to assert more forcibly the position he (and others) hold to be true, rather than a resolve to control their talk.

A2 begins this session by attempting to explore M3's understanding of his medication and diagnosis in order (it would appear) to give a lie to his illness claim. The conversation thereafter is inherently argumentative from the perspective of A2, but misunderstood as such by M3, who resists the second order accountative position this entails with a guile that is entirely plausible (extracts 8.15-8.22, below).

In this instance we are reminded of Lobjoit's (cf. Jones, 1972: p.253; The Mental Treatment Act, 1930) - concern that the mental hospital should not give succour to a malingering, or indigent population of patients, who, in their wish to avoid work or responsibility, feign a *sickness,* a view, that Szasz (1994: p.149) would argue has been, and continues to be, the primary purpose of the mental hospital.

Interestingly, A2 opens this talk with a question that presupposes the opposite to be true - a position of apparent moral rectitude that sets the tone of this conversation: *'do you think you need ECT'*, he asks (extract 8.15: line 11, below). This is (or so it would

seem) a 'rhetorical formulation that expresses a strong affirmative by using the negative of its contrary' (The Modern University Dictionary, 1955) - a litote, which is only revealed in the feedback turn that closes this extract (lines 20-21, below). Bergmann (1995: pp.149) claims that litotes of this sort are much used in psychiatric interviews because they have the advantage of: 'talking without specifying what one is talking about' and/or 'avoid[ing a] more direct or explicit description [whilst creating] the possibility that the co-interactant will be the first to introduce such a description and by doing so, show openness and honesty.'

Extract 8.15: Informants A2 & M3

11 A2:Do you think you need ECT?
12 M3: I think I need it because my medication
13 needs to be renewed anyway I used to be
14 on Largactil until they took me off that last
15 summer (.) I was on that for six months
16 and then they said they were going to try
17 me on ECT something they haven't tried
18 me on (.) so it's a toss up between that
19 and ECT treatment.
20 A2:It surprises me a little bit because they
21 don't treat the same condition.

But, if M3 understood this to be the case (and it is doubtful he did) he avoids the moral advantage this might accord him with a two part claim: the first of which, insists (oddly it would seem) that he *'think*[s] *he needs it because his medication needs to be renewed'* (line 12, above) and second, and rather more importantly, that others, an unseen authority he refers to simply as, *'they'* - *'said they were going to try him* [him] *on ECT'* (line s 16-17, above). A fact that clearly warrants his understanding and one, the importance of which Habermas (1991: p.302) is wont to emphasise. A2's response to

this - a first person avowal[9], though, is interesting because, whilst he appears to acknowledge the absent *voice* of this otherwise unimpeachable medical authority, he suggests his *'surprise'* in a choice of treatment, which, he asserts, is not compatible with the diagnosis M3 claims (lines 20-21, above)[10].

Extract 8.16: Informants A2 & M3

22 M3:Don't treat the same condition?
23 A2:Are you talking about injections they are
24 normally used to treat sort of psychotic
25 illness- (0.5) do you know what I mean by
26 that (0.5) has anybody told you what you
27 are suffering from?
28 M3:Pardon.

Mild though this injunction is - repeated in extract (8.16: lines 23-25, above), it signals the end of what is, A2's only direct challenge to M3's position, which, it would appear, is validated by a medical authority more knowledgeable than his own and one which it would be professionally indiscreet to confront directly, but it is one that collapses almost immediately under the weight of M3's benign misunderstanding of the point that A2 is trying to make - that his position of meaning/understanding is not factually correct (extract 8.16: line 22, above).

Not surprisingly A2 abandons this approach in favour of a question, that possibly ought to have been his start, but he does so in such a way as to invite into the conversation the *voices* of those absent others M3 has already claimed to warrant his position -

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[9]It is interesting to note that this is the last position of claim that A2 makes, hereafter, he reflexively questions M3.

[10]Electro-convulsive therapy (ECT) is invariably used to treat affective disorders such as mania and/or depression and would not be used to treat the psychotic symptoms of schizophrenia *per se*.

voices that will be difficult, if not impossible, to disabuse: *'Has anybody told you what you are suffering from'*, he asks (lines 26-27, above).

Extract 8.17: Informants A2 & M3

29 A2:Has anybody ever explained what they
30 think you are suffering from?
31 M3: I have been told I was schizophrenic.
32 A2:Who told you that?

Not surprisingly, given, its rather convoluted construction, M3 fails to grasp the meaning of the question posed and he invites a repetition that now asks: *'has anybody ever explained what they think you are suffering from'* (extract 8.17: lines 29-30, above) - the effect of which is to position M3 (if it wasn't already the case) in relation to what ever it is those others have said, rather than what he himself might know. To which he answers: *'I have been told I was schizophrenic'* (line 31, above). Asked, who told him this (line 32, above) he answers with equal brevity: *'the psychiatrist at ...'* (extract 8.18: lines 33-34, below).

Extract 8.18: Informants A2 & M3

33 M3:The psychiatrist at ((Name of hospital
34 omitted)).
35 A2:What problems does schizophrenia
36 cause you?
37 M3:It causes me to get run over by cars
38 and traffic (.) walk off the edges of
39 buildings and things I've gone to attack
40 people but- lost control (.) I've committed
41 suicide a few times.

Had it been A2's design to undermine M3's position - his claim to be a schizophrenic,

he has made a poor start, merely fuelling his belief in this particular social identity by calling forth the discursive argument he uses to define himself as such - that is, the report(s) of reliable others (cf. Harré & Gillet 1994: pp.176-180). If this was not enough, A2 then asks M3 to confirm the veracity of his claim by self referentially describing the problems that *'schizophrenia cause* [him]' (lines 35-36, above) - which, not at all surprisingly, he does (lines 37-41, above).

Something of the spurious nature of M3's claim is signalled in his dramatic description of the problems he has encountered with his schizophrenia - none of which are, in themselves, testimony to the psychotic illness he claims (see ICD-10, 1992: pp.86-109; DSM-IV, 1994: pp.273-301). However, despite the image this conjures he has offered a 'completion' that is entirely in keeping with the question posed and in this sense it has probably done much to reinforce *his* own understanding of the *illness* he professes (see Leudar & Antaki, 1988).

Given, that this second conversation was apparently initiated by A2 as a challenge to the validity claims made by M3, it has drifted somewhat from its original intention as a consequence of what appears to be A2's feigned 'neutrality' (Clayman, 1995) - an attempt, that is, to avoid any 'controversial opinion statement' that might support blame or criticise M3's understanding. In doing so, he has allowed M3 to resist the imputation of falsehood that was his position by little more than the relatively quiet insistence of his own position. A position made ever stronger by A2's later explorations which do little more than invoke a repetitious retelling and reinforcement of his story and the claims he holds to be true.

In the following extracts of talk (8.19- 8.22, below) A2 now begins a more direct and detailed reflexive exploration of M3's claim to illness and he does so in a manner reminiscent of the sometimes mocking tones of informant M in conversation one, above. Interestingly, though, whilst the remainder of this conversation lays claim to some important factual discoveries - notably, the hallucinatory experience of M3, the net effect does little more than reinforce his already entrenched and vivid position (mentally ill/sick role identity) and one, which will be inordinately difficult to retrieve - if it is ever thought prudent to do so.

M3's account of the problems his illness has posed him (extract 8.18: lines 37-41, above) closed with him making a remarkably unabashed claim to have, *'committed suicide a few times'* (lines 40-41), a not improbable account of the facts as understood by him (see extract 8.19: lines 43-44, below), but something A2 now uses to explore his credibility with a question that is cast as a correction of this obvious, but benign, misunderstanding: *'or tried to'*, he suggests (extract 8.19: line 42, below). Importantly, though this appears to be little more than a gentle sarcasm, it does in fact signal A2's want (as he had done before: see extract 8.7: lines 20-21) to use his expert medical/nursing knowledge (a position of greater understanding) to obliquely discredit M3's account, rather than the understanding it might otherwise pretend (see extract 8.21, below).

In this sense the remainder of this conversation can be heard as an attempt by A2 to passively invoke the correspondence rules for the diagnosis of schizophrenia (DSM-IV, 1994: pp.285-286 - a diagnosis he tacitly agreed in extract 8.18: lines 33-36, above),

or for that matter, any other psychotic illness, as a counter to M3's apparently spurious symptomatology, than it does the exploration it might appear to be. However, whilst this is a not improbable position (argumentative and disjunctive) on which to base a rebuttal, it stands in stark contrast to the person-centred therapy it describes and the medical *truth* this form of therapy resists - not to say, the contested claims that currently undercut the very concept of schizophrenia (see Boyle, 1990).

Extract 8.19: Informants A2 & M3

42 A2:Or tried to?
43 M3:Yes(.) I did it successfully last time but
44 they restarted me.
45 A2:How did you do that?
46 M3:Od'd on my medication and I was in
47 hospital for 15 weeks.
48 A2:In London? so you you attempted to kill
49 yourself.
50 M3:Yeah
51 A2:Overdoses and you said something
52 about walking off buildings?
53 M3:Overdoses walked off the roofs of
54 buildings and things.
55 A2:Yeah

M3's response to A2's apparently equivocating gibe is to offer a marginal account of a serious episode of self-injury, one which he claims to have been *'successful'*, in terms, he desribes as, requiring him to be *'restarted'* (lines 43-44, above). A silly, but not unreasonable justification of his prior assertion, but one that A2 now explores from the perspective of the method used to achieve this end, *'How did you do that'*, he asks (line 45, above). To this, M3 admits to having *'od'd on* [his prescribed] *medication'* and by way of emphasis declares a stay in hospital that was, in any circumstance, an inordinately long, fifteen weeks (lines 46-47, above).

Interestingly, the issue that A2 appears to pursue in this sequence is not the possible fiction of this particular report, but rather that M3 agrees he attempted to commit suicide, rather than the suicide he previously claimed - a increment in his testimony that apparently gives a further lie to his story (lines, 48-49). Having confirmed this to be so, but without significantly denting the carapace of M3's personal understanding (line 50, above). A2 then summarises his scepticism with an extension that now includes M3's earlier claim to have *'walk*[ed] *off buildings'* (lines 51-52, above; see extract 8.10: lines 38-39) - an embellishment that M3 readily confirms and A2 accedes with an elision that now shifts the topic of talk towards the contested diagnosis this account always assumed (see extract 8.20: lines 57-58, below).

Extract 8.20: Informants A2 & M3

56 M3:'Sright
57 A2:Is that because you're depressed or
58 because of something else?
59 M3: I wasn't depressed (.) not depressed-
60 I was sick of hearing voices the
61 medication I was on used to stop the
62 voices but only used to stop for fifteen
63 months (.) they used to come back (.) so
64 then they renewed the medication they put
65 me on higher doses of medication
66 I'm alright for about a day or so but once
67 the stuff gets out of my system I start
68 hearing them again.

Asked if he did the things he claims to have done (the dramatic nature of which appear to cast doubt on their 'rationality or reasonableness' - cf. Ingleby, 1982: p.139) because he was *'depressed or because of something else'* (lines 57-58) - a return, it will be remembered, to the contradiction that originally launched this line of inquiry (see extract 8.7: lines 20-21), M3 denies the former and emphatically concedes the latter with the

introduction of a so far new, and inevitably more revealing, piece of information - he *'was,* [he claims] *sick of hearing voices'* (line 60, above).

Whether, M3 has been, or still is, hearing voices is a moot point, but he obviously believes he does and backs his claim with a history of treatment and *symptom* relief that clearly pathologises the imagery he describes and to a degree that would probably satisfy at least one, and possibly two, of Habermas's (1991) validity claims, notably, his claim to *rightness* and *sincerity* - wherein, what is right, is what *normally ought to be the case,* and what ought to be the case, is that anti-psychotic drugs reduce the experience of hallucination (lines 60-68, above)[11].

However, M3's *communicative* failure, is clearly his failure to convince his hearer, A2, that his claim is *true* - that it fits the facts as he understands them to be, and this (and no more is required) is sufficient to render his position false (ibid, 1991: p.276). Asked if he *'recognise*[s] *these voices'* (extract, 8.21: lines 69-70, below) he interestingly and variously reports hearing the voice of his *'mums mum'*, and the *'devil'* (lines 71-76, below). If it wasn't already clear - and surely it is, A2 doesn't believe a word that M3 is

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[11]Note, in this regard, Rosenhan's (1973) landmark study in which he reported how eight pseudopatients had gained admission to twelve different psychiatric facilities, in five different states on the East and West coasts of north America, simply by 'complaining that they had been hearing voices' (ibid: 251).

The hallucinatory experience reported by these pseudopatients was deliberately vague and when 'asked what the voices said, [they] replied that they were often unclear, but as far as [they] could tell they said "empty," "hollow," and "thud" (ibid) - however, despite this cryptic, if marginally existential, reporting of hallucinatory experience, it was sufficient to warrant the diagnosis of schizophrenia in all, but one case. Interestingly, none of the psuedopatients was ever diagnosed as *sane* and, of the twelve admissions to hospital, ten pseudopatients were later discharged with a diagnosis of 'schizophrenia in remission'.

The consistency of diagnosing in the Rosenhan study is highly significant and clearly underlines the power and salience of a single 'situational impropriety' - in this instance, hearing voices, in the formulation of an insanity ascription.

saying, a position of incredulity he obviously sees no point in declaring and would probably find difficult to support in the current circumstance of their talk.

Extract 8.21: Informants A2 & M3

A2:Do you recognise these voices that you get?
M3:One of them is a voice of my mum's (.) my mum's mum but she's dead now (.) I don't know why I keep hearing her voice (.) the last few days I have been listening to her (.) It's weird like I've been hearing the voice of the devil he chants things at me and things (1.0) he tells me things to do.
A2:Gives you commands?

If Rosenhan (1973) is to be believed (and there is no reason to think that he shouldn't, see Schneider, 1959; ICD-10, 1992; DSM-IV, 1994) then there is warrant enough (one would think) in this last statement for psychiatry to be concerned for the mental health (if not the mental status) of M3, but this is to forget the 'discredited and discreditable identity' that he has apparently trailed into this encounter (Goffman, 1990) - one which presumes his story to be fraudulent before it begins (cf. Habermas, 1979; Ingleby, 1982)

Something, of this is captured in A2's concern to pursue the notion of agency/volition that M3 injects into his story when he posits the idea of demonic control of his behaviour (75-78, above) - a persuasive attribution of blame that is as old as time and one that provides him with a all too plausible excuse for the misdemeanors he has so far admitted (see Plato's, *Phaedrus* 244/Hackforth, 1996: pp.491-492) - the issue now, it would seem, is whether the voices M3 hears are real or imagined - or, as others

might contend, good or bad [12] [13].

Extract 8.22: Informants A2 & M3

80 M3:Yes.
81 A2:Do you feel compelled to act upon those
82 commands?
83 M3:Some of them.
84 A2:Just some of them.
85 M3:Not all of them (.) nothing stupid
86 nothing by mistake.
87 A2:So a certain degree you can be
88 selective on what commands to act on or
89 not to act on?
90 M3:Yeah.
91 A2:Where does this voice come from you
92 said the devil but how did the devil try to
93 communicate with you?
94 M3:It's all communication.
95 A2:Is the voice inside your head or does it
96 come from the outside?
97 M3:Comes from inside.
98 A2:Is it not maybe your imagination?
99 M3: No it's not my imagination no.

To this end, A2 constructs an argument that captures, in its expression three associated ideas: agency, discrimination and source of imagery (extract 8.22: lines 81-82, 87-89 & 91-93, above). His thinking, it would seem, is to test each of these as a measure of the diagnosis M3 has assumed. Interestingly, M3 appears to be unaware of the salience of the first two of these items to the diagnosis he claims and he discloses that *'not all of them'* [the voices] command him and then, rather more importantly, that he

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[12]Schneider's (1959) *First Rank* Symptoms of schizophrenia describe a variety of hallucinatory voices and include the sort of commanding hallucination M3 posits, however, these voices are invariably accompanied by some degree of *cognitive derailment,* or what Bleuler (1911) referred to as *loosening of associations* - which, to all intent and purpose, is absent from his account so far (see ICD-10, 1992: pp. 86-89 & DSM-IV, 1994: 274-278).

[13]Sarbin and Juhasz (1967) distinguish between 'good' and 'bad' hallucinations - or those calling for action from authority and those not (see Loyolla,1963).

does *'nothing stupid'* and *'nothing by mistake'* (lines 85-86, above) - a rational *association of ideas* that tends to undermine the position he has assumed and one he readily confirms (lines 85-90 & 87-90).

Having confirmed the identity of his voices and the degree to which he feels controlled by them, A2 then poses a question that is unquestionably the kernel of the problem he poses himself and the *sick* identity M3 has assumed - *'where does this voice come from'* - is it real (line 91, above). Though, marginally confused by A2's use of the word *'communication'* (lines 93) M3 confirms the voice *'comes from inside'* his head (lines 95-96 & 97). A2 then offers a conjecture that is both awkward in its construction and improbable in its satisfactory outcome: *'is it not maybe your imagination'*, he asks (line 98, above). Not surprisingly, M3 refuses the position offered and is emphatic in his denial of this highly charged presupposition.

Not-with-standing, the difficulty he would have separating these phenomena - given the inchoate, fluid and altogether indeterminate nature of the self experience, it is hard to see what is proved or not proved by this sequence, other than it attests to a lore that A2 believes supports the medical diagnosis of schizophrenia. A lore that would inevitably pathologise the *voices* of such luminaries (if equally misunderstood) figures as Pythagoras, Socrates, St Augustine, Jeanne d'Arce, Loyolla, Pascal, Luther and probably many others besides (see Leudar, 1998; Sarbin and Juhasz, 1978: pp.117-144)

More important, though, than this, it is a dialogue that in its determinate (if polite)

construction has contributed so significantly to the synchronic repetition of words and phrases that are the most likely explanation of M3's claims to illness in the first place and with which, he barters his stay in hospital (Tannen, 1992: p.68; see Informant H: extracts 6.14 & 6.15)[14]. In his inveigling circularity A2 has failed to make clear the premise on which this beginning to their conversation is built - the fact that he, and probably others besides, emphatically disbelieve the claims to illness he makes (cf. Bergmann,1995).

Like conversation one above, it is a talk that can have no satisfactory conclusion if its purpose is to dissuade M3 of his self identity by a process of reflective questioning/innuendo, rather than one that 'makes available [to him] construals of [his situation] that are [more] adequate and fulfilling' than those he apparently pretends (Harré & Gillet, 1994: p.178). To this end, it is talk that might reasonably be recast as a form of 'education and/or reform', rather than the self revealing therapy it otherwise pretends (Orlinsky, 1989: p.419). Speaking, of the latter and the complexity of talk it describes, Patton (1984) posits that:

> 'It is one thing to be troubled and/or hurting and to ask for the counsellor's sympathetic and humane concern ... It is quite another thing, however, to take a reflective interest in oneself and to welcome another person to do likewise while interacting with that other person' Patton, 1984: p.453)

In the following conversation (three, below) counsellor N tries (it would seem) to do just that - to lead her client away from his current understanding of the *hurt* and anger he claims, towards the reason(s) she perceives to be the better explanation of his current

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[14]Once again the readers attention is drawn to the *contrived* nature of this and other encounters in this set.

feelings by a process of benign, if well meaning, reflection. In this sense, her talk can be read as an attempt to urge upon him the *confession* she feels it will be good for him to make. Not surprisingly her client resists and their conversation is a constant disagreement of their position that hinges on what others have said or done to him on past occasions - third person referents he deploys to warrant and mitigate his aggrieved position.

Conversation Three: Disagreed Positions

In the following conversation between informant N, who, it will be remembered, was the nurse who argued a weak , if not improbable, distinction between real and contrived mental illness on the basis of a text book standard and concluded that some *'people need a bit of help'* (extract 6.11: line 151) and informant B3, a drug addict admitted under Section 2 of the Mental Health Act, 1983) for assessment and detoxification and awaiting Crown Court trial for burglary and possession, both counsellor and counsellee resist the attributions of the other in what is an argumentative assertion of their own *disagreed* position.

In this instance, the position of the client *is* challenged, but in a way that is both artful in its use of reflection and limiting in the actual contribution it makes to his meaning/ understanding[15].

The conversation begins with N making an observation about B3's mood, that he

[15]It is interesting that in this conversation N makes no first person avowals, but couches her particular understanding in the plural *we* - she has, it would seem, no position of her own.

appears to be, *'a bit down'* (extract 8.23: line 01, below), which he confirms by describing himself as, *'stressed out'*. In what appears to be a classic counselling form of talk - of which there is more later, N reflects this self denomination back to B3, who readily confirm her understanding with a clarification that claims he is *'stressed out'* and *'can't sleep'* (lines 02-03, below. Surprisingly, given her prior knowledge of his circumstances (see extracts 8.25 & 8.30, below), N asks, *'why'* (line 04, below).

Extract 8.23: Informants N & B3

01 N:It's going- you seem a bit down.
02 B3:Yeah (.) stressed out (.) can't
03 sleep.
04 N:Stressed out why?

B3's initial response to this open-ended question is to claim that he doesn't know why he's stressed out and assert, instead, that he, *'gets like this sometimes'* (extract 8.24: line 05, below). Pressed a little further B3 concludes that *'things sometimes get on top of* [him] (line, 07, below) an inconclusive remark, which he fails to expand under N's confirmatory prompt (line 08, below).

Extract 8.24: Informants N & B3

05 B3:Dunno (.) I get like this sometimes.
06 N:What does stressed out mean?
07 B3:Things just get on top of me.
08 N:Yeah.
09 B3:Yeah.
09 N:You get angry?

B3's reticence, however, begins to falter when N suggests that he, *'get*[s] *angry'* (line 09, above), an assertion/prompt which, whilst suggesting the potential to do so, observes more accurately his current mood state - one that is confirmed when N asks

him, *'who* [he is] *angry with'* and rather more tellingly, whether he is angry with himself, *'or the situation'* (extract 8.25: lines 11-12). Though it is never explicated N's ambiguous reference to the *situation* appears to capture B3's compulsory admission and detention in hospital and his impending prosecution.

By 'fishing' (see Pomerantz 1980), as it were, with a bait that Kreckel (1981: pp.25-26; see also Tannen, 1992; Markovà, 1990) describes as her retrospective knowledge of the *situation,* N has brought B3 to a topic he now feels an imperative to discuss, that is, the strictures imposed upon him by the nursing staff - but she has done so (though it probably couldn't have been otherwise) emphasising his aggrieved and intimidated position (cf. Jones & Pittman, 1980). Responding to N's last question B3 denies that he is angry with himself and offers an account of the events of the last weekend which centre on a nurse *'pissing* [him] *off'* by asking for a (urine) sample every *'five minutes'* (lines 13-16, below)[16]. His remark is undoubtedly an extreme case formulation, but it one he uses to emphasise his sense of personal injustice and the position of victim he is want to contend.

Extract 8.25: Informants N & B3

10 B3:Yeah.
11 N:Who are you angry with (.) yourself or
12 the situation?
13 B3:No (.) at the weekend (.) Pete ((name
14 of nurse)) was pissing me off (.) got a visit
15 and every five minutes they come asking
16 me for a sample (.) you know?

[16]Substance misusers are invariably screened in this manner, particularly folowing any leave of absence or following visits from known acquaintances. It is an intrusive process that does much to undermine the trust intended by nurses.

Interestingly, N's response, an audible pause of indeterminate meaning (extract 8.26: line 17, below), now signals the beginning of her proactive search for new information, rather than a clarification or explanation of the circumstance that B3 has just described, in this sense, it captures Searle's (1993a: p.92) belief that, 'a speaker can perform an illocutionary act in a meaningful utterance and produce perfect understanding in the hearer even though the hearer does not agree and the speaker may be totally indifferent as to whether or not he agrees.'

The indifference that Searle (1993a) speaks of now begins to dominate the rest of this conversation, which apparently ignores the possibility of a consensual understanding between speaker and hearer (Habermas, 1993) in favour of a dialogue that N orchestrates, but contributes little to, in terms of her understanding of the validity claims he raises.

That B3 believes the events he describes to be both extreme and unwarranted (by his definition at least) appears sufficient sanction to shift the topic of talk away from the events of the last weekend towards a new (or possibly so far concealed) concern for his possible, non-compliance to a policy of non-therapeutic, drug abstinence, whilst in hospital - one, that is, in part, prompted by B3's bullish claim to have, *'told them* [the nurses] *what* [he] *thought of them'* (lines 18-19, below). Did he *'give a sample'*, N asks (line 20, below) and, more importantly, *'do*[es] *he think* [it] *will it show anything'* (line 22, below)?

Extract 8.26: Informants N & B3

17 N:Mmm.

18 B3:So I told them what I thought of them (.)
19 you know (.) just doing my head in (.)
20 N:Have you given a sample?
21 B3:Yeah (.) loads(.)
22 N:Do you think it'll show anything?
23 B3:No (.) there's nothing there to show (.)
24 it's like (.) I'm sat here talking to you (.)
25 about my problems (.) right (.) I've got to
26 trust you to tell me my problems (.) like
27 they don't trust me so why the fuck should
28 I trust them(.) you know what I mean (.) it
29 doesn't work one way (.) it works two
30 ways.

B3 responds by denying her suspicion and then in a garbled, but undeniably strong attack (note the first of several expletives to come in line 27, above), questions the basis of their trusting relationship: *'I've got to trust you to tell me my problems'* he declares (lines 25-26, above). Though, it is a construction that bears the hallmarks of a statement composed in haste and/or anger, its intent does, in fact, appear to signal a want to be believed - a reciprocity demand that clearly fails to ignite N's backing (lines 26-30, above & extract 8.27: lines 33-37, below).

Extract 8.27: Informants N & B3

31 N:Yeah (.) we think we're doing the right
32 thing.
33 B3:You know what I mean (.) it works two
34 ways (1.0) that was all it was (.) he had
35 a sample off me two days before (.) so
36 what's the fucking point (.) you know what
37 I mean?
38 N: I'm sure they must have explained to
39 you what- {why-

If this was an opportunity to support B3 - and it appears that it was, then N has ignored it in favour of a peremptory and inclusive assertion that, *'we* [my colleagues and I]

think we're doing the right thing' (lines 31-32, above) - a positioning of her solidarity/responsibility with those others which very quickly collapses under the strain of B3's increasingly strident tones (lines 33-37 & 38-39, above). Having foregrounded the issue of trust B3 invites N to explain why her colleague found it necessary to repeat the sampling process when he had given one to him only, *'two days before so what's the fucking point'* (lines 35, above). A simple enough question, if overly stressed by his insecurity, but one she refuses to answer by intriguingly, positioning herself outside the argument it raises - *'I'm not sure'* she says *'they must have explained to you what- why-'* (lines 38-39, above).

This last turn of talk is replete with unspoken possibility, not least that N might take the opportunity to explain the policy and/or procedures that support the random drug sampling he was subject to; or more precisely, offer some clarification of the motives invested in this particular incident (the visit of his friend being suspicious in the circumstance) - that she didn't, though, appears to be part of a process, only just beginning to emerge, that insists that B3 must first confessess what he knows before she tells what she does.

In their talk so far, N has demonstrated a remarkable (and laudable) self composure whilst limiting her own contribution to talk to a minimum - a spartan approach to their communication that has done little to help her client modify and/or change his position on the things he describes and which now begin to invoke an increasingly aggressive reaction from him.

Responding to N's belief that *'they must have explained'* matters to him (lines 38-39, above) - a distal pro-term that B3 is clearly sensitive to, he offers an account of events which clearly assert that *'they'* didn't, and a self reflection that begs to know *'what's the fucking point'* (extract 8.28: lines 40-43, below). Though, this undoubtedly references the test he has undergone, it also hints at a belief in his own compliant and reasonable behaviour - a position of virtue he believes has been so far ignored - not least, one might presume, by N (see extract 8.29: lines 54-55, below; see extract 8.27: line 36, above).

Extract 8.28: Informants N & B3

40 B3:No} (.) they said random sampling (.) as
41 soon as I walked in off my visit (.) right (.)
42 so I was just pissed off from there on (.)
43 I thought what's the fucking point.
44 N:Well they do it with everybody.
45 B3:They don't though.

Remarkably, N once again refuses the opportunity this provides to explain the reason for his testing, or in anyway clarify the motives invested in this particular incident - which quite clearly capture the recent visit of his friend (extracts 8.25: lines 14-16 & 8.29: lines 51-52, below), but rather, she absolves herself - not to say, distances herself from this activity, with a euphemistic fudge that insists that, *'they* [those absent others] *do it with everybody'* (line 44, above) - a hedge that B3 emphatically refuses and one that looks more than a little suspect (line 45, above).

N's positioning is interesting - not to say paradoxical, because it clearly represents an attempt on her part (not at all successful) to separate her counselling/psychotherapy

from the position of power and control her colleague (nurses one presumes) have invested in the random drug sampling that B3 has found so damaging to his sense of personal security and/or self esteem (extract 8.28: lines 40-43, above). A position of veiled neutrality that looks not only tenuous, but increasingly problematic as this conversation continues and one which clearly begs to know - whose side is N on anyway, and for that matter, all other counsellor/psychotherapists in this series, who claim a position of empathic meaning/understanding with their clients, whilst subordinate to the institutional imperatives of their primary social role (see chapters five, six and seven, this volume and particularly conversation four, below).

Once again, though, N's unwillingness to declare more than she knows about the so far 'referred-to-facts' (Bergman, 1995) looks more and more like a prompt to get B3 to 'tell his side of the story' (Pomerantz, 1980: p.193). If true, it is a clever device that, whilst posturing as an opportunity for the him to tell his side of the story also suggests an oportunity for him to *confess* his understanding in a manner more self revealing than the deflections he has so far admitted.

Cast in this light, N's fudge, now looks more strategic than it first did and, though, success alludes her, it does in fact tempt an admission of sorts from B3, albeit against a background of repeated invective (extract 8.29: lines 47-49, below), which concedes his understanding of the motives that conspired to produce the test in the first place (lines 51-52, below).

Extract 8.29: Informants N & B3

N:How do you know that?
B3:They don't (.) why is it every fucking two days after giving a sample (.) why is it two days after?
N:Why do you think?
B3:Because they think my mate give me something when he came to see me.
N:Mmm.
B3:They think I'm fu::cking stupid (.) but I'm not.

Prompted to say more with an audible pause, B3 replies with an aggressive *double entendre*, which exclaims an innocence cast as a knowing that should by all accounts, have been taken for granted: *'they think I'm fu::cking stupid but I'm not'*, he remarks (lines 54-55, above) - an affirmation of his understanding that, in effect, neither confirms or denies the suspicion of drug taking that was conjured by his visit. Though, it may seem otherwise the conversation so far has produced remarkably little new information, but it has generated an awful lot more heat and anger and to a degree which suggests his concerns are rather more pressing than the random drugs test they have been speaking of.

Extract 8.30: Informants N & B3

N:What are you so angry about it if you've got nothing to hide?
B3:It's just the people are on my case every five minutes (.) so I feel like I'm being hassled that's why I'm so fucking angry (.) you know what I mean(.) so they're doing things for themselves not other people.
N:Do you think you're worked up at all about court (1.0) the night nurse said you were asking round the clock last night about how we're going to get there and that.

It is certainly a possibility that N is alive to - indeed, has been since the beginning of this conversation (see extract 8.25: lines 11-12, above). Interestingly, knowing what she knows (extract 8.30: lines 63-64, below) N responds by asking B3 to explain: *'what* [he is] *so angry about if* [he's] *got nothing to hide'* - a challenge, if ever there was to his probity (lines 56-57, above), but one he fends with a deflection that casts doubt on the motivations of the people caring for him (lines 58-61, above). Positioned, as victim in a conspiracy he now gives a possible first indication of his desire to be helped (or otherwise understood), with a challenge that suggests that: *'they're doing things for themselves not other people'* (lines 61-62, above).

Intriguingly, N responds to this with an elision that is more precise in its speculation, that he is, in fact, *'worked up'* by his impending court appearance and not, as he would contend, the random drug sampling of the previous weekend and, most importantly, that this was evidenced by his *reported* behaviour of the previous night (lines 63-67, above; see extract 8.23).

Extract 8.31: Informants N & B3

68 B3:Well (.) I'm stressed out a bit about that.
69 N:Sorry.
70 B3:It does do my head just thinking about
71 that.
72 N:Yeah (.) what are you worrying about
73 it?
74 B3:Dunno (.) if they're going to give me a
75 fine (.) I'm not going to be able to afford to
76 pay it.
77 N:The fine?
78 B3:Yeah (.) you know what I mean (.) I
79 can't afford a fine (.) got a fucking flat and
80 no furniture and they're asking me for a
81 fine (.) you're like these lot (.) you don't

82 know nothing about my problems (.) you
83 know what I mean (.) Yous don't
84 understand jack shit about me (.) you
85 know what I mean fuck knows (.) no point
86 asking me how I am (.) is there?

In this penultimate extract (8.31, above) B3 confirms that he is '*stressed out a bit about that*' - an understatement one must suppose (line 68, above), and in so doing suggests a naïvety in N's response that is possibly the real source of his *current* anger and hostility and one which links back to his claim that people (nurses) *'are doing things for themselves not other people'* (extract 8.30: lines 61-62, above). A view that resonates some-what with the pretended nature of the nurse/patient relationships that emerged so forcibly in chapter eight - notably, in the accounts of nurses M2 (extracts 7.4 & 7.5), G (extracts 7.6 & 7.7) and patients H (extract 7.19), B (extract 7.20 & 7.21), J2 (extract 7.22) and M3 (extract 7.26).

Ignoring, the possibly pretended nature of their relationship there follows a dramatic sequence which begins when N asks B3, *'what* [it is, he is] *worrying about'* (lines 72-73, above) - to which he answers, not unreasonably, a concern that he might be *'fined'* and, possibly more important than that, that he won't be able to afford it (lines 74-76, above). Once again, though, N's response to this is little more than a prompt to say more about it (lines 77, above) which stimulates a rejoinder both hostile in its intention and illuminating in its expression - one, that is all the more salient for its attack on her abilty to understand his problems, than it is anything else: 'yous don't understand jack shit about me (lines 81-86, above) he says with a conviction that is only matched by his condemnation of her and her *'like'* (extract 8.32: lines 88-89, below).

Extract 8.32: Informants N & B3

87 N:So you're cross with me?
88 B3:Yeah (.) fucking pissed off with you and
89 your like.
90 N: Why (1.0).

Had it been N's intention to explore B3's mood state from a position of benevolent, if feigned, neutrality (as it seems to have been), she has been confounded by his now inclusive declaration that she is, *'like these lot'* (line 81, above) - a damaging, if cryptic, referent that appears to capture all of those absent others who have done so much to annoy him in recent times. If this were not enough - and it would seem to be more than enough he then confirms her decidedly, understated reading of the situation, to wit, *'so you're cross with me'* (extract 8.31: line 87, above) with an invective that is emphatic in its plurality - an invective that aligns N's position with the nurses who are the object of his current anger and hostility (lines 88-89, above).

Though they are very different forms of talk there is a similarity between this conversation and the two preceding conversation, in-as-much-as, all three are premised on the counsellor's undeclared and very particular knowledge of the client under discussion - M understood S to be improved; A2 understood M3 not to be the schizophrenic he claimed to be; and N understands B3 to be more concerned about his forthcoming trial than the random drugs test he was subjected to. In all of these there appears to be a want to preserve the therapeutic relationship - empathy and client subjectivity, at the expense of a communication that might have been more honest and focused in its intent - not to say more, reliant on the counsellor's own position, cast as first person avowals, than they have been (see Patton, 1984). The effect of which is to

ensure that the position of the one is always resistant and dialogically opposed to the position of the other and without promise of their future reconciliation and/or mutual understanding.

Conversation Four: Denying the Positions

This form of *self*-serving dialogical resistance is again observed in this next conversation between informant L2, a community psychiatric nurse and informant G4, a middle-aged housewife with history of violent behaviour, alcohol and prescribed drug misuse. The beginning is once again argumentative as L2 tentatively explores the reason for G4's most recent admission to hospital - a reason she clearly understands, but wishes G4 to voice aloud.

This conversation unfolds with G4 synchronously parrying every initiative by L2 with a response that appears to avoid the second order accountative position that she is trying to impose upon her (extracts 8.33 - 8.31, below). The conversation begins with L2 asking G4 *'how are you'* (line 01, below) - an opening which, in other circumstance, might be viewed as little more than a polite inquiry into her current state of wellbeing, but in this instance functions as a probe that is intended to excite an explanation of her recent behaviour. G4's response, though, is a hedge cast as a cryptic assurance that she is *fine*.

Extract 8.33: Informants L2 & G4

01 L2:How are you?
02 G4:Fine.
03 L2:How have you been?

Interestingly, L2's feedback response - a polite rejoinder, imposes a temporal shift on her search for information that is more specific to her inquiry - *how are you*, is now reformulated to ask, *'how have you been'* (line 03, above). Though, not immediately apparent, this is a first reference to G4's recent *boozing* behaviour, which is the real focus of this conversation (extract 8.37: line 30, below).

Extract 8.34: Informants L2 & G4

04 G4:Fine.
05 L2:That's two fines (0.5) what's happened
06 to you today?
07 G4:Not a lot.

Once again, G4 answers in the affirmative, but her repetition is a deliberate self positioning that signals a continuing refusal to be drawn into the topic of talk that L2 is apparently encouraging upon her. It is a stall that is neatly captured in L2's reply which, first offers a declarative invitation to say more: *that's two fines'* (extract 8.34: line 05, above) and then a repair that attempts a topic shift - neither of which G4 accepts and she closes with a conclusive, *'not a lot'* (line 07, above).

In the next extract (8.35, below), L2 begins to flounders as she tries to counter G4's continued negativity with an open ended question (line 08, below) that speculates the possibility of a hidden disclosure whilst avoiding naming specifically what it is she wants to know (cf. Bergmann, 1995). In essence, G4 knows, that L2 knows, that she knows, that she wants to talk to her about her drinking behaviour, but G4 refuses to acknowledge this for reasons which can only point to the disapprobation this self denomination will later reveal (extracts 8.37-8.39, below). In this sense, G4 is refusing

the position of supplicant, to L2's barely concealed position of intimidator (cf. Jones & Pittman, 1980)

Extract 8.35: Informants L2 & G4

08 L2:Anything (0.5) nothing?
09 G4:No (.) nothing in particular.
10 L2:Just been another boring week?

At this point L2 uses a second temporal shift to capture more conclusively than before the reason for G4's admission (line 10, above) and with it a riposte that attempts to fix the conversation on an interview she had with her doctor, during which, one might suppose, her pre-admission state was discussed (extract 8.36: lines 12-13, below), but G4 is obdurate in her refusal to allow L2 access to a topic of talk she is so unwilling to discuss (lines 11-26, below).

Extract 8.36: Informants L2 & G4

11 G4:Yeah.
12 L2:Have you seen Dr ((name omitted)) (.)
13 been to see him?
14 G4:No.
15 L2: No
16 G4:Seeing him tomorrow.
17 L2:Did you not see him last week?
18 G4:Yeah.
19 L2:Are you still seeing him monthly?
20 G4:No (.) I saw him last week.
21 L2:Why was that?
22 G4:He knew I was in last week.
23 L2:Do you want to tell me about it then?
24 G4:Nothing to tell
25 L2:No
26 G4:No

This extended extract is interesting because it highlights Bergmann's (1995: p.157)

concern that undue discretion of the type this sequence displays is, 'vulnerable to being heard by the recipient in moral terms and may therefore trigger uncontrollable, interactionally disasterous social situations' of a type that emerges in extracts (8.37 & 8.38, below). In this next extract (8.37, below) G4 responds aggressively to L2's continued intimidation cast as an indirect search for new (if already known) information (lines 28-29, below) and, in what seems, a compliance to the emerging tone, L2 abandons the prevarication that has so far failed her and asks G2 directly, *'had* [she] *been boozing'* (line 30, below).

Extract 8.37: Informants L2 & G4

27 L2:How did it go?
28 G4:I don't know (1.0) I don't care how it
29 went.
30 L2: Had you been boozing (2.0) did you go
31 drinking after you left me in the morning
32 (.) had you had a drink when you came to
33 see me (.) truthfully.

But L2's question fails to draw the turn it invites and she continues with an accusation that is both pressing and pejorative in its manner. There is an overwhelming sense of the aggrieved in the position that L2 now adopts (see also extract 8.39, below) one that hints at the reason for G4's earlier sustained resistance to this talk: *'did you'*, she asks, *'go drinking after you left me in the morning'* and, then with a mein of polite, but insistent indulgence, *'had* [she] *had a drink when* [she] *came to see* [her]' (lines 30-33, above). The condescension implicit in L2's request for truth (line 33, above) is quite remarkable and calls forth the image of a recalcitrant child that was so well developed in informant G2's account of the system/culture of care (extract 6.9; see also Rogers, 1962) and wherein, submission and/or compliance is a determinate of his relationship with patients'

(extracts 7.1-7.3). G4 responds to this insinuation of guilt (not surprisingly) with a noticeable hostility and asserts that *no::o* [she] *hadn't been drinking'* (extract 8.38: lines 34-35, below).

Extract 8.38: Informants L2 & G4

34 G4:No::o I hadn't been drinking when I
35 came to see you.
36 L2:Alright (1.0) you hadn't been drinking
37 but you'd been having tablets?
38 G4:I felt OK at the time so I didn't see the
39 point of mentioning it.

Interestingly, L2 concedes that G4 hadn't been drinking (line 36, above), but counters with a conditional second utterance which argues that, though the former might be true, she had in fact, *'been having tablets'* (line37, above) - a surmise that G4 doesn't deny, but insists wasn't relevant to their last meeting (lines 38-39, above). Though, she had hoped to deny the topic of talk, G4 has been forced to concede that, though, she wasn't intoxicated in the manner L2 had first supposed, she had in fact been intemperate with her medication - a not improbable explanation of her behaviour (extract 8.39: line 47, below).

Extract 8.39: Informants L2 & G4

40 L2:I don't think that's quite true is it (1.0) I
41 knew something was going on which was
42 why I asked you (.) I automatically
43 thought it was booze.
44 G4:I had eight ((name of prescribed anti-
45 depressants)) left and I took them before
46 coming.
47 L2:Did you think I wouldn't notice?

This portion of text closes with L2 first consolidating her position of prescient

understanding with a first person avowal of the truth she believes (lines 40-43, above) - the position of vantage she had always assumed and G4 had denied and then, censuring her for her guile in believing that she, *'wouldn't notice'* (line 47, above). This is an important point in this beginning and one which clearly imposes an asymmetry of power and knowledge on their pretended relationship - which, intriguingly , L2 is driven to justify with a surprisingly obsequious defence of her position (see extract 8.42, below).

Interestingly, in previous conversations there was a sense that positions were negotiable - albeit within fairly limited parameters, but in this case, the topic of talk and the implication of guilt this intended has been imposed without regard for the want or sensibilities of the client and with the expectation that she would at some time *confess* her aberrant behaviour by a process of non-specific probing. In this sense it is a conversational beginning very different from any other in this set - one in which, the counsellor has deployed facts known to both her and her client as the lever for her agreement.

Having established the facts as she believes them to be, L2 now abandons her position of moral rectitude in favour of a reconciliation that tries to foster her client's understanding of the threat her behaviour poses (see extracts 8.40-8.42) - which, it emerges, is potentially more serious than her counsellor's momentary disapprobation (extract 8.40:lines 48-49).

Their conversation continues with G4 responding to L2's admonition of her recent

intoxication - a tart assumption of personal knowledge and expertise with an admission that captures something of the complexity of their relationship and one which clearly positions her as agent of an other more powerful than her - her absent doctor (extract 8.40: lines 40-49, below).

Though this sequence might be read in a number of ways - not least, a posturing of self regarding virtue on the part of L2, it is in fact pivotal in its expression of the relationship L2 intends with G4 and one which she is apparently wont to deny - a relationship which hinges on G4 *trusting* her in a way only a *client* can (extract 8.41, below). In this sense, these extracts go to the heart of the moral dilemma faced by mental health nurses, who, though they might wish to disavow the authority of medical colleagues in matters that obtain to their therapeutic relationship/practice with clients, are none-the-less, duty bound to do so, in matters medical and/or legal (see Pilgrim & Rogers, 1994; informant M: chapters 5, 6 & 7).

Extract 8.40: Informants L2 & G4

48 G4:No::o (0.5) but you'd have told ((name
49 of doctor omitted)) wouldn't you (.) yes?
50 L2:Well (.) yes I may have done that (.)
51 and then- but what do you assume would
52 have happened?
53 G4:He'd take me up to ((G4 references
54 another mental hospital with a personality
55 disorder unit - a PDU))?
56 L2:So he would have taken you to ((name
57 of hospital omitted)) instead of here?

L2's response is interesting because whilst the first part of her utterance affirms the possibility that she may have acted in the manner G4 had supposed (line 50, above), the second, speculates the possibility that she might have done otherwise with what

amounts to two possible readings of the text: *'what do you assume would have happened'* (lines 51 & 52, above). The first reading appears to ask G4 to consider the possibility that she may have acted other than she was thought constrained to do - what might be called, the counsellor option, the second that she could or would not - the institutional option.

But, G4 is in no doubt of her position in this regard and she confirms her understanding of their relationship by describing the action that her doctor would have taken had she been reported - an action which would have discharged her to the personality disorder unit of another hospital (PDU) (lines 53-57, above). A trajectory that does much to explain the confrontational nature of this account and the reason for her sustained negativity in earlier extracts of this talk.

Extract 8.41: Informants L2 & G4

G4:Yeah
L2:The only time he'd use ((name of hospital ommited)) in those circumstances- and I would discuss it with you in the first place and let you know how it's been and hope to come to some sort of agreement with you (.) is that sometimes you reach a stage where you've got to be helped to be made safe (.) when you're out of control (.) it would be a place of safety.
G4:It's not a place of safety (.) it drives you more insane (.) you come out more fucked up after a minute there than when you go in.

The constraint that this must impose on their relationship is clear to both and is one that L2 is want to explain in terms of her institutional position if her admission to the PDU

should ever be the case (extract 8.42: lines 59-68, above). She begins by agreeing the possibility of G4's surmise cast as what her doctor might do - note that she speaks of him in the third person singular (lines 59-61, above), but counters this with a therapist's concern that this would only ever be considered if she agreed to the action they proposed (lines 61-64, above) - a circumstance, she might possibly recognise when there was a need to *'help* [her] *to be made safe ... when you're out of control'* - when in fact, L2 is to blame (lines 64-68, above).

At this point it is useful to be reminded of both Bean's (1986) and Szasz's (1997) belief that the coercion of this medico/legal complex is so powerful that it must preclude the sort of acquiescence and discussion L2 imagines possible. Not surprisingly, G2 gives short shrift to L2's explanatory powers and the attribution of personal fault and responsibility this positioning intends and in tones both angry and distressed describes her previous experience of that same place in terms that are unequivocating in their dissent (lines 69-72, above).

Extract 8. 42: Informants L2 & G4

L2: I don't dispute that I don't think ((name of hospital ommited)) is the best place for you either (.) I really don't (.) especially after the last time (.) but there are occasions when sometimes we've not got an awful lot- there's no choice we have to use ((name of hospital ommited)) on the odd occasion to make you safe (.) safe from yourself (0.5) do you understand what I'm saying ((name of client omitted)) (0.5) what are you thinking about now (0.5) ((name of client omitted)) I think you test people out all the time (.) you test them out with your bad behaviour (.) you

87 test them out with how difficult you can be
88 (.) how abusive you can be on occasions
89 (.) it's as if you are constantly saying (.) if
90 you love me enough (.) you'll still hang on
91 in there but when does it stop- when does
92 the testing stop (.) when will you trust
93 somebody enough to actually accept that
94 they are there for you (0.5) that's how it
95 seems to me?
96 G4:Why should I trust you or anyone else
97 for that matter.
98 L2:I've never let you down ((name of client
99 omitted)) (0.5) does it seem like that to
100 you (0.5) your dad let you down so you
101 can't trust anyone else is that it.

There then follows a quite extraordinary plea for understanding on the part of L2 that begins with her agreeing G4's perceptions and experience of the PDU and her belief that she doesn't *'think* [it is] *the best place for* [her] *either'* and not it would seem, *'after the last time'* (extract 10.21:lines 73-76, above). It is an astonishing admission on which to premise her position as trusted friend and/or supporter (lines 92-95 & 98-101, above), but one she clearly expects to bear results - that it doesn't, causes her no little consternation (lines 81-82, above). Note that she uses the inclusive *we* to align herself with the hospital, but in a way that attempts to limit her own culpability (lines 77-78, above).

Three times L2 offers G4 a turn of talk (lines 81, 83 & 84, above), ostensibly, it would seem, to affirm their mutual understanding of the facts as known to them both - facts which appear to suggest that she is the agent of her own downfall and L2 is in some way the victim of the circumstances this then contrives. Unable to initiate a response in the manner she might have supposed, L2 then begins to articulate her own frustration with G4 in a plea for understanding that is its own confession (lines 84-95, above). A

confession, which after Foucault (1981: p.62) she might hope, 'exonerates, redeems, and purifies [her]' in the eyes of G4. A position that must of necessity distance her from the medical psychiatry they both feel responsible for her suffering.

Intriguing, is L2's belief that G4 is testing her (and others) in some way (lines 91-94, above) - that her actions demonstrate a volition that undercuts the mental disorder on which her behaviour sits. Like many person-centred therapists before her (see Rogers 1957 & 1962)[17] L2 apparently believes that her own integrity and honesty - her authenticity in relation to her client is the bridge to her therapeutic success and, when (and/or if) this fails, demonstrates a transferential resistance on the part of her client that must be overcome - an idea that is much disputed (see Greenson, 1967; Liotti, 1989; Rennie, 1994; Rorty, 1976a & Strean, 1985).

This extract concludes with G4 asking *'why* [she] *should .. trust* [L2] *or anyone else for that matter'* (lines 96-97, above) - a not unreasonable question, given the extreme of *coactus voluit,* which describes her experience of mental hospital life and wherein her intoxication and aggression are thought to mark her resistance to care, rather than the mental disorder under which she labours[18]. L2 responds to this by claiming that she has *'never let* [her] *down'* (line 98, above) - a not improbable circumstance, but one that

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[17] Barker *et al* (1997: p.666), it will be remembered, are amongst those who argue 'that [psychiatric] nurses' primary attitude should be one of addressing people as human beings first, and patients with problems second ... Developing an effective relationship with people-in-care must be the primary concern for all nurses', but should have a more specific concern in psychiatric nursing. Such a relationship may express the necessary respect for the unique experience of the person 'in' psychosis (for instance) but might also provide the beginnings of *their* search for *the* 'truth' about themselves and their life experiences' (my emphasis)

[18]The nature and difficulty of personality disorder was discussed in chapter six in the context of informant G's account (extracts 6.4 & 6.5).

ignores the fact that the hospital, of which she is very much a part, apparently has - a position of contradiction that clearly undercut her credibility. Here, a parallel, might be drawn between the position that L2 assumes and that of informant M, who, it will be remembered, did so much to honestly disregard the thrall of the medico-legal complex (extracts 6.1-6.3; 7.1-7.4; 8.11-8.17),.

The extent to which her own undoubted complicity with an absent medical authority is disregarded (see extract 8.40: line 50, above) is captured in L2's final utterance, which attempts to conflate her failure to twice elicit a response from G4 to compromise her own understanding of their mutually antagonistic positions (lines 99 & 100, above) with an elision that juxtaposes her current lack of trust with her father having *'let* [her] *down'* on some past occasion (line 100, above) - a connection which appears extraordinarily bold in the circumstance of this particular talk, where the issue of their personal relationship has been very much to the fore - a relationship that in itself appears tenuous in the extreme.

Throughout this conversation L2 has attempted something really quite difficult, that is, to make separate in some marginal way her own position of trusted confidant from that of agent of some absent medical authority to whom she reports. In doing so she has denied G4's position of intimidation which quite clearly assumes the contrary - G4, it would appear, trusts L2 no more than her medical colleague. Though she might wish it was otherwise, G4's sense of personal identity cast as authentic is not the prop for L2's complementary understanding of their relationship or the events she has described, but rather something else besides. In this sense, their dialogical resistance

to one another is as complete as it was in the previous three conversations.

In the following conversation the dialogical resistance of participant's to the position of the other is less easily described as an incompatibility, rather, it stands as an example of their failure to view the excepted topic of their talk from anything but a disputed, if undeclared view point - this is particularly true of nurse S2 who makes no personal avowal of his sceptical position. In this sense, it represents (to some extent) the middle ground in this series of conversational talks (chapter nine & ten), one which readily admits the topic, but not the mutual alignment that is so evident in conversations six through to ten to in chapter ten to follow.

Conversation Five: Disputing the Positions

In the following extract informant S2, a male staff nurse, talks to informant P, a thirty something male client, with history of deliberate self-poisoning with prescribed insulin and *nuisance* behaviour, about his first interview with his psychiatrist. Unlike the previous conversation which described the problem the counsellor encountered in trying to force the topic of talk, this one begins *off topic*, as it were, with the counsellor using this earlier conversation as a lever into his own. It is a subtle opening, but one that gives rise to more than a little confusion.

The first two extracts of this beginning (extracts 8.43 & 8.44) describe P's negative impressions of his encounter with his doctor, whilst the third extract (extract 8.45) is a clarification of the misunderstanding the counsellor has of the emerging facts - in this

sense the first two extracts are relatively simple examples of tacit, first order positioning, whilst the third describes a second order intentional positioning which attempts to signal a new and more fruitful direction in their talk.

S2's start position is relatively unambiguous and to this end he recruites his own retrospective understanding of the client's interview with a doctor as a specific prompt: *'you weren't too impressed',* he asserts without equivocation and asks, *'why was that'*? (extract 8.43: lines 03-04, below) - a prompt that was previously described as 'exploring by fishing'[19]. P's response is an oblique confirmation that S2's understanding is appropriate and he offers as reason his doctor's failure to give him *'any 'sort of feedback'* and/or *helpful suggestions'* and he accuses him of *'just taking note's'* (lines 05-07, below).

S2's opening to this talk is interesting because it conjures an image of feigned sympathy with P's position of misunderstood, not to say naïve, victim, that his story does much to resist (see extracts 8.46-8.49, below) . It is a relational ploy (probably much used in *interrogations* of this type) which by agreeing, or otherwise implying, some fault in an absent third part actor suggests an accord with your partner in talk that may not really be the case and one which, in this instance, is underpinned by P's tendency to blame others, particularly his doctors for the plight he feels himself in (see extract 8.46-8.49, below).

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[19]By 'fishing' Bergmann (1995) means that S 'has only indirect knowledge, an outsiders knowledge of the referred-to-facts' - in this sense, the conversation develops as a conversation about a conversation and is in effect, a third order account.

Extract 8.43: Informants S2 & P

01 S2:Let's start off really (.) you saw doctor
02 ((Name omitted)) this morning (.) err and
03 you say you weren't too impressed (.) why
04 was that?
05 P:Mmm I didn't get the sort of feedback
06 err any helpful suggestions really (0.5)
07 just taking notes (.) err I could go all week
08 and not feel that I want to do anything(.)
09 do you know what I mean?
10 S2:So did you go in there with expectations
11 of what?

Interestingly, P concludes this first turn of talk by insisting that he *'could go all week and not feel that* [he] *want*[s] *to do anything'* (lines 07-08, above) - a first allusion (it would appear) to his proclivity for deliberate self-poisoning that is either over-looked or ignored. Instead, P continues to explore negative feelings toward his doctor, which he now recasts (rightly so) as a failure of *expectation* (lines 10-11, above). P emphatically confirms that this was the case (extract 8.44: lines 12-13, below) and then, once again, raises the lid on what he believes to be symptomatic of his problem state - his medication.

Extract 8.44: Informants S2 & P

12 P:A lot more} a lot more expectations than
13 I got.
14 S2:Right.
15 P:One thing I wasn't expecting I didn't get
16 was medication (.) I think I am taking
17 enough anyway

But he does so using an odd conjuction of clauses, which S2 appears to hear as a criticism or possibly a failure to receive the medication he felt entitled (lines 16-19, above). Not surprisingly, S2 is asks P to clarify what exactly he means (extract 8.45:

lines 18-19, below). Pressed to do so, P confirms that he meant, that he *'think*[s that he is] *taking enough'* (line 20, below) and, if by way of emphasis, suggests that he '[doesn't] *want to go on antidepressants because they tend to be addictive'* (lines 21-24, below) .

Extract 8.45: Informants S2 & P

18 S2:You you don't think you are taking
19 enough?
20 P:No I think I am taking enough (.) I am
21 taking quite sufficient (0.5) err I don't want
22 to go on anti depressants (.) mainly
23 because most err err anti depressants
24 tend to be addictive when when I was on
25 Prozac last mmm and all the Prozac done
26 because nobody warned me was that I
27 when (0.5) I went home on leave I went
28 for a pint and after the first pint all I done
29 was slept.
30 S2:Right.

P's account of the effects of his medication - particularly his experience of Prozac and alcohol (lines 24-29, above) - is illuminating because it begins to describe something of the position he appears to view himself from, one which appears to render him victim of circumstances he believes he has little or no control over - the management of his medication. This is a contradiction in his previous position (extract 8.44: lines 15-17), but one that becomes a little clearer in extract (8.46, below) when he claims that, *'nobody warned* [him]' *alcohol and Prozac done that'* (lines 31-32, below) - an unlikely understanding (though not entirely implausible) of the well known and much publicised, potentiating effect of alcohol on all psychoactive drugs.

Extract 8.46: Informants S2 & P

31 P:Nobody warned me that alcohol and
32 Prozac done that.
33 S2:Is that when things go wrong (0.5)
34 when you mix alcohol and drugs?
35 P:Yeah (.) that and my mum (.) well not so
36 much her as the rest of them (.) the
37 outlaws as I call them ((laughs)).

It is at this point, though, that S2 asks what appears to be a key question, one which confirms the link between his drug and alcohol consumption and his deliberate self poisoning - the intended topic of talk, but more importantly, one that begins to populate his storyline with those other persons he believes responsible for his problem state: *'is that when things go wrong'*, he is asked (line 33, above) - *'Yeah'* he replies and foregrounds the conditional influence of his *'mum'* and *'the outlaws'* in this regard (lines 35-37, above). Once again, P's account construes a negative impression of non-present third party actors - all of whom, are silent on the claims he makes.

The important point to bear in mind here is the unconfirmed nature of P's accounting and the validity claims he makes, none of which, are tested in the context of this discussion (see extracts 8.47-8.49, below). Counselling simply takes as truth the belief that P invests in his own subjectivity and only assumes a warrant to assist him to reflexively explore the matter further. To do otherwise, is to selectively evaluate his account and do injury to the unconditional positive regard that counselling invests in his person (see Rogers, 1957: pp.98-99).

By a process of quite subtle elision S2 has ushered in what is the intended topic of their talk and has called forth the principle actors in P's tale: his doctors, his mum and his

sister and brother in law. All of whom are deeply implicated in his frequent and apparently *unintended* episodes of self harm. But, here-in-lies a problem - and one not easily resolved in a subjective communication that is always reliant on the self reflexive understanding of its own witness - how credible is P's account and should it stand as the basis of the talk to follow?

Speaking of this - the psychotherapeutic process and the actuality of patients conduct, Goffman (1972) remarks:

> 'Even worse, they [psychiatrists] have tended to labor under a telephone-booth bias that what the patient was engaged in was somehow a type of talking, of information imparting, the problem being that the line was busy, the connection defective, the party at the other end shy, cagey, afraid to talk or insistent that a code be used ... [when in fact] there has been a general blindness to the following fact: very often the misconduct of the patient is a public fact, in that anyone in the same room with him would feel he was behaving improperly, and, if not quite anyone, then at least anyone in the same conversation' (Goffman, 1972: p.139).

Though he may wish to deny it P's so called, *nuisance* behaviour is a public fact[20] and one he is unlikely to confront in talk that is always circular in its disposition of blame to others he believes responsible. In this sense, P is his own worst witness possessing neither objectivity nor credibility in his accounting. This problem emerges more strikingly in extracts (8.47-8.49, below), wherein, their disputed understanding of each other reveals itself more vividly than hitherto described.

S2's approach to this, though, is typically person-centred and he positions P as both

[20]P's admission to hospital was a consequence of his proclivity to self overdose and the nuisance this was perceived to be to his GP., the ambulance service, and the admitting hospital, none of which could be attributed to his diabetes.

informant and actor in his own story-line which, though it illuminates the relationships he describes, probably distorts the facts under discussion (Pomerantz, 1980; see conversations three & four, above). The danger of this approach is that it simply invites a diachronic repetition of the construals that are 'ready made in prior speech' (Tannen, 1992: p.56) and which possibly have no validity claim other than their contribution to the imaginings of its teller - sincere though these might be (see also conversation two, above) - a problem that becomes even more likely when argumentation of the sort Toulmin (1991) describes gives way to mere homily.

In extract (8.46: lines 34-35, above) S2 attempts a shift in the mode of talk from the tacit, first order positioning it first described, to a second order intentional positioning that begs an explanation for his behaviour. That it doesn't, though, appears largely due to the infiltration into the story line of those persons P called the *'outlaws'* (extract 8.46: lines 35-36) - a deflection that S is clearly prepared to allow (extract 8.47: lines 38-39, below), but interestingly, P is not (line 40, below).

Extract 8.47: Informants S2 & P

38 S2:The outlaws (.) your sister do you
39 mean?
40 P: Yeah (1.0)
41 S2:Tell me some more about the
42 medication- the overdose?
43 P: Since January[21] I've had in ex- err
44 approximately about thirty admissions to
45 ((Name of hospital omitted)) not always
46 with an overdose but admissions to A&E
47 or whatever.
48 S2:Admissions for various things you have
49 done to yourself what sort {of thing-?
50 P:Sometimes} sometimes it has just been

[21]This interview is dated October 1996.

51 (.) you know err I have a glucose
52 imbalance problem when the blood sugar
53 has been too low (.) I have had the GPout
54 and he's said (.) you know (.) the best
55 thing to do is to go in and he explained to
56 me the problem and what I have got to
57 avoid which is mostly sugars (0.5)
58 because he showed me (.) apparently errr
59 err he got a graph and I had a glucose
60 test.

Intriguingly, this momentary stall has the effect of changing the shape of S2's inquiry, from a conjunction that suggested an association between P's alcohol consumption and drug taking (*qua* overdose) to a muted reference to his, *'medication'* and something he now describes as *'the overdose'* - a reference, one might suppose, to the serious episode of self injury that prompted his first admission to a psychiatric hospital (lines 41-42, above; see extract 8.48: line117, below). From this, it transpires that P has had *'approximately 30 admissions'* to other hospitals in a ten month period (lines 44-45, above) - *'not always with an overdose'* and not always to accident and emergency departments (lines 45-47, above).

Though P is somewhat blithe in this brief, but illuminating account of his *accident* prone behaviour, the *nuisance* label he has acquired now takes on a new and more sinister meaning - one that denotes a prolonged and serious catologue of self inflicted injury that extends beyond the self poisoning it first appeared - his problems are without doubt very serious. That S2 might know more than he is willing to tell emerges in his next question which tentatively asks P to say more about the *'various* [other] *things'* he has done to himself at this time (lines 48-49, above). But this is not a road that P is prepared to tread and he interjects with a forceful and summary *'sometimes'* (line 50, above) that

quickly dissipates the spore of this particular trail into a description of his *'glucose imbalance problem'* (lines 51-52, above) - that is, it would seem, both the prop and the pall of his current problems.

The obfuscation in this utterance (lines 50-60, above) is obvious and hints at a poorly controlled diabetes that has led in some arbitary way to episodes of hypoglycaemia - which, of course, it could be - a position of genuine physical illness.[22] S2, however, makes it clear that isn't the case with a question that prompts an admission from P that he has overdosed with prescribed insulin up to twelve times and that this last time has resulted in *'the worst'* episode yet (lines 116-117, below). His final utterance in this turn of talk is remarkably important, but is either overlooked or ignored by S2, in favour of a question that asks whether this particular episode, *'was ... planned'* (line 120, below) - a question, that had he realised it, P had already answered with a candour that admits a knowledge of insulin, hitherto unknown: *'normally* [he says] *it has been sort of lowish units but this time {I needed'* (lines 117-119, below).

Extract 8.48: Informants S2 & P

111 S2:So how many err err times out of the
113 thirty would you say you have been
114 admitted through injecting yourself with
115 insulin?
116 P:Possibly ten or twelve (.) this last time
117 was the worst (.) normally it has been
118 sort of lowish units but this time I
119 {needed-
120 S2:Was} was that planned or did it just
121 work out that way?

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[22]There is a weak possibility that P's hypoglycaemia (low blood sugar) is caused, by something other than his own self medication with insulin, but this is an unlikely medical explanation - one that has probably already been discounted.

Indirect, though his comment might appear to be , P has in fact, made a clear reference to the calculated dosage of insulin he has used on all previous occasions and the mistake that has so recently occurred - one, which implies a resuscitation not previously experienced. Insulin, as P would know, is measured in concentrations described as Insulin Units - more Units, means more insulin - *'lowish units'*, implies (it would suggest) less insulin. It seems at least likely that P did indeed plan these episodes for the very effect they produced.

Interestingly, P is offered the opportunity to account for his behaviour in a way that does little or nothing to stoke the subjective inertia his story is wont to tell with a second part completion to the original question (line 120, above) which asks: *or did it just work out that way'* - implying a possibility that his behaviour might be understandable in terms of the accident he claims. Not surprisingly P chooses the latter and contrives a story that positions him in a mystery that he can't altogether explain - that he *'can't put his finger on.'* Ignoring, all other factors he says he *'just got up* [and] *took the insulin'* (extract 8.49: lines 122-133, below).

Extract 8.49: Informants S2 & P

122 P:No I was watching the telly (.) for some
123 unknown reason (.) I can't put my finger
124 on it (.) I just got up (.) took the insulin (.)
125 sat down and watched the telly again (.)
126 took my night medication (.) fell asleep
127 and I woke up and obviously by then my
128 blood sugar was that low that I contacted
129 a duty doctor who unfortunately happened
130 to be ((Name of doctor omitted)) and his
131 answer to everything is an ambulance
132 (1.0) if he had come out (.) I had no

133 Glucagon[23].
134 S2:You think that it could have been
135 averted
136 P:If he had come out and given me that
137 then I don't think I would have needed to
138 go into hospital.

Having concluded that there was no particular antecendent to this accident or impulse (other than his carelessness) he follows through with a guile that suggests his innocence in the face of a negligent, but altogether absent medical authority, whose *'answer to everything* [apparently] *is an ambulance'* (line 131, above). He then speculates that *'had* [he] *come out'* - or rather more intriguingly, *'had* [he had some] *Glucagon',* his admission to hospital, rather than his overdose, would have been unnecessary (lines 131-132, above) - a circumstantial interpretation of the facts as he saw them that surely suggests a more incisive response than the compliment he is offered in lines (134-135, above).

Once again, it would seem the counsellor/psychotherapist S2 (like A2 in conversation two, above) appears constrained by a form of talk that admits no direct challenge to his client's privileged understanding of events and wherein, he must barter every opportunity to confront that understanding in a way that does least injury to the therapeutic relationship he intends. The net effect of S2's approach is to delay or possibly even avoid without any notice of future challenge, the topic that is the real object of his inquiry: why P self medicates an overdose of prescribed insulin knowing the risk to his life this must involve?

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[23]Glucagon is an injectable concentrated glucose solution used to correct an abnormally low blood sugar or hypoglycaemia. Most, if not all diabetics, have home emmergency access to this.

Though it may be otherwise conversations one through to five, above all appear to share a similar problem - the ever present danger that they will never get to the point. That they are trapped in their own self serving storyline, one which entertains only one voice, one perspective and one privileged identity - that of its authors. That their self determination - position in respect of others, separates them in some privileged way from any 'extrinsic moral consideration' that is the *reality* of their life-world (Giddens, 1994: p.180).

Summary

Though these are enormously complex, not to say, awkward, conversations that have failed to invoke the parallax in client thinking that the nurse counsellors apparently intended, they are also enormously reassuring, in-as-much-as they each recognise the clients' right to speak from the position ascribed to them and in a way that has confounded the counsellors meaning/understanding - a circumstance that appeared far from certain from the accounts of relationships described in the previous chapter (eight).

But they are not, one must conclude, communications of a type, that Habermas (1991), Mühlhäusler & Harré (1990), or Davies and Harré (1990), would agree, rather, they are speech events of a type that hint at Thorne's (1992: p.118; cf. Rogers,1975: p.4) belief that a, 'therapist need only to be faithful companions, following the lead which their clients provide and staying with them for as long as is necessary' and wherein, one must presume, the validity claims they raise are accepted without question for the purpose

of *therapy* (cf. Searle, 1969/1990; 1994; Rennie, 1994b). A dialogical positioning which, though, well meaning in its intention, must necessarily confirm - or do much to confirm, a client's position.

In this sense, they point to a concern voiced most forcibly by informant G (chapter six: extract 6.7: lines 195-196), that *'no amount of talk is going to get* [them, the clients] *better*'. This, was an unequivocably arch position to take, but it does capture something of the dilemic nature of this type of reflexive talk - which attempts to modify or change a clients self denomination, whilst resisting the temptation to impose upon him/her construals - avowals, if you will, of some other meaning/understanding, that might better explain or illuminate their understanding of the things they contend (Rogers,1957; 1975)

That informant, S (extracts 8.1-8.14, above), is possibly, *more improved* than she supposes herself to be; that informant, M3 (extracts 8.15-8.22), is not the *schizophrenic* he claims he is; that informant, B (extracts 8.23-8.32, above), is indeed *culpable* for the impression others have formed of him; that informant, G4 (extracts 8.33-8.42, above), was *intoxicated* in the manner supposed; and that informant, S2 (extracts 8.43-8.49, above) is *responsible* for the episodes of self-poisoning he describes.

To do so, it is argued by social care theorists, is to demonstrate the same sort of 'bias', 'prejudice' and 'discrimination' towards the client that medical psychiatry is wont to impose upon the subject of its *gaze* (Foucault, 1977/1991b) - one, which, from the position of the *selfsame*, logo-centric medical discourse, will always argue the fallability

of their understanding.

Though it may not be immediately obvious, there has been a certain, if imprecise, ranking of these five conversations - one which describes the extent to which the counsellor/psychotherapist has positioned himself/herself in opposition to their clients story, using first person avowals of dissent or disapproval[24]. It was a ranking - never very convincing in the force that it carried, but one that saw informant M, conversation one, make the best effort to counter the claims of his client with his own understanding and subject S2 conversation five, make no effort at all - a ranking that now continues in chapter (nine) to reveal therapeutic talk that is complicit in its co-construction of meaning/understanding.

[24]See: Informant M: extracts 8.4: lines 98-99; 8.5: line 101; 8.6: lines 107-108 & 8.8: lines 278-279. Informant A2: extracts 8.15: lines 20-21; 8.16: lines 23-26 & 8.22: line 98. Informant N: extracts 8.23: line 01; 8.27: lines 31-32 & 38-39 & 8.28: line 44. Informant L2: extracts 8.39: lines 40-43 & 8.42: lines 73-76 & 98-99.

Chapter 9: The Discursive Position(s) of Mental Health Nurses/Therapists and their Clients in Therapeutic Talk - Compatible Positions, Confessions and Complicity

> (9.1) What is that which always is and has no becoming, and what is that which is always becoming and never is? That which is apprehended by intelligence and reason is always in the same state, but that which is conceived by opinion with the help of sensation and without reason is always in a process of becoming and perishing and never really is (Plato's Timaeus 27d-28a/Jowett, 1996: p.1161).

Introduction

This fifth (and final) analysis is a continuation of the description and interpretation that began in chapter eight of participants' *self* and *other* positions at a *beginning* in an ongoing series of therapeutic talks (counselling/psychotherapy). In contrast to the incompatibility and resistance that was so apparent in chapter eight, all five conversations in this series, take the form of an assisted story telling - a complicity, if you will, between the counsellor/psychotherapist and the client to tell a version of events, that appears to 'muffle' the clients' contribution to the things they contend (cf. Rennie, 1994b: p.237) - a feature of talk made more certain by the counsellors'/ psychotherapists' failure to make any avowal of personal understanding that detracts from their position[1].

But, no less than conversations one-five (chapter eight), these are idiosyncratic explanations and/or accounts that selectively focus on particular features of the clients'

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[1]Reflecting on Toulmin's (1991: p.11) definition of argument - if there is no avowal, there is probably no cause for argument, there is in fact, no 'claim on our attention and to our belief ... the claim implicit in an assertion is a claim to a right or to a title.' The discourse this then describes is a *tacit* formulation, albeit permissive in what it allows the client to say.

complex and (in certain instances) enduring storyline, in a way that gives coherence and meaning to the trouble and/or distress they experience (cf. Russel & Van Den Broek, 1992) . They are, however, (or so it appears) repetitions of talk that owe more to the 'opinion' and 'sensation' of their authors, than they do to the reasoning they might otherwise pretend (Dialogue, 9.1, above).

The first two conversations in this series are constructions of talk that are very obviously co-authored/co-sponsored by the counsellors' empathy with the stories their clients have to tell.

Conversations eight, nine and ten, are similary compatible conversations, but they differ from the former, in-as-much-as, they are self-initiated confessions of wrong-doing that take the form of an abstracted, almost disembodied positioning of the client in relation to those others they intend in their talk.

Conversation Six: Compatible Positions in Supported Self Reflection

This first conversation between informant A, a community psychiatric nurse and his client Mrs H - a depressed lady/housewife unfolds (unlike those already reviewed) in an almost scripted manner[2] and as such presents no immediate problem in terms of the counsellor's or the client's position, but it does pose a problem cast in terms of the counsellor's empathic understanding - which has to be judged against a pattern of

[2]The beginning of this conversation, more so than any other so far, suggests something of the contrived nature of these encounters, all of which have to be read with the unseen trace of the researcher in mind.

reflexive questioning that is entirely resourced by his client's subjectivity - her first person point of view (extracts 9.1-9.5).

In every respect, this conversation is formulated as a tacit, first order account which positions both participants in recognisable and mutually agreeable, dyadic social identities[3] - nurse therapist/client. But no less than the preceding conversation, conversation five (chapter eight) - and those to follow, it asks whether subjectivity can ever be a credible witness to the events it describes given the orientation of the counsellor to the position his client attests.

Extract 9.1: Informants A & Mrs H

01 A:Can you want to tell me why you were
02 admitted ((Mrs H) (.) go back to the
03 beginning?
04 H: My doctor advised me to come in I've
05 been depressed and having problems with
06 my husband (1.0) I've got in such a mess
07 (.) mostly since I lost my father a few
08 years ago (.) two years ago in fact and
09 I've just found my relationship with my
10 husband just hasn't been the same since
11 then.
12 A:What sort of problems have you been
13 having?

A's start position to this talk is an odd formulation that requests information that one might suppose he already knows (extract 9.1: lines 01-03, above) - in this sense, it is a 'fishing-trip' no less than any other observed in this series and one that invites Mrs H to tell her 'side of the story' and ratify his prescient understanding (Pomerantz 1980: p.193). Mrs H responds (it would seem) with alacrity and provides a considerable

[3]Oddly, it would seem, and without explanation, Mrs H was referred to by her married surname throughout this conversation.

amount of information, including, confirmation (if it were needed) of her depression; a reference to the *problems* she is experiencing with her husband; and the focus and temporal frame of her current distress (line 04-11, above) - the recent death of her father two years ago (lines 07-08, above). Validity claims that A readily accepts as true and also as his warrant for the position of intimate/confident he takes up in the story she has to tell.

Not surprisingly, given its overt and repeated reference, A chooses the, *'problems* [Mrs H is having with her] *husband'* (lines 05-06 & 09-11) as the topic of his next question rather than her depression or bereavement - a trajectory she clearly specifies in her utterance and one that she is willing to enlarge upon. Interestingly, her immediate response is a non specific, self-reflecting allusion to her husband (as a problem) cast in terms of her own behaviour, rather than anything he has done: she is, she says *'far less tolerant of him'* (extract 9.2: line 14, below) and, most strikingly, that she doesn't *'want him home any more.'*

Extract 9.2: Informants A & Mrs H

14 H: I think I am far less tolerant of him and
15 he works away you see so I am finding-
16 whereas I used to look forward to him
17 coming home that I don't want him home
18 any more.
19 A:You said it started when your dad died?
20 H:Well it was a very emotional time and
21 because of my husband's job (.) he didn't
22 spend- he was there for the funeral and he
23 was there through the latter stages of his
24 illness but he wasn't actually there for any
25 time after that and I spent a lot of time
26 then with my mum and er I suppose I
27 resented him not being there for me but I
28 also resented when he came home I

29 wasn't there for my mum.

Again, the sense that A knows more than he has so far revealed emerges more clearly in his next question, which abandons the proactive search for new information begun earlier (signalling a completion not contained in her answer - cf. Leudar & Antaki, 1988) and asserts, instead, that *'it started when your dad died'* (line 19, above), in this instance, *it* is clearly an anaphora that alludes to more than it tells[4] - the problem they both appear to know, but have so far failed to specify.

The problem, as it transpires, is a complex weave of personal emotions, family relationships, expectations and responsibilities, made large by her fathers death. At a very difficult time in her life her husband, it would seem, let her down by his absence and lack of emotional support and this, in turn, made her relationship with her mother more difficult - and for this, she appears to resent them both (lines 20-29, above & extract 9.3: lines 39-40, below).

Extract 9.3: Informants A & Mrs H

30 A:You resented him for not being there
31 and then for being there?
32 H:Yes (.) I don't think I was aware of it at
33 the time but when I thought about it then
34 (.) you know he's never really let me
35 express how I feel about losing my dad I
36 err was very close to my dad (.) my
37 husband thinks (.) well he's died now the
38 funeral's gone you shouldn't be upset
39 about it any more (1.0) I don't think then I
40 was able to express myself to my mum
41 and not my husband which I feel that I

[4]This is an anaphora that occurs again and again in this series and hints at the abstractions clients are want to make of their problems.

42 should be able to (.) I think from there it's
43 just become err you know (.) I'm resentful
44 now about things that have never ever
45 bothered me before.
46 A:So you've not spoken to your mum or
47 your husband about losing your father?

In these first extracts (9.1-9.3, above) A has used (in a very competent way) his retroactive knowledge of Mrs H's problem state to bring her to where *she* wants to be in terms of the story *she* wants to tell and, indeed, where, it must be supposed, *she* ought to be, if resolution of her personal feelings is to be achieved in the context of person-centred therapy, but once again (see conversation five, chapter eight), key accounts are absent and neither her husband nor her mother bear witness to the validity claims she makes - in it is effect a telegraphic form of communication entirely resourced by her subjectivity - her version of events, her 'side-of-things' and one in which her aggrieved position is reinforced (see Descartes 1968; McCulloch, 1990; Mühlhäusler & Harré, 1990)[5].

Empathy, as it is conceived here (and also in those conversations to follow) is simply, or so it would appear, a matter of the hearer understanding the speaker's representation of things and/or events - that he/she may not agree with the sentiments (often repeatedly) expressed is, at least for the present, marginal to the therapy it

[5]Though, Mrs H undoubtedly talks about her feelings and problems from her position of understanding, her exclusive first person point of view raises particular problems. It will be remembered that Descartes (1968), argued an extreme subject-centred universe, but his *internalism* has been shown to be 'fruitless for many psychological phenomena, including the central ones of meaning and understanding, which are better approached from the third-person [intersubjective] point of view' (McCulloch, 1990: p.217). Importantly, once 'subjects are seen as physically embodied agents one can hardly ignore the fact - explicitly imagined away Descartes - that they are situated in a physical environment' (ibid: p.218) - a pre-existing, intersubjectively shared, life world, one which derives from the cultural store of human knowledge and against which all communicative action takes place. A cultural store that is both a resource for interpretive action and the object of interpretative enquiry (cf. Habermas, 1991).

intends (see Grice, 1957; 1975; Hegel, 1892-6/1966;1979; Rogers, 1951; 1957; 1975; Searle, 1993) [6] [7].

Both, Labov (1972) and Tannen (1993) testify to the frequency of occurrence of this sort of diachronic/synchronic repetition in talk and/or therapy and they argue that it is a device that speakers use to make a point or reference a key phrase and/or idea - the truth of which, though, cannot be taken for granted [8]. But, the fact that someone repeats something often enough does not mean that they are not deceptive or, indeed, deceived by their own account. That Mrs H is experiencing quite awful relationship difficulties does not suggest she is rational in her beliefs (Ellis, 1962); nor does it suggest that her attribution of blame towards her husband is entirely appropriate (Ellis, 1977); nor does it suggest that he, or anyone else for that matter, is the real *focus* of the distress she claims - that the problems she describes are, indeed, the problems she must first address.

In what appears to be a stylised episode of counselling/psychotherapy, nurse A, has acted as a perfect foil for Mrs H's explanation and/or account, but he has done so in a manner that now suggests he is doing more than just that (though, possibly unconsciously) - that he is, in fact, assisting her to formulate a problem that may exist more in its telling, than it does in the actuality of her life world experience (see extract

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[6]The 'co-operation' of the client is a condition of person -centred therapy and assumes that what they say is an implication of *truth*, *right* and *sincerity* - that it 'can be worked out' by the hearer, if they are disposed to do so.

[7]Rennie (1994b: pp.237-240) suggests that storytelling (of the type implied) in therapy offers two main outcomes for the client: one, it allows the client to distance him/her self from the disturbances they describe and two, it allows them to gain temporary emotional relief.

[8]The allusion here is to the repetition by Mrs H of a story-line A has heard before.

9.27, below).

From the outset of this talk Mrs H's husband has always been deeply implicated in her distress and in the following extracts (9.4-9.5, below) A continues his exploration of her account to reveal a woman who now defines herself (in part at least) in terms of her husband's insensitivity. Importantly, and oddly one might suppose, she claims never to have spoken to him about her feelings - a circumstance A examines, from what is an entirely prejudiced and arbitary position of trust and empathic understanding (see extract 9.27 & extract 9.26: line 48, below).

Interestingly, and somewhat precipitously, A formulates *the* problem of Mrs H not telling her husband of her concerns in terms of her prior acrimonious testimony, asking, not why *she* hadn't told him, but rather, *'has he ever allowed* [her to do so]' (line 49, below) an implication of (as yet unwarranted) blame that conjures a description that reveals him to be a man who is, *'not very demonstrative',* who *'finds it difficult to cry',* who tries to *'jolly* [her] *out of it'* and, most importantly, who won't let her *'express how* [she is] *really feeling'* (lines 51-56, below).

Extract 9.4: Informants A & Mrs H

48 H:No (.) no I haven't, not at all.
49 A:Has he ever allowed you to do you
50 think?
51 H:Well he's not a very demonstrative
52 person you know feelings and you know
53 real men don't cry and I think he finds it
54 difficult if I cry (.) he tries to jolly me out o
55 it instead of letting me express how I'm
56 really feeling.
57 A:So this is something that you were

aware of maybe something before your
dad passed away?
H:Yes but that didn't bother me then that
was him and I loved him for it you know
just sort of whatever he was (.) it wasn't
something that I thought was- when I say
it wasn't something that I thought was a
bad thing err I would have preferred him to
be more open more able to say what he
was feeling but it wasn't an issue (.) but
perhaps now it is because I have to
suppress my feelings I don't know.
A:How do you feel about that now?
H:Well I suppose (.) how it's coming out is
that when he tells me he's coming home
or when he's due to come home I'm not-
I just don't look forward to it and I resent
the time he is home I feel sometimes he's
invading my space.

Intriguingly, A treats Mrs H's present tense description of her husband's behaviour as both conclusive and derminate of his next entry, which now speculates that: *'this* [was] *something* [you] *were aware of maybe before your dad passed away'* (lines 57-59, above). Mrs H, responds to this by recasting her husband's current failings as qualities that previously attracted her to him, stating that: she *'loved him for it'* (line 61, above) - in fact his behaviour at that time, wasn't an *'issue'*, though she admits that she would have *'preferred him to be more open more able to say what he was feeling'* (lines 61-67, above). Only now, it would seem, because she has *'to suppress her feelings'* (lines 67-69), does *his* behaviour emerge as a point of concern.

This is an artful closing, one that makes a very definite temporal shift from the past to the present and one that signals a return to talk about her currents feelings, rather than any past experience of her husband, wherein the solutions to her present problems might possibly reside. In a sort of grammatical parallelism A is carried along by this *volt*

face and asks, somewhat confusingly, *'how do you feel about that now'* (line 70, above) - a possible reference to her current understanding of their past relationship, but one she clearly hears as an inquiry into her present feelings towards him - the topic she most favours. In answer Mrs H is categorical: *'I resent the time he is home I feel sometimes he's invading my space',* she says (lines 75-77, above; see extract 9.2: lines 15-18 & extract 9.3: lines 43-45).

This last statement is replete with oportunity for talk about her - not least the meaning she intends by the phrase, *'he's invading my space',* but this is not the issue A wants to pursue and he speculates that things *'seem to be coming to a head'* in some particular way (extract 9.27: line 109, below). A proactive, not to say prescient prompt, that Mrs H readily concedes (line 110, below) and A follows with a question that suggests they are now viewing the object of their discussion - her husband, from the same biased and presumptive perspective[9]: *'does he realise how these changes- how much they are due to you',* he asks with apparent credulity (lines 112-113, below). Having, thus, agreed a mutually complementary understanding of their position in relation to one-an-other, the talk hereafter is about *him* and in such a way as to invoke a partisan reading of the text (lines 111-140, below).

Extract 9.5: Informants A & Mrs H

109 A:It seems to be coming more to a head?
110 H:Yes (.) it is (.) yes.
111 A:Does he realise- obviously he's aware of
112 changes (.) does he realise how these

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[9]Graumann (1990: p.109).), it will be remembered, reminds us that 'from a subject's particular point of view [Mrs H's first -person perspective] an object [in this instance Mr H] is seen in those aspects that correspond to the given viewpoint.'

changes- how much they are due to you?
H: I don't think he realises particularly
where they come from.
A:Does he want to know?
H: I think he would find it easier to feel that
there is a particular reason (.) like I'm
having an affair or something like that
because then there's no blame on him (.)
so.
A:Right (.) that may make it easier for
him?
H:Yes (.) yes (.) I don't think he would see
it as a problem the fact that we didn't
particularly talk about how I felt after
losing my dad.
A:What do you think would happen if you
actually told him what was happening (.)
why it was happening?
H: I suppose I'd find it a bit difficult really
because I've felt for the past two years
that he didn't want to know and I've coped
with it in the way I thought was OK to cope
with it but there again (.) I suppose, for the
sake of saving the marriage I should be
able to but I would resent now having to
open up to him two years down the line
when he should have been there for me
two years ago.

This extract is particularly interesting because it suggests that by empathically getting 'on-side', or 'on-message' with Mrs H, an 'indexical offence' of the sort Silverstein (1985) describes has occurred, wherein A, has adopted the same, or a similar, condescending attitude towards the person spoken of. In fact, it is hard not to read extract (9.5, above) as anything more than gossip - let alone the factual account Mrs H *represents* it to be (cf. Searle, 1969/1990).

Speculative though it is, A's positioning in relation to Mrs H has the feel of a stratagem that posits a two-fold effect: first, by compliantly agreeing the position of the other of

their talk in the way that he has, A has reduced the relational distance between them and, second, in allowing her to fuel the topic of their talk with her personal invective he has done much to 'keep the conversational apparatus running' (Bergmann, 1990: p.216; cf. Brown & Levinson, 1992: pp.117-118)[10]. Arguably, though, if Mrs H's husband was never the problem she thought him to be - a possibility at least, A's empathy, which casts him as 'confident companion [in] her inner world', probably does much to reinforce her belief that he is (Rogers, 1975: p.4).

Conversation Seven - Compatible Positions in Guided Self Reflection

The possibility that a client's problem[11] might be other than that which is immediately apparent (or agreed) emerges again in this next conversation between R, a female staff nurse and D, a thirty something, part-time higher education student. The conversation opens with D announcing an eating disorder that is (one must assume) both readily discerned and easily specified, but she does so in a manner that suggests there is something more to tell (extract 9.6: line 03, below).

Once again the conversation is formulated as a tacit, first order account which positions both actors in complementary, dyadic, social identities. Their talk unfolds as an agreeable, non-contentious elicitation of the facts of D's weight problem and the secondary medical difficulties this has caused her over time and it concludes with a

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[10]There is no suggestion that their gossip - if gossip it was, wasn't therapeutic, in as much as, it affords Mrs H 'emotional relief', or 'contact with [her] inner experience' and/or 'private processing of [her] experience' - it probably was (Rennie 1994b: p.239-240).

[11]Attention is drawn to the word problem (highlighted in red) which is repeated in the text and appears to 'funnel' the talk in a particular way (Goffman, 1973).

summary of her understanding of the *problem* as she (though more properly, others) conceive it to be (extract 9.12, below).

Something of the projected nature of this account, though, is signalled in R's first question which requests that D specify her most important problem - a question (once again) that appears to insinuate a retroactive premise that has yet to be declared (see extract 9.6: lines 01-02, below and extract 9.10-9.12, below). D appears to complement this assumption by answering R using the indefinite article to describe her *'weight* [as] *a problem'*, rather than the problem it might at first appear to be, or indeed is (line 03, below).

Extract 9.6: Informants R & D

01 R:What would you say was your most
02 important problem?
03 D:My weight is a problem (.) I'm now
04 twenty two stones (.) I should be about
05 sixteen stones.
06 R:Have you always had a weight
07 problem?

In turn, R confirms her *immediate* understanding and asks that D give some historical context to her obesity (lines 06-07, above). Interestingly, D claims her obesity is of relatively recent origin and she points to her late teens as a significant period in this regard (extract 9.7, below). Once again, her response has the hallmarks of a retelling of a story (possibly often) told before (see extract 9.9: lines 39-44, below) and one that begs no particular contradiction - she has, one must conclude, an admitted weight problem of something like a ten years duration.

Extract 9.7: Informants R & D

08 D: No (.) I haven't really (.) when I was
09 a small child (.) I was big for my age (.)
10 my Mother always said I was big for my
11 age (.) I got to size 16 when I was about
12 19 (.) when I was 20 I went up to a size
13 22 and then came down again to a size
14 18 (.) I have never been smaller than
15 that (.) my current weight of 22 stones
16 has been there for about three or four
17 years now.
18 R:Do you have any health problems
19 related to your weight?
20 D: My doctor says I 've got asthma.

Having fixed the temporal parameters of D's problem, R begins to explore her physical health in a manner that suggests she has knowledge of the complex physical sequelae this problem foretells (extracts 9.6 & 9.7) - *'do you* [she asks] *have any health problems related to your weight'* (lines 18-19, above). To which D offers an indirect report that, '[her] *doctor says* [she has] *asthma'* (line 20, above). Her response is interesting because it appears to muffle her culpability - if not acceptance, of a diagnosis she takes very seriously (see extract 9.8: lines 35-36, below) whilst investing her account with the authority of an absent, but incontestable, third party source. One that R clearly accepts with a next question that asks: *'what medicine do you take for that'* (extract 9.8: line 21, below).

Extract 9.8: Informants R & D

21 R:What medicine do you take for that?
22 D:I take two inhalers (.) one is called
23 Ventolin (.) I don't know what the other
24 one is called.
25 R:Any other problems you have
26 physically?
27 D:Yes I have problems with my stomach.
28 I get a lot of stomach ache irritation.

29 R:Do you have diarrhoea or
30 constipation?
31 D:No (.) I sometimes have diarrhoea but
32 I don't really have a problem with it (.) I
33 have problems with my back (.) I can't
34 stand up for more than 20 minutes (.)
35 but the worst problem I have is
36 breathing.

Continuing, D reveals that not only has she got a breathing problem (asthma), but also has persistant problems with her stomach and her back (extract 9.8: lines 27-28 & 33-36). All-in-all, in what appears to be an *ground-clearing* exercise, D is positioned by R's prescient sequencing of questions as someone who is both grossly over-weight and significantly unwell from her eating disorder, but not, it would seem, sufficiently alarmed to have reduced her weight in any significant way in the last *ten* years (see extract 9.7: lines 15-17, above) - but, arguably, in need of the help that R can offer from her position of expert understanding.

Extract 9.9: Informants R & D

37 R:What have you done in the past to try
38 and deal with this?
39 D: I have been to Weight Watchers (.)
40 two of three times and I have been
41 seeing different people now (.) doctors
42 (.) counsellors (.) therapists etc for the
43 last eight years but none of it has
44 helped.
45 R:Why do you think that hasn't helped?

Not surprisingly, D admits to having attempted a number of therapies over the years in order to tackle her eating disorder, notably, dieting with *'Weight Watchers'* (extract 9.9: lines 39-40, above) and, more significantly, *'seeing different people ... doctors,*

counsellors and therapists' (lines 41-42, above) - and she concludes that *'none of this has helped'* (line 44, above). A view which suggests that despite her best efforts the problem(s) she describe are more complex than has yet been described. The secondary consequence of this form of positioning is also rather flattering to R - who, it would seem, is now positioned as someone capable of resolving her difficulties in some satisfactory way.

Bracketed, (as it were) by this attribution of competence, R then closes this extract by asking her *'why she thinks* [therapy] *hasn't helped'* (line 45, above) - a legitimate and appropriately timed response that begins to shift the focus of the conversation away from the apparently uncontestable *facts* towards the underlying psycho-social discourse (pathology) that D reasons is the cause of her continuing weight problem (see extract 9.10, below).

In general terms, person-centred therapists (Cox, 1987; Egan, 1990; Nelson-Jones, 1991; Rogers, 1957) would argue that R has done all that she might have done in the early stages of this therapeutic talk - she has assisted her client to begin to tell *her* story. But what story do they *both* intend? This, it must be remembered, is a continuation of their talk, and it appears to have stimulated, what appears to be, a synchronous and incremental 'shaping' of the text in the direction they *both* want it to go - a complicity, that is undoubtedly empathic, but necessarily one-sided and biased (Tannen, 1992). In effect, the problem of D's obesity has been partially augmented and possibly even substituted in favour of something potentially more serious (extract 9.6: line 03 & 9.9: lines 39-44, above).

The contrast between the person-centred approach and the standard medical interview could not be clearer (see Silverman, 1987) - whilst the former will allow the client to subjectively specify his/her own problem state without benefit of objective measure, the latter will not. In consequence, person-centred therapists undoubtedly avoid the 'alienating object-orientated medical cosmology' that Silverman (1987: p.24) and Jewson (1976) are wont to speak of, but they run the risk of never bringing into (dioramic) view the real *focus* of their clients problem - the 'moral orientation [they the counsellor/psychotherapist take] to be right' (Taylor, 1994: p.99).

The beginning to this talk was postured as a question of problem *focus*, a concern that the topic of their talk - D's eating disorder, was in fact, no more than a fraction of a more complex whole - that her *'weight problem'* is, in fact, a symptom of something else besides. A supposition that is carried by the very fact that she is having counselling/psychotherapy for a problem that apparently assumes a more *credible* explanation than the *gluttony* she now begins to describe in extract (9.10: lines 50-61, below).

Extract 9.10: Informants R & D

47 D: I don't know why (.) I just can't seem to
48 stop eating.
49 R:Tell me about a typical day's meal then.
50 D:Well (.) I get up and normally have a
51 large English type breakfast (.) fried eggs
52 fried bacon fried bread fried mushrooms
53 (.) cups of tea and I have several slices of
54 white bread and when I am really not well
55 and feeling really depressed and anxious
56 I will eat a full loaf (0.5) at lunchtime I may
57 have two or three barm cakes or a large
58 loaf again and in the evening I may have

59 fish chips peas gravy or a pie and chips
60 again with lots of bread (.) then I will have
61 supper.
62 R:Why do you think you eat so much?
63 D:Well (0.5) I have spoken to lots of
64 people in the past and they say it is
65 because of problems I had as a child.
66 R:What sort of problems?

Responding to R's last question - a reference not only to her obesity, but also her many other health problems, D declines any particular reason for her failure in therapy, but asserts, instead, that *'she just can't seem to stop eating'* (extract 9.10: lines 47-48, above). Though it is in no way conclusive, her answer argues the same lack of motivation to diet properly that informant T (Conversation nine, below) also finds to support her anorexia - an obvious, though possibly unwanted reason for her eating disorder. It is an interesting response because it is the first time that her eating disorder *per se* has been mentioned by either R or D and she does so in a way that appears to affirm her powerlessness.

Asked to describe *'a typical day's meal'* (line 49, above) D offers a remarkably frank description of her normal diet, which, interestingly she cast as a symptom of unwellness (lines 54-55, above). That D believes herself to be unwell goes without saying, but the potential complexity of this self denomination is obvious and suggests a misuderstanding on her part of the position this assumes - one, which argues that her subjective experience of an apparent *symptom* of unwellness/disease (over eating) is the objective evidence of that disease and the 'sick role' she claims (Talcot Parsons,

1951; & Szasz, 1997)[12].

It follows that the disease she implies has a cause (other than her disposition to eat more than she should) and to this end she uses the reports of authoritative others as the substitute for her own understanding - their position, it would appear, is her position. Note for instance, that when she is asked: *'why do you think you eat so much'* (line 62, above) she replies using the pronominal *they* to reference the opinion of others whom she regards as credible: *'they say it is because of problems I had when as a child'* (lines 63-65, above). Note, also, that she uses the anaphora *it* to signal something that is apparently beyond her control.

This is an important position of understanding - the passive acceptance of the power/knowledge of professional others, and one that R is cued to ask: *'what sort of problems'* (line 66, above). Speaking for herself in the first-person singular, D now offers a Spartan recollection of her childhood and troubled relationship with her dad - one, which is empty of any pertinent detail, not to say the problems she alludes to (extract 9.10: line 65, above). In essence, the problem she claims is embedded in some family squabble - a not uncommon experience for many people (extract 9.11: lines 67-69 & 71-86, below)[13].

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[12]Fabrega,1973; Frankenberg,1980 & Kleinman,1978 give an interesting account of this relatively commonplace self attribution of illness - an attribution that is, in part at least, stimulated by a welfare conscious society concerned to protect its resources from malingerers (cf. Lobjoit, in Jones, 1972: p.253)

[13]Describing the aetiology and maintenance of eating disorders, Cooper (1995: pp.66) concludes that 'it is unlikely that studies of family functioning of patients with eating disorders will reveal anything significant about the aetiology.'

Extract 9.11: Informants R & D

D:Well (.) my dad and myself don't get on
in fact I don't get on with anyone in the
family.
R:Why's that?
D:It all started when I was a small baby (.)
my dad was in the Air Force and we
moved around a lot (.) when I was
eighteen months old (.) we all stayed
home whilst my dad went travelling round
the world (.) we stayed in one place (.)
we didn't see him for about three years (.)
only off and on (0.5) when he came back
he wanted everything to be like it was
before with playing with us and hugging us
but I didn't know him he was a stranger
and when he wanted to hug me I wouldn't
let him (.) in fact I didn't really like him and
I have never liked him since (.) because
since then he has never hugged me or
anything anyway.
R:Have you any other brothers or sisters?
D:Yes I have a sister.
R:Did she have any problems with your
family?

Arguably, this is the terminus of this particular beginning, wherein, talk about D's family relationships was always the focus of her concern (see also informant B: conversation ten, below). However, an important element in their empathic relationship then suggests itself when R asks D whether her sister had '*any problems with* [her] *family*' (lines 89-90, above), a repetition of the word *problem* that may have little or no relevance, but one that Tannen, (1992: p.51) suggests has a connective function that 'foregrounds and intensifies the parts repeated, and also foregrounds and intensifies the parts that are different.' Family and problem are now twinned in a manner not previously heard, but possibly understood by both.

Interestingly, in describing her only sister in the manner she does (extract 9.12: lines 91-94, below), D gives a first negative indication of the person she construes herself to be: her sister, she says, is someone, *'more likely to make friends* [to have] *boyfriends* [and who, importantly, didn't] *think there* [were] *any problems when* [they] *were children'* (ibid) - she, by contrast, positions herself as friendless and somewhat daunted by life's vicissitudes.

Extract 9.12: Informants R & D

91 D:No she is totally different to me she's
92 more likely to make friends (.) she's had
93 boyfriends she thinks there weren't any
94 problems when we were children.
95 R:So why do you think it was a problem?
96 D:Well (.) my dad never showed me any
97 affection after that.
99 R:Did you let him or give him an
100 opportunity or did you encourage him?
101 D:No.
102 R:Why not?
103 D: I felt angry at him in fact I still do feel
104 angry at him (.) I don't want him to show
105 any affection so even if he tried I wouldn't
106 let him.
107 R:So he did try then?
108 D:He did until I was about six or seven but
109 after that he just gave up.

Not surprisingly, R then asks D *'why* [she thought] *it was a problem'* (line 95, above) - a question made more salient, it would seem, by the word *'problem'*, which has trammelled their discussion from start to finish and in a way entirely reminiscent of Goffman's (1973: p.102) concept of the *'betrayal-funnel'*. Though not immediately obvious, it was R who first introduced this token (extract 9.6: lines 01-02 & 06-07; extract 9.7: lines 18-19 & extract 9.8: lines 25-26) and, has done so in a way that suggests she is reflexively cueing D to sustain or otherwise expound a particular view

point, whilst ignoring the 'administrative facts'[14] - there is, it must be supposed, a problem, but it is not her obesity.

Unerringly D returns to her relationship with her father - which, apparently has never recovered from the ambivalence she showed him as a child (see extract 9.11: lines 78-86, above) and towards whom, she *'still feels angry'* and resistant (lines 103-106, above). Whether her relationship with her father is the locus of her current eating disorder or not, is a moot point, but it is a position that R has been allowed - possibly even encouraged, to develop and will now have to deal with, improbable, though the outcome will be.

The merits of R's approach to counselling/psychotherapy are well attested in person-centred therapy and in a few brief words she has exposed (in an artful and eperienced way) a number of interesting possibilities for future discussion - all of which may prove valuable. However, much of the discussion is now anchored to the dubious relationship D claims to have with her family - none of which can purport to support or otherwise explain her current eating disorder (see Cooper, 1985).

Problematic for this and all other conversations in this series (chapter nine) is the idea that subjectivity (as it is inferred by person-centred therapist's) is in some way privileged - a Cartesian theatre that is separate in some way from its articulation. That the very idea of subjectivity invites a polite understanding of the rules this assumption entails - which argues, that the diorama this claims is only possible when mediated by he

[14]Some caution is expressed here as the possibility that R was getting her client *into-story* for purposes of this study cannot be ignored.

client's own particular view point.

Here, the arguments trailed in chapter two suggesting that subjectivity ignores the fact that 'thought and expression are simultaneously constituted' (Merleau-Ponty, 1986: pp.183-4) and that, 'the search for the appropriate word in order to make something known to somebody else may often, in authentic speech, actually serve to make that something known to the speaker himself' (Rommetveit, 1974: p.22), are particularly apposite and undercuts the idea that a story, no matter how it is told, can exist outside its moment of telling without regard for the position(s) assumed by those invited to hear it - and more particularly, *agree* it. A problem that becomes more urgent when the form of talk allowed is a confession grounded in an equally well-meaning mutually conceived complicity.

Conversation Eight: Compatible Positions in Counsellor Initiated Self Confession

The next three conversations in this series (eight, nine & ten) are confessional in form and appear to reflect a maturity in the counsellor/counsellee relationship that is more certain of their clients' own position of understanding - or if not this, their own position of confessor. The first two conversations in this set - like conversation seven, above (informant D: extracts 9.6-9.12), emerged out of the eating disorder clinic attached to ward Y, however, whilst they each represent a very particular primary physical focus they inevitably mask a complex and enduring pathology (psycho-social discourse) that is not always open to reason.

Confession of *wrong-doing* of the sort these three conversations now describe are at the heart of person centred therapy[15] [16] (without which, there could be no therapy of this type - cf. Harris, 1994) and has a tradition that extends from St Augustine of Hippo (AD. 354-430/Pine-Coffin, 1961); Ignatious of Loyolla (AD.1491-1556/Corbishley, 1963); Wordsworth (1770-1850, 1968); to Freud (1915-1917; 1949; 1973) and Rogers (1951; 1957 & 1975). In essence person-centred therapy invokes (as a matter of ritual) self-exploration and self-*disclosure* as the key to personal growth and self-understanding - speaking of this, Rogers (1975) writes:

> 'Let us turn to a more specific result of an interaction in which the individual feels understood. He finds himself revealing material he has never communicated before, and in the process he discovers a previously unknown element in himself. ... To perceive a new aspect of oneself is the first step toward changing the concept of one self' (Rogers, 1975: p.7)

In this first conversation (eight) between informant C, a female staff nurse and informant R2, an anorexic/bulimic young woman in her early twenties, the confession is elicited by C simply inviting R2 to give an account of the food she has eaten in the last few days (extract 9.13: lines 01-2, below). However, whilst, this is undoubtedly an issue of great

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[15]Psychotherapists invariably use the term *self disclosure*, rather than *confession*, because the former speaks of an open awareness, whilst the latter hints at a wrong-doing that can never be implied in person-centred therapy (cf. Corsini & Wedding, 1989; Egan, 1990; Nelson-Jones, 1991).

[16]Foucault (1981: p.174) argues that confession is a ritualised form of discourse and that 'Western man has become a confessing man.' His critique of the confession is puissant and conjures an image of the power and dominance of the 'Selfsame' (Cixous & Clément's (1986: pp. 78-91). Confession, he posits, is defined first by topic - 'the speaking subject is also the subject of the statement' and then by the power relationship between those involved: 'one does not confess without the presence (or virtual presence) of a partner who is not simply the interlocutor but the authority who requires the confession, prescribes and appreciates it, and intervenes in order to judge, forgive, console and reconcile (Foucault, 1981: p.61). Confession he posits has the peculiar feature that the very act of doing it changes the person who does it; it 'exonerates, redeems, and purifies him; it unburdens him of his wrongs, liberates him and promises him salvation' (ibid: p.62). Furthermore, the value of the confession is increased by the obstacles and resistance one has to overcome to make it (cf. Fairclough, 1995: pp.52-54).

sensitivity and concern to R2 she responds to C's inquiry with an absolute and unashamed candour.

The first part of her confession unfolds in three parts: part one, describes a temporal frame of anorexia that covers the last three days (extract 9.13); part two, an episode of bulimic bingeing, that might possibly indicate a causal event (extract 9.14); and part three, an affective mood change that is entirely symptomatic of her condition (extract 9.15; see ICD-10, 1992: pp.176-180; DSM-IV, 1994: pp.539-550). That R2 would confess (indeed must confess) appears implicit to this encounter and it captures something of Foucault's (1981: p.6) belief that in the very act of confessing she will find judgement, forgiveness, consolation and/or reconciliation for the *wrong doing* her behaviour apparently suggests[17].

Extract 9.13: Informants C & R2

01 C:Tell me what you've eaten in the last
02 twenty-four hours?
03 R:Nothing.
04 C:What have you drunk?
05 R:Only Coke.
06 C:When was the last time you ate?
07 R:About two or three days ago. ((starts
08 crying))

Importantly, this sequence also demonstrates a highly specific search for information that is reminiscent of Silvermann's (1987: p.48) paediatric interview - which was an equally focused investigation of the *facts*. However, there is one significant difference between the two - in the Silverman account, the paediatrician in question used the

[17]Similarly, Orlinsky (1989: p.419) suggests that *redemption* is one of the four intentions of psychotherapy - the others are *treatment, education* and *reform*.

objective data of a third party account to test the mother's understanding of her babies illness. An objectivity entirely absent from this account - or indeed, any other in this series.

Extract 9.14: Informants C & R2

09 C:What did you eat?
10 R:I binged again.
11 C:What did you binge on?
12 R:I ate about six Star bars (.) four packets
13 of chocolate nuts and a cake.
14 C:Were you sick afterwards?
15 R:No (.) but I felt sick and I've felt sick
16 since.

It is a simple method of triangulation used by most (if not all) investigators (cf. McLeod, 1994), but not one that is fundamental to the counselling process. In this circumstance, claims to right, truth and sincerity, are assumed correct, until the contrary is proved the case - but even then, the variance that may be observed is recast as a discrepancy in the client's self concept, rather than any factual distortion on their part (cf. Nelson-Jones, 1991: p.313).

Extract 9.15: Informants C & R2

17 C:Tell me what happened (.) why did you
18 do it?
19 R: I was depressed (1.0).
20 C: Why (.) why are you depressed

This process of face-value acceptance of the client's version of reality is once again self evident in this conversation and also again in the two that follow (nine & ten, below), wherein C fails - or sees no reason, to challenge any statement made by R2, rather,

she treats each entry she makes as conclusive and determinate of the next question she asks. However, in fairness to C, a counter possibility does present itself in extract (9.15, above) - one which might better explain her ready acceptance of the facts as told.

This extract begins with C asking R2 *'tell* [her] *what happened (.) why did she do it'* (lines 17-18, above) - a reference to her recent bingeing behaviour (extracts 9.13 & 9.14, above). Interestingly, R2 answers using a past tense construction to suggest she, *'was depressed'* (line 19, above), which C then modifies to reflect a present tense inquiry *'why are you depressed',* she asks (line 20, above). It is temporal shift which might be construed as a recognition by C of R2's incoming mood state and a choice of questions which are prescient in their understanding of its probable cause and need to deal with this as topic before any other - though, her complicity in arranging the facts cannot be ignored (see extract 9.16, below).

This is an interesting start because it hints (and no more than that) at something Mishara (1994: p.138-143) refers to as 'commonsense oppositions and mutual concealments' - the idea that in their knowledge and experience of each other, participants in talk (or action) will compensate for the discrepancies they know to exist in the account (or behaviour) of the other in ways that ensure there is 'coherence [in their] mutual effort (ibid: p.139)[18]. R2's bingeing is clearly an issue of great concern to both her and C and one which appears to urge an explanation that is in tune with her understanding of her weight problem - one which (for the moment at least) abstains the

[18]Patton (1984: p.449) refers to something that has the same feel as this when he talk of the need to 'keep the client talking.'

issue of her voluntary control.

> 'Illness involves a transformed relationship to one's own body in which certain parts of one's body, or body self, previously under one's disposal, now take on an alien character as resisting one's subjective will. These parts become a resistant *it*. They are no longer under the free control of the *I*, but are experienced as foreign or *other*' (Mishara, 1994: p.142).

To this end, R2's depression is transposed into a cause rather than a symptom[19] of her anorexia and bingeing behaviour and one which projects an inquiry that supports this view - in this sense, their conversation so far might be construed as face-saving beginning that avoids a confession that might otherwise admit 'guilt or responsibility' for a behaviour over which she has at least some control (Brown and Levinson, 1992: p.68).

Extract 9.16: Informants C & R2

21 R:There's a bloke at work that I really
22 really fancy at the moment (.) I've quite a
23 crush on him (.) really like him (.) he's
24 single (.) he's everything I like (.) he likes
25 to go out (.) likes to walk (.) he's got a
26 really good career (.) everybody likes him.
27 C:So what's your problem?
28 R:I'd like him to ask me out come out with
29 me one night.
30 C:That 's a problem is it?
31 R:Yes ((Crying)).
32 C:Why is that a problem (.) why is that
33 making you depressed?
34 R:Well (.) look at me (.) I am hardly God's
35 gift to men am I?
36 C:Tell me what you mean by that (.)

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[19]'Studies in which the psychopathological profile of patients with bulimia nervosa have been compared with depressed and anxious patients reveal differences of clear diagnostic significance: the affective symptoms are predominantly secondary to the core eating disturbance in the patients with bulimia nervosa' (Cooper, 1995: p.64)

37 because you look quite thin to me.
38 R:No I'm not I'm fat and flabby.
39 C:What do you mean you're fat and
40 flabby (.) where are you flabby.
41 R:Underneath my arms (.) my thighs (.)
42 my legs.
43 C:Do you think he notices things like that?
44 R: I don't know.
45 C:But you think he does?
46 R:Yes.

Answering C's last question (extract 9.15, above) R2 responds by declaring that, *'theres a bloke at work I really really fancy'* (extract 9.16: lines 21-22, above) - a relatively commonplace circumstance one might suppose, but in the context of R's claims to *illness* it conjures a relevance that goes to the heart of her problem and offers a spore that C must inevitably follow.[20] Interestingly, C's response to this new information is unexpectedly abrupt and she barely conceals her astonishment with a riposte that asks: *'so what's your problem'*, she asks (line 27, above). Unabashed by the slight this appears to suggest, R2 confirms that it is, indeed, a problem, but with a qualification that is much more specific and telling - the problem, it seems, is not her, but rather, him - his failure to ask her out, an initiative, over which she believes she has no control (lines 28-29, above).

Though it may be otherwise, R2's problem cast as a romantic fancy is intriguing and suggests an abstractedness towards herself that is metaphorical - conflating, as it were, her understanding of her recent eating behaviour into a single fateful experience. An experience, though, that is ultimately circular in the story it is want to tell - she *'bing*[es]

[20] Bruch (1973) was the first to conclude that body image was pathognomic with anorexia nervosa and Garfinkel & Garner (1982) that anorexics over-estimated their body size. Cooper & Taylor (1988) found the same to be true of bulimia nervosa.

to cheer [herself] *up'* (extract 9.17: lines 55-57, below). Confirming that the problem is as she has described it, C then asks *'why is that a problem .. why is that making you depressed'* (lines 32-33, above) - a prompt that not surprisingly ushers forth a construal that is inordinately focused (as it surely must be) on her negative self denomination and body image: *'I am hardly God's gift to men am I',* she declares with feeling (lines, 34-35, above).

Interestingly, and rather importantly as it transpires, C counters this self abnegating position of passive distress with an utterance that first proffers a question and then suggests its own answer with an second clause equivocation that looks decidedly suspect: *'tell me what you mean by that* [she asks] *because you look quite thin to me'* (lines 36-37).

Intriguingly, whilst, this conversation was always premised on the issue of R2's anorexia this is the first indirect mention of it and in such a way as to imply an ill concealed, if strategic, duplicity on the part of C - a confirmation, apparently, that R2 is as thin as she might wish to be, though, arguably much thinner than she possibly ought to be (cf. Mishara, 1994).

Not surprisingly, R2 responds to what appears to be a weak inversion of the *truth* she is wont to claim with an emphatic denial that she is anything but thin and asserts instead that she is both *'fat and flabby'* (line 38, above). Unerringly, C responds to this invective with a repetition that first questions her claim to *fatness* and then calls for proof of her *flabbiness* - an elision that looks highly suspect in the conviction it purports (lines

39-40, above). Importantly, their conversation now appears to have reached its inevitable impasse - a terminal point, that argues two potentially implacable and mutually pposing positions, in this instance, R2's belief that she is overweight and C's muted - though, probably correct belief, that she is not.

That R2 has distorted ideas about her weight and shape is central to the maintenance of her eating disorder (Fairburn, Cooper & Cooper 1986; Garner & Bemis, 1982), but the opportunity to counter this is ignored when C appears to agree the disposition of R2's *flabbiness* (line 41-42, above) with a reconciliation that asks: *'do you think he notices things like that'* - a position/stall that hints at Patton's (1984) concern that the client is kept talking regardless (line 43, above) and a closing that suggests that '[she, R2] *thinks he does'* (lines 45 & 46, above).

Extract 9.17: Informants C & R2

47 C:So why did you binge?
48 R: I just got home and wanted to ask him
49 out but didn't know how and I won't ask
50 him (.) I know I won't ask (.) but when I
51 got home the thought that if I did he could
52 say yes made me depressed (.) I don't
53 know why (.) more like if I asked him and
54 he said no and that made me even more
55 depressed (.) suppose I just wanted to
56 cheer myself up I eat.
57 C:You binged to cheer yourself up?

Having, as it were, agreed R2's understanding of the things she claims, the talk then returns to the issue of R2's bingeing and with this an explanation that is both frank and revealing in its convoluted construction (extract 8.17: lines 48-56, above). This sequence, though, has an almost dream like quality - a positioning that might be

described as a sort of 'self-talk' (Goffman, 1981) in which R2 construes the reason for her bingeing cast in terms of some misconceived romantic notion - that may, or may not have a basis in fact.

> 'With self-talk, then, one might want to say that a sort of impersonation is occurring; after all, we can best compliment or upbraid ourselves in the name of someone other than the self to whom the comments are directed. But what is intended in self-talk is not so much the mere citation or recording of what a monitoring voice might say, or what we would say to another if given a chance, but the stage-acting of a version of the delivery, albeit only vaguely a version of its reception' (Goffman, 1981: pp.82-83).

Though this is only the beginning to this particular conversation, the talk so far is abstracted - in the sense that it grants to R2 a position (self promotion and/or ingratiation) that is not altogether convincing of her wont to starve and binge herself and one that hints at a convention that assumes that talk of this type must in some way preclude any direct reference to the client which might do injury to their subjective understanding. In consequence, it carries with it the assumption that R2 is rational in her understanding of her behaviour and not, as might be construed (in a moment of speculation), motivated by a 'tendency [towards] irrational thinking, self damaging habituation, wishful thinking and intolerance' - all of which might be exposed in a communication more forceful in its conviction of the facts as they purport to be (Ellis, 1989: p.197).

In the next conversation (nine, below) the problem this sort of passive (if sometimes reluctant) collusion might represent rises to a new level of meaning when informant T assumes what amounts to be a disembodied and highly irrational and dangerous view of herself in relation to her anorexia - one which is not disabused by the conversation

in which she is engaged.

Conversation Nine: Compatible Positions in Client Initiated Self Confession

This conversation between informant H2 a male staff nurse and informant T, a thirty something professional lady with a twenty year history of anorexia nervosa, begins with T, teasing H2 about his ability to get her to talk about her *'hassles'* (extract 9.18: line 02, below) and a plea that he doesn't *'see* [her] *as a lost cause struggling with anorexia'* (lines 04-05, above). Once, again this appears to be a 'face-saving' beginning that T uses to prelude the quite significant confession she is about make regarding her eating behaviour, which, significantly and rather ominously she describes as *'it'* - a distal reference that is more telling than it immediately suggests (line 09; see lines 16-22, below).

Her positioning in respect of H2 is fascinating, because it suggests an attempt on her part to preserve both the identity and the social relationship she has fostered in therapy, whilst admitting the possibility that these might be challenged by her recent behaviour. A behaviour, which she describes in terms of her passivity (lines 08-09, below); over-valued ideas about size (lines 10-12, below); preoccupation with food and eating (lines 13-18, below); and now, most importantly, vomiting (line 16, below) - (see ICD-10, 1992 & DSM-IV, 1994). None of which, one must suppose, will inspire confidence in her therapist.

Extract 9.18: Informants H2 & T

01 T:You're crafty you know (.) I wasn't

02 going to talk about my hassles at all but
03 we're doing it now (1.0) I have to admit
04 it helps (.) as long as you don't see me as
05 the lost cause (.) struggling with anorexia
06 (.) I know you think you know which way
07 I am going at the moment (.) I can see it
08 too (.) but I just can't convince myself to
09 do anything about it (.) you know that it's
10 starting to come back (1.0) last weekend
11 I bought size eight clothes (.) they were
12 too big (.) I felt really uncomfortable and
13 you know like always I'm struggling now
14 to go into a shop if I have to buy any food
15 (.) it's easier to walk out even when I am
16 eating it's coming straight back up (.) I'm
17 thinking {of just going back to fluids
18 again.
19 H:Hang on a minute} you say you're
21 throwing up again (.) how often?
22 T:Oh daily.

Interestingly, her confession takes the form of a glib, affable repartee - a self-talk, almost, that attempts to mask the very serious reversal in her condition her story is wont to tell, but one that implicates no one but her self[21]. Not surprisingly, H2 is momentarily aghast by what he hears and he interjects with a voluble exclamation that asks if she is *throwing up again* [and] *how often'* (lines 19-21, above) - to which she replies, with a nonchalance that is almost wicked, *'oh daily'*.

Extract 9.19: Informants H2 & T

23 H:How many times a day?
24 T: Six seven (.) I'm not sure
25 H:We've gone over this before haven't
26 we (0.5)

Something of the discursive history framing this conversation is captured when T

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[21]This is the only conversation in this series that doesn't implicate an other in the contentions of the client.

declares that she is not only vomiting, but doing so, *'six* [or] *seven'* time a day (extract 9.19: line 24, above) and H2 responds with an acknowledgement that is clearly familiar and argues that there has been more than one telling of this particular story - *'we've gone over this before haven't we',* he concludes, in tones that appear more exasperated, than they are impressed by the decline in her condition this tells (lines 25-26, above).

However, more interesting than this, is why T felt the need to confess her current difficulties in the first place? What would motivate a communication that is likely to invite her counsellor's censure and/or disapproval - given that this was never the intended outcome and it is doubtful that it was (see extracts 9.18 & 9.19, above). The answer, at least in part, was framed by conversation one (chapter eight), wherein, informant M asked informant S, *'where* [she was] *at now'* (extract 9.1: line 68, above) and revealed her wont to talk about things that were of immediate import to her - and, more importantly, from the vantage of her own understanding.[22] Counselling, quite simply, thrives on people talking about themselves - it could not be otherwise, in this sense it could almost be said to be a one-dimensional activity that ignores (or denies) the possibility of truly intersubjective communication (cf. Habermas, 1991).

Speaking of the 'necessary and sufficient conditions of therapeutic personality change' (Rogers,1957), Masson (1993), insists that:

'... if we examine these conditions, we realize that they appear to be genuine only

[22]Cooper (1995: p.69) argues, that despite claims to the contrary, psychological therapies have proven ineffective in the treatment of this condition (ibid: p.69).

> because the circumstances of therapy are artificial. Precisely because the client is seen for only a limited time (less than an hour, once a week), the therapist is (in theory, whether it actually happens is something else again) able to suspend his judgement. In fact, the therapist is *not* a real person with the client , for if he were, he would have the same reactions he would have with people in his real life, which certainly do not include 'unconditional acceptance,' lack of judging or real empathic understanding ..... No real person really does any of the things Rogers prescribes in real life ..... this is merely artifice' (Masson, 1993: p.232)

Though Masson's critique is harsh, it recognises that the pragmatics of everyday human communication are suspended in this type of talk in favour of a one sided, largely uncontested, version of reality (see Goffman, 1972). Speaking of this type of 'story-telling' in therapy Rennie (1994b: p.237) argues that it allows the client to 'maintain [a] distance from the inner experience while acceding to the demands of the therapy situation to talk in personal terms.' In this sense, T's account, so far, might be read as an inversion of Patton's (1984: p.449) axiom that the counsellor must (at all cost) 'keep the client talking' - that in effect, she must have something to say to maintain the therapy her communication intends (note, T's want to be in therapy which was so eloquently expressed in her not wishing to be seen as *'as a lost cause struggling with anorexia* (extract 9.18: lines 04-05, above)!

T's account is in fact a sort of reverie - a disembodied musing out-loud of the position she has adopted toward the problems she describes and not the admission of wrong-doing it might otherwise purport to be. Once again, there is a sense that this conversation (like conversations six, seven & eight, above) is moving in the direction of clients preferred reading of the situation, rather than any other - one which assumes her therapist's compliance and support.

To this end, T makes light of to H2's concern that she is deliberately vomiting *again* with an elision that asserts that she is not only vomiting, but also experiencing difficulty in buying food, *'this last few weeks'* (extract 9.20: lines 27-28, below). An admission that H2 greets with surprise, but not, it would seem the alarm this claim would warrant in any other circumstance - a conversation at home or at work: *'why's it so difficult to buy food all of a sudden'*, he asks, with a benevolence that is remarkable in its understatement (lines 30-31, below).

Extract 9.20: Informants H2 & T

27 T:Yeah I know ((breezy manner)) (0.5) I'm
28 finding it difficult to buy food again (.) only
29 this last few weeks
30 H: You never said (.) why's it so difficult to
31 buy food all of a sudden (.) just tell me?
32 T:it's not the buying of food I find difficult
33 (.) it's the fact that I'm only eating to
34 please someone else (.) not really being
35 me (.) anyway throwing up is no problem
36 (.) if I keep throwing up it helps me lose
37 weight and I'm eating

In answer T offers a remarkable insight into her thinking with an admission that claims that she *'is only eating to please someone else* [and] *not being* [herself]*'* - a positioning of self-abnegating rectitude that speaks of the challenge she experiences and the regard she possibly wants for the effort of will this implies (lines 33-35, above). It is a frank admission (one that sits all too comfortably with her twenty year history of anorexia), but one that H2 greets with a bonhomie that is almost fatuous in its condescension and understanding: *'you know that's cheating'*, he exudes benignly (extract 9.21: line 38, below) - to which she replies, '*but no one else does*' (line 39, below).

Extract 9.21: Informants H2 & T

38 H: But you know that's cheating.
39 T:I do but no one else does.
40 H:It doesn't get any better does it?
41 T:No not a lot but I never expected it to
42 (0.5) I don't have the motivation I did.
43 H:Okay so why do you think you're losing
44 your motivation?
45 T:I don't know (.) I know (.) I just know I'm
46 not tempted to do anything at all (.) I'm
47 struggling to talk myself out of this (.) I
48 don't go to my GP any more don't talk to
49 anyone about it anymore (.) just feel like
50 I'm fading away.

The relationship that nurse H2 has with T is enviable and it is clear that she is able to trust him with an account that she is unable to share with any one else (lines 47-49, above), but it is also disquieting in its apparent complicity - despite his muted attempt to censure her behaviour (line 38, above). Though, she describes a potentially quite remarkable reversal in her mental and physical state H2's position of solicitude towards her is banal in the extreme. However, (in fairness to him) it does point to a peculiar and consistent feature of counselling/psychotherapy - that topics of talk are invariably pursued in 'particular ways' (Dreier, 1995: p.3) and often with no immediate and/or discernable reason for doing so.

Something of this and the intimacy of their positioning in relation to one another - a relationship that is bartered on the basis of her chronic, but clearly understood anorexia, is captured when H2 prophetically suggests that *'It doesn't get any better'* (line 40, above) and ushers forth an admission from T that claims she *'never expected it to'* and rather more worryingly, that she no longer '[has] *the motivation* [she] *did'* (lines 40 & 41, above). Despite her affectations T is obviously a very *ill* young woman and one, whom

it might be supposed, H2 knows only too well[23].

So-much-so, it would seem that a certain inevitability now begins to suggest itself in the text (extract 9.22: lines 4 0-50 & 9.23) and in a manner that hints at the irreconcilable and contrary nature of their positions - but one that is inevitably supported by their good intentions towards one-another in a therapy that describes their relationship and the conversation this intends.

Extract 9.22: Informants H2 & T

H:Are you sleeping?
T:Go to bed about one o'clock (.) but then I'm sick (.) I make myself sick.
H:Why (.) why do you make yourself sick?
T:((Laughing)) You know why- I lose weight (.) anyway I don't want to keep anything in my stomach.
H:Why not?
T:Oh I don't know (.) it doesn't make sense but when I'm physically okay and I'm eating I feel well physically I get these thoughts which just keep coming and I get so depressed I can't stop losing my self-confidence but when I'm physically in a wreck I'm mentally fine (.) I feel really in control of it (.) I know you look in there watching me being sick (.) think that that's all wrong but it isn't (.) when I'm physically sick I feel more in control than when I'm physically well I feel like I'm losing control.

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[23]The seriousness of T's condition cannot be underestimated - writing about the course and outcome of anorexia nervosa, Cooper (1995: pp. 71-72) states that, 'after 20 years, almost 40 per cent of the patients were gravely incapacitated by the illness or had died. Indeed, an alarming and consistent finding of the outcome studies is that the mortality rate for anorexia nervosa is around 15 percent (Hsu, 1990). In the Maudsley sample (Ratnasuria,*et al* 1991) [half of] all deaths were due to illness associated with electrolyte imbalance'. Hyperemesis, of the type T describes, will lead inextricably to electrolyte imbalance, if not corrected.

The sense that they are returning to an all too familiar position exerts itself in this final extract (9.22, above) when H2 counters T's concern that she is *'fading away'* (extract 9.21: lines 49-50, above) with a solicitude that presciently asks if she is *'sleeping'* (extract 9.22: line 51, above) - a concern, she answers with an admission, that she isn't, because she is '[making herself] *sick'* (lines 52-53, above) in an attempt *'lose weight'* (lines 55-56, above). In response, H2 then asks what is arguably the most important question in this conversation: why doesn't she want to *'keep anything* [in her] *stomach'* - why, in effect doesn't she take the nourishment she appears to need (line 58, above)?

The obsessive and intractable nature of T's eating disorder is made immediately apparent in her response to this, which is, by any standards, a highly articulate rendition of her understanding of the voluntary and obviously contrived nature of her anorexia - which she knows, H2 (and possibly many others) finds incomprehensible (lines 59-71, above). Importantly, she (no less than anyone else, it would appear) can make no sense of the contradiction that argue, that when she is *'physically in a wreck* [she is] *mentally fine*' and when she is not, she is *'obsessive*', *'depressed*' and lacking in '*self confidence'* (lines 61-64, above).

In a client so obviously able to self reflect in the way that T has, it seems appropriate to suppose that she is able construe (with others) an understanding of why she needs to starve herself in the way she does - that there is, in effect, a cause for her cognition and behaviour that is meaningful to her and possibly other besides. In this respect, the modern tradition of counselling/psychotherapy owes much to Cicero's (106-43 BC.) who

suggested that:

> 'Herein indeed the mind and the body are unlike; that though the mind when in perfect health may be visited by sickness, as the body may, yet the body may be disordered without our fault, the mind cannot. For all the disorders and perturbations of the mind proceed from a neglect of reason; these disorders, therefore, are confined to men; the beasts are not subject to such perturbations, though they act sometimes as if they had reason' (Cicero, M.T 1878. The Academic Questions, Treatise de Finibus, and Tusculan Disputations, p.410, Quoted in Alexander & Selesnick, 1967: p.47).

But, interestingly, though, T has made it obvious that she wants H2's help (see extract 9.18: lines 04-05), their talk is challenged by a possibility most (if not all) social-care theorists are probably loathe to admit - that there is no discernable social or inter-personal/relational reason for her eating disorder that can be rendered from her life world experience, other than her own self delusion. Problematic though, is that talk of this type may not always agree this possibility and encourage a clients' self reflection in search of an improbable truth [24] - a possibility that emerges more forcibly in the last conversation in this series, conversation ten, below.

Conversation Ten: Compatible Positions in Confession as Reminiscence

In this final conversation between G3, a senior ward manager, who, it will be remembered was the nurse who described mental illness in terms of ICD-10 (1992) and DSM-IV (1994) classifications, but interestingly held out the possibility that, *'lots of worried well ... come across as* [mentally ill]' (extract 5.10: lines 318-320; see also,

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[24]There is no suggestion that this encounter was not therapeutic in terms of T's 'emotional relief', 'contact with [her] inner experience' and/or 'private processing of [her] experience' (Rennie 1994b: p.239-240) - it probably was, but there in lies the rub. Who would know? Is it communication or confession as self-absorption and personal reconciliation?

extracts 5.9, 6.10, 6.11, 7.8, & 7.9), is in conversation with informant B2, a thirty something obese and depressed, single lady, who begins her account with a reminiscence that takes the form of what might be construed as a 'plot' development (Eagleton, 1993: p.105; cf. Drew, 1989), wherein, the events she describes have been reversed chronologically to give a subtle, but as yet imprecise meaning to her 'story' (extract 9.23: lines 01-13 & 22-23, below).

Extract 9. 23: Informants G3 & B2

01 B:I'm feeling really upset after seeing Mr
02 ((name omitted)) today (.) he made a
03 comment about the colour of my eyes
04 which made me think of when I was
05 about 18 years old (.) I had a boyfriend
06 then who in front of my dad said he
07 thought my eyes were beautiful (.) the
08 colour of brown (.) my dad looked up and
09 laughed and said he thought green eyes
10 were much nicer (.) stupid (.) I know to
11 get upset about not having right colour
12 eyes (0.5) but thinking about this makes
13 me really upset ((crying)).
14 G3:Why has this upset you so much now?
15 B:Well dad always thought my eyes were
16 too dark or not nice enough then again
18 there was not an awful lot he did like
19 about me (.) it makes me wonder really
20 (.) if mum feels the same way (0.5) I'll
21 have to ask her one day (0.5) I'm sorry
22 I don't like memories like this and feel
23 really depressed I don't know why (.) I
24 just cry for no reason (.) I seem to cry for
25 no reason a lot these days (.) I just get
26 really hurt inside and it takes over (.) I
27 feel as if I am suffocating (.) when I'm
28 with other people it happens just the
29 same ((crying)) makes me feel like I lose
30 control.

Like any good detective story this episode of counselling begins with a reported event

and an investigation to discern the reason why it happened (extract 9.23, above). To this end, it invites B2 to speak of any action and/or circumstance that may have bearing on the story she wishes to tell - her depression (lines 22-23, above). In this instance she calls forth an encounter with an unknown man earlier in the day which has left her *'feeling really upset'* (lines 01-02, above) as a position of enduring unhappiness to recount a story which begins to trail the relationship problem she claims to have with her father as reason for her current distress (lines 04-13, 15-16 & 21-30, above; see informant D, conversation two above).

But, unlike any detective story there is no way of knowing that what B2 says about the incident concerning her *'eyes'* (lines 02-13) is true. B2's positioning in this regard is interesting, because it describes something of the protean nature of counselling/psychotherapy, which, in its well meaning support of the client, makes any event in the complex narrative structure of their life world potentially salient to their understanding of the trouble and/or distress they contend. A life world that makes available multiple speaking parts, but generally only one point of view.

This is an interesting (not to say profoundly complex) self reflexive opening to therapy and one, over which G3 exerts no control, until, that is, she asks, *'why* [her reminiscence has upset [her] *so much now'* (line 14, above). An appropriate question in the circumstance, but one that B2 answers with a dénouement that first compounds her father's oculistic perturbations into a generalised criticism of her demeanour: *'there was not an awful lot he did like about me'* (lines 18-19, above) and, then implicates her mother, with a muse that is no less pointed in its implication of blame, than was the

latter: *'it makes me wonder really* [she says] *if mum feels the same way I'll have to ask her one day'* (lines 19-21, above).

This is a pivotal moment in their talk, one that changes the discussion from the so far past tense reminiscence to a present tense declaration of her feelings: a *'depression'* which calls forth a vivid expression of the pain and suffering she is experiencing and a claim, that despite the presence of others, it makes '[her] *lose control'* (lines 23-30, above).

Not surprising, given B2's obesity, G3 is prompted to ask her, *'what do you mean you lose control'* (extract 9.24: line 31, below) - a cue that hints that her family relationships are construed to be the cause of her over-eating, rather than any other circumstance she might describe (line 31, below). But, this is not what B2 meant and she responds to this with a complex abstraction that argues that certain *'silly things'* make her lose control (line 32, below) - not least, receiving *'a portrait of a cow'* from her mum (lines 34-35, below).

Extract 9.24: Informants G3 & B2

31 G3: What do you mean you lose control?
32 B:Silly things like I received a letter
33 recently from my mum (.) I couldn't
34 believe it (.) she sent me a portrait of a
35 cow (.) I was really upset about it (0.5) I
36 rang her up and said why have you sent
37 me that (.) and she said it was just to
38 make me laugh (.) she said it suddenly
39 occurred to her that I never laugh anymore
40 (.) she's not heard me laugh for a long
41 time and that made me sad because mum
42 gets upset (.) I've tried not to let her know
43 how I really feel about dad because it

44 upsets her (.) I suppose she's got a
45 mother's instinct (0.5) at least that proves
46 she likes me.
47 G3:Is that important to you that she likes
48 you?

The word cow, probably innocent in any other context, is now cast as a metaphorical symbol of all her distress and hints at what Eagleton (1993: p.168) - after Lacan (1977), suggests, is her apparent separation from the 'real' - an imaginary state 'in which [she] makes identifications, but in the very act of doing, [she is] led to misperceive and misrecognise herself' - in effect, she is positioned as she believes others perceive her to be (ibid: p. 165). A cognitive appraisal of her self in relation to others that posits a complex association of disparate, but (loosely) connected events to construe the meaning of her obesity [25].

Her account so far appears to be little more than a homily - a kaleidoscopic representation of events that by allusion attempts to give meaning to her distress from a number of probable, but no less certain points of view - all of which, deeply implicate her father, but also suggest an unresolved relationship with her mother: (lines 35-46, above; see extract 9.25, below). G3 responds to this with, what seems, a prescient understanding of her client with a prompt that asks, *'is that important to you that she likes you'* (lines 47-48, above).

Extract 9.25: Informants G3 & B2

49 B:It's pathetic (.) it's pathetic that I've

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[25]Rennie (1994b: p.238) suggests that this sort of 'belief management' (if it is such a thing) occurs when clients are unable to deal with their disturbance honestly because it threatens their sense of self too much. It is also the case, that in coping with distress some people *ruminate* to a degree that pathologises the events they describe.

50 reached nearly thirty and I still don't know
51 if my mum loves me (.) I know dad doesn't
52 but my mum never tells me she loves me
53 (.) she never hugs or kisses me (.) I can't
54 remember the last time that she kissed me
55 ((cries)) I hate this feeling it won't go
56 away I just want to scream all the time (.)
57 the panic in my stomach (.) I don't know
58 what will ever make me feel better (.) I
59 feel ugly (.) I feel overweight (.) nobody
60 loves me ((Cries))- I wish my eyes were
61 green (.) I wish I was like my sister (.)
62 she's had a boyfriend for the last eight
63 years and she's still happy (.) I don't want
64 to talk about this any more as it hurts too
65 much.
66 G3: Sure?
67 B: Yes

B2 answers this probe with a highly emotional and deeply evocative account of her need to be loved by her mother which she invokes as challenge to her knowing that her *'dad doesn't* (line 51, above). Tearfully, she concludes that she *'hate*[s] *this feeling'* and *'want*[s] *to scream all the time*' (lines 55-56, above) - an elision that then calls forth a self denomination of quite damning proportions, one that construes an ugliness in relation to her obesity (lines 58-59, above); her want of paternal approval - *'I wish my eyes were green '* (lines 60-61, above); and her want to be like her sister and have a boyfriend (lines 61-63). None of which G3 contests.

That this conversation was always intended to be the confession it is, is captured in the closing moments when B2 terminates her self deprecating reverie with a conclusion that is emphatic in its closure: *'I don't want to talk about this any more',* she says, it *'hurts too much'* (lines 63-65, above) and is answered, by an acknowledgement that postures its assent whilst inviting her to say more (line 66, above) - an invitation, she

refuses (line 67, above).

Like conversation nine, above, this conversation ends with a relatively determinate portrait of a client deeply unhappy with her self, but unlike informant T, her disillusion is focused (like informant D, conversation seven, above) on her problematic and altogether incontestable relationship with her parents - most particularly her relationship with her father, whom she clearly dislikes. But, no less than conversation nine, it begs the question, why? Why confess this at all - did it, or will it at some future time, resolve the tragedy she feels, or will it make more certain in her mind the construals she uses to explain her obesity?

Importantly, confessions of this sort - indeed, all conversations in this series (chapter eight and nine) entail a situated reconstitution of an identity the individual supposes of himself/herself (cf. Davies & Harrë, 1990) - and one that others might also think to be plausibly true:

> 'In confession, one is subjectified by an other, for one confesses in the actual or imagined presence of a figure who prescribes the form of the confession ... But in confessing, one also constitutes oneself. In the act of speaking, through the obligation to produce words that are true to an inner reality, through the self examination that precedes and accompanies speech, one becomes a subject for oneself. Confession, then, is the diagram of a certain form of subjectification that binds us to others at the very moment we affirm our identity' (Rose, 1989: p.240).

In effect, the danger, this sort of confession poses itself, is that it reinforces the moral orientation/position of the client in favour of a truth that is possibly more rational than the explanation they are want to give.

Summary

Foucault (1984) contends that 'no position is to be seen as more or less justified than any other. All are ultimately based upon fiat. Such are the regimes of truth' (Taylor, 1994: p.99; cf. Davies & Harré, 1990) - a view, that social care theorists take as a given and nurse therapists in this series of talks would seem to approve. A series of talks which unashamedly, espouse the client's position in relation to those others they intend in their talk and which allow: informant, Mrs H, (extracts 9.1-9.5, above) to construe a version of events which deeply implicates her husband in her distress; informant, D (extracts 9.6-9.12, above) to impugn her father as cause of her obesity; informant, R2 (extracts 9.13-9.17, above) to conceive a sense of romantic rejection as evidence of her fatness/flabbiness; informant, T (extracts 9.18-9.22, above) to abdicate responsibility for her recent vomiting to the vicissitudes of an *illness* over which she claims to have little or no control; and informant, B (extracts 9.23-9.25), to invoke an account that purports to explain her suffering in terms of the poor relationship she has with her parents - particularly her father.

They are, in effect, self delusions (no greater, but certainly far worse than many others in terms of the injury they do to the person) that are the bedrock of the clients' understanding of their distress. But are they plausible? Given that 'regimes of truth' are amorphous, it could be argued, that the truth they tell is an imposition on moral certainty no less credible than any other and therefore worthy of consideration. But this is to ignore the fact that they are construals which have done so much to isolate the client in their understanding of their lives - as Taylor (ibid) so aptly puts it, 'they are not

construals you could actually make of your life while living it'.

In this sense, the counsellor's well-meaning complicity in their clients' construction of talk is no less problematic than the awkward politeness (and resistance to talk) observed in conversations one to five (chapter eight, this volume), both have privileged their clients *subjectivity* (assumption 2, chapter one, this volume), but have produced outcomes - or more properly, have the potential to produce outcomes, that fail to agree a position their clients can *live* with.

Chapter 10: Conclusion

> (10.1) Stranger: 'When there arises in the soul of men a right opinion concerning what is good, just, and profitable, and what is the opposite of these - an opinion based upon absolute truth and settled as an absolute conviction - I declare that such a conviction is the manifestation of the divine occurring in a race which is in truth of supernatural lineage.'
> Socrates: 'It could not be more suitably described.' (Plato's Statesman 309c/Skemp, 1996: p.1082).

Introduction.

In chapter one it was argued that the discourse of madness (Foucault, 1992; Hacking, 1997; Habermas, 1979; Ingleby, 1982; Plato, 1996; Scull, 1993; Szasz, 1962; 1973; 1994; 1997) was a complex and enduring argument that articulated an intransigence between two irreconcilable positions - the social care model of mental disorder (Rogers, 1951; 1957; 1962; 1975), with its emphasis on client *autonomy*, *empowerment* and the essential legitimacy of their version of reality - their *subjectivity* and the medical model of mental illness, with its emphasis on diagnosis, physical treatments and control and it was suggested that the former was dominated by the latter in a medico-legal complex of historic and enduring proportions (HES, 1997; ICD-10, 1992; DSM-IV, 1994; Mental Health Acts, 1983 & 1995).

It was also suggested that in this difficult and often puzzling argument, mental health nurses are expected to effect significant changes in their patient's/client's mental state by their positive therapeutic interventions - interventions which are grounded in the *subjectivity* of person-centred therapy and the social care model this promotes and

describes.

However, the aspiration of mental health nurses to 'turn-away' from the medical model and work as counsellors/psychotherapists - person centred therapists, finds powerful opposition from within medical psychiatry - not least because of the hegemony of medical *diagnosis*) and the legislative power (*system/culture of care*) this both promotes and sustains. To bring this off, as it were, mental health nurses must construe a position for themselves that is free from the stigmatising labels of medical diagnosis; advocates a system/ culture that is permissive; and a relationship with their clients that is empathic (Rogers, 1957).

Problematic though, is that subjectivity as it is conceived by the social care theorists such as Rogers (1951; 1957) has been disabused by a number of theorists: Davies and Harré (1990); Mühlhäusler and Harré (1990); Harré and Van Langenghove (1991); Harré and Gillet (1994) and Van Langenghove and Harré, 1993a; 1993b; 1994), who argue that subjectivity is not a mental entity that can be unearthed by the gentle probing of the person-centred therapist, but, rather, is something produced moment by moment in talk - that, in effect, subjectivity is a *position* in a discourse and not a fixed mental state of the sort cognitive psychologists would contend.

An important feature of subjectivity cast in this form is its immanent, mutable and negotiable nature - that is, its claims to truth, right and sincerity are only plausible if agreed by others (Habermas ,1991). Capturing this idea, Harré and Van Langenhove's (1991) posit two modes of positioning: tacit and intentional positioning. Tacit positioning,

they argue, limits participants allowable contribution to talk to that which is permitted by their alignments in a moral order of talk. In contrast, intentional positioning does not impose the same constraint(s) as a pre-condition of talk.

Tacit position/positioning is most easily understood in terms of social role. A guise mandated by a particular moral and/or institutional order of talk that a person uses to claim the rights and/or authority of a particular social identity - parent, doctor, nurse, mentally ill patient/client, counsellor, counsellee. However, unlike Goffman's (1981; 1986) static concept of *footing* - which closely approximates this idea, Davies and Harré (1990) argue that tacit positioning, though constrained by social ritual, can, in fact, be done in any number of ways. In effect, the notion of tacit positioning supports the idea that, despite the domination of a medico-legal complex, mental health nurses can, if they so wish, construe a discourse that supports the person-centred therapy the social care model posits. But can they *bring it off* as it is supposed? Is talk quite so imaginative as they suppose?

In chapters five, six and seven of this volume this idea was explored and revealed that mental health nurses and mental health patients/clients are not disposed to agree conditions one, two, or three of the social care model[1], but rather aligned themselves in a less than certain appreciation of the person-centred therapy this model intends. Paradoxically, whilst, nurses and their patients/clients could not agree an understanding of each other's position in the wider context of their daily interaction, they could in their

[1]Autonomy, empowerment and subjectivity. Autonomy argues a freedom from stigmatising labels which undermine personal and social identity; empowerment, argues a freedom from coercion and social control; and subjectivity argues a freedom to assert a self conscious understanding of who you are, or who you claim to be.

therapeutic talk (chapters, eight and nine) - talk which always agreed the clients subjectivity - their version of events.

To understand this paradox more fully - though not, it must be said, completely it is useful to be reminded that Davies and Harré (1990) and Harré and Van Langenghove (1991) don't, as might be supposed from the preceding text, have a monopoly on the discursive construction of social identity and, in fact, the freedom of self expression they claim is possible in communication stands in stark contrast to the position taken by others.

Post-Modernism/Structuralism and Discourse

The concept of positioning discussed in chapter three of this volume finds interesting parallels in the work of some of the poststructural theorists - notably: (the early) Foucault (1972/1994); Hindess and Hirst (1977) and Laclau and Mouffe (1985) all of whom emphasise 'the central importance of discourse in social life, the relativist distrust of truth and the discursive constitution of the subject' (Larrain, 1994: p.90). But, whilst they acknowledge the force of discursive practices in the formation of individual subjectivity they posit a version of 'positioning' that is at odds with the one so far expressed in this thesis.

Foucault (1972/1994), typical of this particular genre, asserts that discursive formations - positions, are composed of 'groups of statements', or 'groups of verbal performances' which require:

'a referential (which is not exactly a fact, a state of things, or even an object, but a principle of differentiation); a subject (not the speaking consciousness, not the author of the formulation, but a position that may be filled in certain conditions by various individuals); an associated field (which is not the real context of the formulation, the situation in which it was articulated, but a domain of co-existence for other statements); a materiality (which is not only the substance or support of the articulation, but a status, rules of transcription, possibilities of use and re-use)' (Foucault, 1972/1994: p.115).

Such a view, though, shifts the locus of subjectivity from the realm of self reflective consciousness that Davies and Harré (1990) contend to be true, to the material character of a preexisting autonomous discourse - for instance a text[2], written or otherwise, that might describe in some particular way the mental health nurse's role in terms of institutional psychiatry. Note particularly Foucault's description of the subject - which he describes in terms of: 'not the speaking consciousness, not the author of the formulation, but a position that may be filled in certain conditions by various individuals.'

Similarly, Laclau and Moufe (1985) co-opt Foucault's strand of continental social philosophy and cultural analysis to posit that:

'the material character of a discourse cannot be unified in the experience or consciousness of a founding subject; on the contrary, diverse *subject position* appear dispersed within a discursive formation ... .' Laclau and Moufe (1985: p.109).

'Whenever we use the category of 'subject' in this text, we will do so in the sense of 'subject positions' within a discursive structure. Subjects cannot, therefore, be the origin of social relations -not even in the limited sense of being endowed with powers that render an experience possible - as all 'experience' depends on precise discursive conditions of possibility' (Laclau & Mouffe, 1985: p.115).

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[2] In this sense, the text acts as a convention or tradition that guides the nurse in his/her work (Giddens (1994).

Like Foucault, they adopt a radical perspective which insists on the primacy, unity and relational identity of a discourse. A perspective which argues that a subject position is expressed, not as the product of 'intersubjective praxes, of action and interaction' (Crossley, 1996: p.74), but as the articulation of some preexisting, autonomous 'nodal' point of meaning.

The same view is expressed by Parker (1990: p.190), who, lamenting Potter and Wetherell's (1987/1992) pale acknowledgement of the role or contribution of post-structuralism in work on discourse in psychology asserts that his 'only understanding of discourse is informed by post-structuralist work.' By this he means a series of writings on 'language, discourse and texts' generated by 'Foucault (1972, 1980); Barthes (1973, 1977); Derrida (1976); and Lyotard (1984)' - but of these, it is Foucault who makes the most pressing claim on his work.

Orientated in this way, Parker (1990: p.191) claims that 'discourse' refers to those ways of speaking which have been historically, culturally, socially, and/or politically constituted - in essence, a multiplicity of *fixed* repertoires which are the resource of all talk, which inhabit all talk, and which, most importantly, 'construct' the very 'objects' of which they speak - not least of which, he would surely contend, are the logocentric medical discourses that characterise mental health services - the 'Empire of the Selfsame' as Cixous and Clément (1986) might put it and, within which, the asymmetries of role and relationship endure.

In essence what Parker claims is that discourses are not only 'coherent' and

'systematized' in their historical context, but 'once an object has been circumscribed by discourses it is difficult *not* to refer to it as if it were not real' (1990: p.200) - that is, refer to it in any other way.

Problematic though, is that in doing so, Parker (1990) turns discourse into the realisation of a set of pre-existing statements, and their analysis a process of understanding the effect(s) of those statements on one another, rather than the communicative practices they constitute (cf. Gill, 1990: p.151). A process which does much to reify the sets of statements and turn the discourses they form into fixed, all encompassing monoliths which are impossible to escape - frames of talk, one might suppose, of a type implied by Bateson (1972) and Goffman (1981; 1986). A view which Potter *et al* (1990) claim 'excludes the actual working of discourse as a constitutive part of social practices situated in specific contexts' (ibid: p.209).

Such a view (Foucault, 1972/1994; Laclau and Moufe, 1985; Parker, 1990) - if true, would argue that, whilst informants in both studies (parts two and three, of this volume) were *tacitly* positioned in a particular moment of talk - interview and therapy talk, their talk did little more than express a pre-existing nodal point of meaning/understanding that is the resource of that talk. Burman and Parker (1993: p.4) are in no doubt that this is the case, and they claim that resources (positions) are simply repertoires - 'repertoires we do not create anew when we speak, but which we have to borrow and refashion for our own purposes.'

The Discursive Position(s) of Mental Health Nurses in Talk Framed by the Topic Mental Illness (Diagnosis/Insanity Ascription), the System/Culture of Care and Relationships

To some extent, the Burman and Parker (1993) argument appears to have carried into these three topics of talk, if for no other reason than it is difficult to imagine that participant in this series of interview/conversation were offering anything more than a relatively well rehearsed understanding of the issues under discussion. This appears to be particularly true of the nurses who, with the exception of informants M - who positioned himself in very close proximity to the social care model, adopted relatively loose alignments towards the social care and/or medical models, particularly in the way they described mental illness, but no less so, in their interpretation of the system/culture of care in which they worked and the relationships they described with their patients/clients.

Speaking on the topic of mental illness the nurses managed to capture most of the confusion apparent in mental health services at this time - there was no *singular* view that transcended *conventional* understanding, but it was a confusion that was entirely plausible in a topic of talk so heavily contested in the literature and in an education and training of nurses (ENB;1982; 1989b) that encourages this discussion in pursuit of the interpersonal qualities it so values. Intriguingly, though, their positions did not altogether preclude the possibility that in certain circumstances condition *one* (autonomy) of the social care model might not be achieved.

However, if this was ever thought possible, it foundered on the conformity of explanation

and/or accounting observed in the nurses' talk about the system/culture of care in which they worked - which suggested that they had introjected a meaning/understanding of this issue in a way that Bourdieu (1994) describes as 'authorized language' or 'ritual discourse':

> 'There is a rhetoric which characterizes all discourses of institution, that is to say, the official speech of the authorized spokesperson expressing himself in a solemn situation, with an authority whose limits are identical with the extent of delegation by the institution. The stylistic features which characterize the language of priests, teachers, and more generally, all institutions, like routinization, stereotyping and neutralization, all stem from the position occupied in a competitive field by those persons entrusted with delegated authority' (Bourdie, 1994: p.109).

In this particular discussion there appeared to be an authorized talk, in which, all of the nurses - including informant M (though he disabused it), understood that a major imperative of the mental hospital in which they worked was to control its patient population and in a way that supports Scull's (1993: pp. 381-388) claim that psychiatry has become society's expert in the definition of normality and the social control of deviance. Simply stated, the nurses did no more than describe an enduring institutional practice in which the domination and control of subordinate others is central to its purpose.

The sense that most nurses felt they were dealing with mental illness - however, they might construe it, as deviance (of sorts) cast in terms of a discursive formulation of rules and codified practices was fairly certain and, in this regard, they said much that would suggest that they conceived the mental hospital to be a community (no less than any other) manifesting acceptable and/or allowable behaviours of persons within a

framework of *law* - regardless of their legal status (Mental Health Act, 1983). But it is here, in this conception of the mental hospital as a 'carceral' society (Foucault 1977/1991b; 1992) that subjectivity of the type proposed by social care theorists is irredeemably lost and the challenge to person-centred therapy centred is made evident (Rogers, 1951; 1957; 1975).

It was the Hegel (1892-96/1968) who claimed that 'the greatness of our time rests in the fact that freedom, the peculiar possession of mind whereby it is at home with itself in itself, is recognized' (1892-6/1968: p. 423) - a perspective that is the core of person-centred therapy, but not, it would seem, the mental hospital. But, Hegel's conception of subjectivity not only expressed 'the freedom and unity of the subject, but also its objectification and alienation as object of its own subjectivity' (Holub, 1991: p.154). To this end, he conceived that the subject of self consciousness (position) is both *individual* and *universal*:

> 'For a subject that is related to itself in knowing itself encounters itself both as a *universal* subject, which stands over against the world as the totality of possible objects, and at the same time as an *individual* I, which appears in this world as a particular entity' (Habermas, 1994: p.40).

In essence, the *universal* subject is the embodiment of the state (its objective social arrangements - repertoires), whereas the individual subject is only a *singularity* - an individual citizen of the state. Inevitably, when conflict arises between these two figures of self consciousness - as it surely must, and certainly in institutions exercising moral and/or social control, 'it is the concrete absolute of the state [which always] receives precedence' (Holub, 1991: p.154).

Inevitably, to assert their subjectivity a person has a two-fold choice: one, to communicate a universal understanding of self in relation to others, thereby *tacitly* adopting the prevailing social/institutional norms or, two, communicate *intentionally* a singularity, that is likely to be in conflict with those norms. Given, its mandate to control (cf. Goffman, 1961/1986; Scull, 1993; Foucault, 1977/1991b; 1992), only the latter is permissible in a mental hospital that construes madness (mental illness/disorder) as deviance. A tacit positioning that in effect undermines completely condition two (empowerment) of the social care model.

Inevitably, given these constraints on freedom, the majority of nurses adopted a disappointing (if predictably) *Proper* view (Cixous and Clément, 1986) of their relationship with patients, rather than the idealised empathic relationship they might otherwise have achieved. But, it did in fact, go much deeper than this and most nurses were disinclined to conceive that their relationship with patients was anything more than an exigency of their work[3].

However, it is important to place this argument in some sort of frame of reference and concede that liking and disliking is a very human thing to do and nurses, no less than anyone else, will make choices about their friendships based upon diverse criteria - not least, the behaviour of people towards them, which must, in all circumstances reflect some desirable characteristic such as a mutuality and reciprocity of feeling (Troll, 1982) - a difficulty, if their patients consistently claim- as they did a certain *singularity* in their

[3]It is important to note that the Registered Mental Health nurse syllabus of education/training (ENB, 1982) is avowedly interpersonal - mental health nurses are expected to build workable relationships with their patients/clients.

position.

It is also important to concede that many mentally ill people behave in ways that would test the limits of any individual - not least informant G, who, it will be remembered, managing a very disturbed all male ward environment, was not disposed to view the men in his care as particularly wanting of his friendship, a view that was reflected, somewhat insistently, in one of his staff, informant M2.

Once again, though, it was informant M who was wont to see things differently and it was he who construed a relationship with his (female) clients that challenged the system/culture of care in which he worked, but he did so in a way that dramatically emphasised the limits of the empathic relationship - one, which is rightly constrained by time, place and the propriety. In this case, though, M appeared to get it wrong and he allowed his *friendship* to assume more than the mutuality and reciprocity of perspective that is the cornerstone of interpersonal communication and be conceived by his client as something that Ussher (1991) cautions is all to probable in this sort of therapeutic encounter - as overtly sexual. A danger some of his colleagues were aware of - and certainly at pains to avoid.

There was in fact little or no evidence of the nurses conceiving an empathy towards their patients that supported their person-centred therapy, instead their talk described the sort of mundane relationships that are commonplace in many service industries - but in this instance it was an inverted service relationship that 'emphasised [the] self-identity and dominance' of the nurses, rather than the patients they serve (Fox, 1993) and,

rather more interestingly, one that suggested that in some instances at least - informant G2, their friendship, demands a *tithe* cast as their compliance to the hospital regimen (cf. Herman, 1991: pp.101-125; Maus, 1967). Not surprisingly, condition three (empathy/subjectivity) of the social care model was far from met.

The Discursive Position(s) of Mental Health of Mental Health Patients/Clients in Talk Framed by the Topic Mental Illness (Diagnosis/Insanity Ascription), the System/Culture of Care and Relationships

In contrast to the nurses, the patients in these conversations were relatively homogenous in their understanding of mental illness (diagnosis/insanity ascription) and in this sense, appeared to accept their medical diagnosis (and the medical model this might imply) as a rational anchor from which to validate their experience of trouble and/or distress. But they did so whilst asserting their subjectivity - informants B and H being particularly good examples of this in their refusal to accept the moral advantage psychiatry implied in their diagnosis, and by accepting what benefits they could from the *sick*-identity they had assumed or had been ascribed. Their positioning, in this regard was, it would seem, entirely pragmatic.

Here, it might be assumed that Parker's (1990) notion of subjectivity and repertoire had lost its place - after all there is no script that describes the patient role in quite the same way as the literature supports the nursing role. But the extent to which patients had rehearsed their sick-role identity through periodic admission, diagnosis and talk with professional others about their *illness* could not be underestimated and there were instances of diachronic and/or synchronic repetitions of medical speak that would

suggest that repertoires of the type he describes are available to support them, no less than the nurses - and often, it would seem, to the chagrin of the nurses who cared for them (see chapters nine of this volume; cf. Tannen, 1992).

Interestingly, the positions adopted by all the patients/clients appeared highly situated in their construction producing accounts, not surprisingly, that did much to mitigate their diagnosis in the face of a credible stranger. On a number of occasions, for instance, they deployed a tactic that cast their diagnosis in the past tense in a way that implied their troubles were now at an end. This was particularly true of informants B, H and L whose life styles were particularly prone to *universal* disapproval. But, they did so offering a view of themselves that was plausible in its current account - not, particularly *reformed*, but aware and accepting as others should also be.

At this point - and with the controversy of psychiatric diagnosis in mind, it is useful to pause a moment and be reminded of Plato's (1996) concept of madness which argued that madness was either natural (that is, certain persons have a physical and/or psychological proclivity to madness, which, though bad, may be *treated* and even *cured*); and madness which was divine. Whilst the former speaks of a deviance of sorts, the latter lays claim to a prescient *understanding* of the *avant garde.*

The question this begs, though, is under what circumstance is the *singularity* of subjectivity in the Hegelian sense perceived to be good or bad[4]? Problematic for mental

[4]Goodness clearly invests itself in the *singularity* of subjectivity of people such as Nelson Mandela, Ghandi or Martin Luther King all of whom were pilloried by a condemning society wedded to a life world view they refused to share.

hospitals is they don't bother to make this discrimination - they don't define sanity, rather they always diagnose and treat patients as if their madness was *bad* in a strictly Platonic sense (HES, 1997). A good example of this is to be found in the Rosenhan (1973) study wherein not one of the pseudopatients admitted to hospital was ever diagnosed as sane - all of them, though perfectly sane, left hospital with a DSM diagnosis. They had become, as it were, *'a thing to looked at'* - a thing to be treated, cured and/or contained (Foucault, 1992).

Despite their wont of autonomy and empowerment - and this was clearly expressed in their subjectivity, there was a sense, that the patients/clients had been rendered 'discreditable' and 'discredited' by their mental illness diagnosis (Goffman's, 1990) and, as such, in need of the *same* social control that was so evident in the nurses accounts - particularly G3 who, it will be remembered argued a controlling atmosphere for the good of all.

Little wonder then, that system/culture of care the nurses described was generally disapproved of by their patients/clients - and more revealingly, their friendship with nurses perceived as reciprocally pretended. However, an intriguing feature to emerge in these accounts was the acceptance by some of patients/clients of the need for control - or to be controlled, which carried the recognition, that they had - in some way, behaved badly. In addition, one or two patients recognised the *care* they had received from nurses in these moments of duress and the obligation they had towards them not to cause them unnecessary hurt. A position of mindful responsibility that was surprising in its concern and testimony to their moral character.

The Discursive Position(s)/Positioning of Mental Health Nurses/Therapists and their Clients in Therapeutic Talk

Given that condition one of the social care model was only partially met by nurses in this study - and certainly not incontrovertibly met, and conditions two and three, were not met at all, except, that is, by subject M who clearly recognised the difficulty this had caused him, and could cause him in the future, if colleagues were to misinterpret his actions, it appeared uncertain whether the person-centred therapy this model describes could be realistically achieved (chapters eight and nine, this volume). That it was, was surprising.

It was in this second study of therapeutic talk that Harré and Van Langenhove's (1991) notion of *intentional* positioning was thought most likely to be expressed - an assumption based on the belief that talk of this type was always likely to disagree the positions it described - if for no other reason than it is human to do so, but this was never really the case and in all instances, talk gave way to a dialogism entirely fated by the subjectivity of the client.

The ten therapy talks described and interpreted in this study divided equally into talk that was either incompatible or talk that was compatible, in terms of the counsellors' position (chapters eight & nine, this volume). However, in both these categories, there appeared to be a tacit assumption - a polite understanding, if you will, that no injury could be done to the clients' subjectivity and in this sense did much to encourage, what Giddens (1994: p.180) has described, as the 'narcissistic withdrawal' of the client into

a subjectivity that denies the possibility of a consensus understanding based upon the validity claims they raise.

But here some sense of disquiet reaches into the positioning paradigm - one which suggests that the freedom Davies and Harré (1990) and Harré and Van Langenhove (1991) contend is a feature of all talk, is not the case. That in reality, the paradigm case for human communication is probably *tacit* communication - a communication that is always bounded by social roles and social expectations and one which, in all likelihood, recruits preexisting discursive repertoires of the type that Foucault (1972/1994), Laclau and Moufe (1985) and Parker (1990: p.190) posit, rather than just the imaginative self constructions that Davies and Harré (1990) and Harré and Van Langenhove's (1991) perceive possible.

This is not to suggest that people don't talk to establish their own position - they obviously do, and in a manner that accords (in part) with Davies and Harré's (1990) paradigm, but they do so expressing more in their talk than they 'could possibly think' (Burman & Parker, 1994: p.4) - an authority and/or understanding of self and others that Giddens (1994: pp. 194-196) argues is the protection we all muster to prevent the 'uncertainty' and/or 'radical doubt' this would otherwise entail. It is, in essence, a practical consciousness that Giddens (1994: p.47) argues provides 'answers to fundamental existential questions which all human life in some way addresses' and without which social life would be impossible.

Cast in this way *intentional* positioning emerges as a relatively special case - talk that

involves the partnership of equals secure in their relationship with one another, or the partnership of persons who, for whatever reason, perceive no special advantage in their reaching a mutual understanding and reciprocity about something in the world. In this circumstance talk can - and probably does, manifest, those argumentative and strategic qualities so evident in the conversation between *Sano* and *Enfermada* (Davies & Harré's,1990: p.57), but not, one must suppose, in a carceral society bent on promoting its own *logocentric* position.

Intriguingly, whilst this research describes an asymmetry in the nurse patient/client relationship, grounded in a *logocentric* system/culture of care, that the patients/clients evidently do not agree, it appeared to represent no particular challenge to the nurses engaged in counselling/psychotherapy, who, adopted - though, in some cases less agreeably than they felt proper (conversations one - five, chapter eight this volume), a position that tacitly agreed their clients' subjectivity and the non contentious part they had to play in its production - an artifice of some magnitude, that hardly seems credible. But one that bore fruit in terms of the practical consciousness it appeared to describe and support.

But, there is an issue here. Given, that counselling/psychotherapy offers the client an opportunity to rethink his/her position - that is, to resolve the dilemmas of the self through their talk and attachment to an authoritative figure of meaning/understanding. What authority - meaning/ understanding do nurse therapists in a carceral society posses and invest in their counselling/psychotherapy? Who do they speak for? Do they speak for themselves or are they the 'authorized spokesperson [of the institution]

expressing himself in a solemn situation, with an authority whose limits are identical with the extent of delegation by the institution' (Bourdieu, 1994: p.109).

Interestingly, the majority of nurses in this series of talks spoke for themselves, but there were a number of notable exceptions - particularly conversations two (M & S), three (N & B), four (L2 & G4) and five (S2 & P), in chapter eight, wherein the nurses appeared to speak as agents of the hospital and recruited to their talk referents which were condescending in terms of their client's position. An alignment which, in moral[5] terms at least, is more credible than the positions adopted by their colleagues, who, no less than them, invoked a diorama of client subjectivity that was never enough to communicate a resolution to their problems, but from a position of meaning/ understanding that never declared itself a better alternative. (Habermas, 1991; Davies and Harré, 1990 & Harré and Van Langenhove, 1991). Speaking of this, Giddens (1994) argues that:

> 'The expert or specialist, is quite different from the 'authority', where this term is used in the traditional sense. Except where authority is sanctioned by the use of force (the 'authorities' of the state and legal authority), it becomes essentially equivalent to specialist advice ... everyone in modern systems is a lay person in virtually all aspects of social activity' (Giddens, 1994: p.195)[6].

However, whilst their moral authority was probably dubious in Giddens (1994) terms and

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[5]Harris (1994), describes the relative ease with which counselling is learned - a process which assists the development of very specific communication skills, but not the moral authority to invest new meaning/understanding in a clients life. Counsellors aligned to the institution in the way it is suggested here can, it would seem, claim a moral authority to engage their clients, absent, or certainly understated , in their colleagues position.

[6]Giddens (1994) conceives 'authority' to be a tradition that individuals or groups buy into - social, political and/or religious systems of one sort or another.

their communication less certain than Habermas (1991) would agree, the nurses probably did achieve a sort of *therapy* in their talks, if their clients experienced 'emotional relief', 'contact with inner experiences' and/or 'private processing of experiences' (Rennie 1984: p.239-240), but they did so with the text/tradition of institutional psychiatry never far from view and the subjectivity of their client for the moment, at least, confirmed - if not always agreed.

But, is this really enough? In a recent survey of the *'quality of care in acute psychiatric wards'* conducted by the Sainsbury Centre for Mental Health (Beadsmoore *et al*, 1998), it was concluded - rather worryingly, that 'hospital care is a non therapeutic intervention'[7]. And, they suggest that 'patient-centred care should be adopted as the fundamental principle underpinning the planning and delivery of acute care' (ibid: p.40). A shift in emphasis (it would seem) from the very particular *self* discrimination invested the autonomous and empowered *client*, towards, what might be inferred to be, the more traditional concept of a dependent patient in need of help. A move that signals a wont to assist the patient make a meaning/understanding of their lives by a communication that takes account of their 'identity and moral orientation' (Taylor, 1994: p.99-105; cf. dialogue 10.1, above).

End Note

Here, an opportunity is taken to briefly discuss the concept of positioning used in the

[7]Acute psychiatric wards remain a key element of current mental health practice. They are the place that most dependent people with the greatest need receive care, especially when they are in crisis. Acute wards also consume about two-thirds of the resources committed to mental health care' Sainsbury Centre for Mental Health (1998: p.9).

discourse analysis, which, though, well founded in the literature appeared somewhat clumsy as a research tool. Two points of difficulty emerged: one *positions* did not demonstrate that dynamic linguistic flux promised by Davies and Harré (1990) and Harré and Van Langenhove (1991), but were locked in often unwieldy explanations and/or accounts, that were never entirely conclusive in the positions they described and did little to impute a name beyond their immediate reference in the text (McCulloch, 1990); two, from the outset the pronominal grammar used by informants was never entirely certain of the positions they were thought to ascribe and, despite many efforts, it was difficult to decide whether the pronouns used were literal in their reference to persons, or merely metaphorical and/or egocentric.

Despite these difficulties Davies and Harré's (1990) positioning paradigm has an intuitive appeal - though one overly prone to pragmatic interpretations borne out of a particular reading and/or understanding of the text. But, one never-the-less, that argues a commonsense understanding of language, which, despite the concerns of text grammarians, asserts that in a particular context of talk and despite the complexity and ambiguity inherent in its formulation, language is invariably understood by those positioned to do so (cf. Wittgenstein, 1953/1992).

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Appendix 1: Informant Profiles

Study one

Ward X - A Single Sex Male Acute Admission Ward

Staff

Informant G: Senior Ward Manager/Charge nurse. Male. Age, forty something. Twenty plus years experience. Assertive, brash and controlling. Popular with staff and patient's alike. Initially keen to be involved in research activity, then reluctant to take part - abruptly ending the interview in the last few minutes. Trained on site and has never worked any where else - professionally or otherwise. Refused to take part in the second study.

Informant M2: Staff Nurse. Male. Age, twenty something. Recently qualified. A maverick respondent with some extreme views about patient care. Trained on site. Previous work unrecorded. Refused to take part in the second study.

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Informant N: Staff Nurse. Female. Age, thirty something. Fifteen plus years experience. Very able nurse, who was thoroughly adapted to working in a very demanding male environment. Trained on site. Previously a solicitors typist/clerk. Agreed to take part in the second study.

Patient's

Informant B: Male. Age, forty something. HES Diagnosis: Mental and behavioural disorder due to psychoactive substances - alcoholism. A man with a long history of hospital admission. Discharged home before second study.

Informant H: Male. Age, twenty something. HES Diagnosis: Mental and behavioural disorder due to psychoactive substances - mixed drug addiction (polypharmacy). Detained under Section 3, Mental Health Act 1983 - a young man with aggressive/violent and criminal propensity. Discharged home before second study.

Informant J: Male. Age, sixty something. HES Diagnosis: Mood [affective] disorder - depression. Recently bereaved man. Very independent man apparently ashamed of his failure to 'cope'. Detained under Section 2, Mental Health Act 1983. Discharged home before second study.

Ward Y - A Single Sex Female Acute Admission Ward - Incorporating a Small Eating Disorder Unit/Clinic

Staff

Informant G3: Senior Ward Manager/Sister. Female. Age, thirty/forty something. Fifteen-twenty years experience. Competent and well respected senior nurse with a long family tradition of mental health work - very proud of her families association with the hospital. Trained on site and has never worked any where else - professionally or otherwise. Agreed to take part in second study

Informant M: Senior Ward Manager/Charge Nurse. Male. Age forty something. Twenty plus years experience. An easy going man with strong views about everything - not least the hospital. A maverick respondent, who articulated a very convincing social care position. Trained on site and has never worked anywhere else as a nurse. Previous work unrecorded. Agreed to take part in second study.

Informant G2: Staff Nurse. Male. Age, twenty something. Recently qualified. One of only two males working on this female ward. An obvious favourite with many of the female patient's and clearly very happy in his role - able and caring. Trained on site and has never worked anywhere else - professionally or otherwise. Refused to take part in the second study.

Patient's

Informant L: Female. Age, twenty something. HES Diagnosis: Disorder of adult personality and behaviour - self-mutilation and para-suicide being the most typical feature of a complex life style which included unstable romantic/sexual relationships, frequent alcohol and drug intoxication and episodes of aggression and violence. She was, however, a likeable young woman with an assertive, brash and quick sense of humour which did much to emphasise her street-wise intelligence. Detained under Section 3, Mental Health Act 1983. Discharged home before second study.

Informant J: Female. Age, thirty something. HES Diagnosis: Anxiety disorder - agoraphobia. A housewife with a long standing and poorly treated agoraphobia who has consistently refused in-patient treatment and who has only recently agreed to attend the ward as an out-patient. A woman who appeared very uncomfortable with her circumstance. Discharged home before second study.

Informant M3: Female. Age, forty/fifty. HES Diagnosis Mood [affective] disorder - depression. A single lady with a long history of psychiatric *illness* and admission to hospital - a singularly unhappy woman, living alone, in very close proximity to the hospital with a child she had conceived whilst involved in a relationship with another patient in the same hospital.

Appendix 2: Informant Profiles

Study Two

Ward Y - A Single Sex Female Acute Admission Ward - Incorporating a Small Eating Disorder Unit/Clinic

Conversation One: *Informants M & S*

Informant M: Senior Ward Manager/Charge Nurse. Male. Age forty something. Twenty plus years experience. An easy going, man with strong views about everything - not least the hospital. A maverick respondent, who articulated a very convincing social care position. Trained on site and has never worked anywhere else as a nurse. Previous work unrecorded.

Informant S: Female. Age, thirty/forty. HES Diagnosis, Mood [affective] disorder - depression. A married lady with a recent history of mental illness. A normally outgoing, very intelligent, housewife/school teacher who has experienced a quite devastating emotional collapse.

Conversation Four: Informants L2 & G4

Informant L2: Sister/Community Psychiatric Nurse. Age, forty something. Twenty plus years experience. A very able woman working in a mixed rural and urban community environment carrying a very heavy case load. She works out of ward Y and ward X. Trained on site and has never worked anywhere else as a nurse. Previous work unrecorded

Informant G4: Female. Age, thirty five to forty. HES Diagnosis, Mental and behavioural disorder due to psychoactive substances. A middle-aged housewife with a long history of violent behaviour, alcohol and prescribed drug misuse and admission to hospital. Interestingly, this lady has not long been discharged from a Personality Disorder Unit (PDU) some many miles away. Her return is an option under consideration. An altogether non-compliant patient.

Conversation Six: Informants A & Mrs H.

Informant A: Charge Nurse/Community Psychiatric Nurse. Age, fifty something. Thirty

plus years experience of hospital and community work. An able man working in a mixed rural and urban environment carrying a very heavy work load. He works out of ward Y and ward X. Trained on site and has never worked anywhere else as a nurse. Very proud of a long family tradition of working in the same hospital. Was very keen to vist hospital museum and show me pictures of his grandfather dressed as a hospital fire-man circa, 1910. Previous work unrecorded.

Informant Mrs H: Female. Age, forty. HES Diagnosis, Mood [affective] disorder - depression. A tense, tearful and obviously very unhappy woman who harbours very strong feelings of resentment towards her husband. Soon to be discharged she is meeting with Informant A as part of her work up to go home. Their relationship appears oddly formal and reserved.

Conversation Seven: Informants R & D

Informant R: Staff Nurse. Female. Age, thirty something. Ten plus years experience. One of several nurses on ward Y working in the eating disorder unit/clinic. A well made, very business like young woman. Trained on site and has never worked anywhere else as a nurse. Previous work unrecorded.

Informant D: Female. Age, thirty something. HES Diagnosis, Behavioural syndrome associated with physiological disturbances and physical factors - obesity. A part-time higher education student with a compulsive eating disorder. Desperate to lose weight, but unable to do so.

Conversation Eight: Informants C & R2

Informant C: Staff Nurse. Female. Age, forty something. Twenty plus years experience. One of several nurses on ward Y working in the eating disorder unit/clinic. A very able woman with a compassionate disposition. Trained on site and has never worked anywhere else as a nurse. Previous work unrecorded.

Informant R2: Female. Age, early twenties. HES Diagnosis, Behavioural syndrome associated with physiological disturbances and physical factors - anorexia/bulimia. A painfully thin young woman who has been attending the eating disorder clinic for several years, well known to staff and somewhat pampered by them.

Conversation Nine: Informants H2 & T

Informant H2: Staff Nurse/Community Psychiatric Nurse. Male. Age, thirty something. Ten plus years experience. Specialises in eating disorders. Knows T very well. Ten plus years experience. Trained on site and has never worked anywhere else as a nurse.

Previous work unrecorded.

Informant T: Female. Age, thirty something. HES Diagnosis, Behavioural syndrome associated with physiological disturbances and physical factors - anorexia/bulimia. A professional lady with a twenty year history of anorexia nervosa. Suffers a chronic eating disorder to an intractable and dangerous degree. In crisis again.

Conversation Ten: G3 & B2

Informant G: Senior Ward Manager/Sister. Female. Age, thirty/forty something. Fifteen-twenty years experience. Competent and well respected senior nurse with a long family tradition of mental health work - very proud of her families association with the hospital. Trained on site and has never worked any where else - professionally or otherwise.

Informant B2: Female. Age, thirty something. HES Diagnosis, Mood [affective] disorder - depression. A very sad and unhappy, grossly overweight, single lady who is attending hospital as a day patient, but not as yet, admitted to the eating disorder unit/clinic.

Ward X - A Single Sex Male Acute Admission Ward

Conversation Two: *Informants A2 & M3*

Informant A: Staff Nurse. Male. Age, twenty five to thirty. Qualified for two years. Previous work unrecorded.

Informant M3: Male. Age, twenty to twenty five. HES Diagnosis, Schizotypal disorder. A young man in his early twenties, thought to be assuming a schizophrenic, with a long history of psychiatric admission. Previously treated for depression.

Conversation Three: Informants N & B3

Informant N: Staff Nurse. Female. Age, thirty something. Fifteen plus years experience. Very able nurse, who was thoroughly adapted to working in a very demanding male environment. Trained on site. Previously a solicitors typist/clerk.

Informant B3: Male. Age, twenty to twenty five. HES Diagnosis, Mental and behavioural disorder due to psychoactive substances. A young man admitted under Section 2 of the Mental Health Act, 1983) for assessment and detoxification and awaiting Crown Court trial for burglary and possession.

Conversation Five: Informants S2 & P

Informant S2: Staff Nurse. Male. Age, twenty five to thirty. Five plus years experience. Trained on site. No previous work.

Informant P: Male. Aged, thirty something. HES Diagnosis: Disorder of adult personality and behaviour - para-suicide. A first time admission to a psychiatric hospital, this man lives with his aged mother who finds his behaviour increasingly intolerable. Unemployed and unable to resolve difficulties he has with his mother, his sister and her husband - the outlaws as he calls them. Recently diagnosed as an insulin dependent diabetic. Under normal circumstances his diabetes is well controlled, but in recent months he has been frequently admitted to a nearby accident and emergency department in a semi-conscious state. His self medication of prescribed insulin, invariably, late at night and with alcohol, is now dangerously out of control - his most recent admission to hospital almost proved fatal.