‘DOING FENCE-SITTING’: A DISCURSIVE ANALYSIS OF CLINICAL PSYCHOLOGISTS’ CONSTRUCTIONS OF MENTAL HEALTH AND ITS IMPACT ON THEIR WORK WITH SERVICE-USERS

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Thesis submitted in part fulfilment of the requirements for the degree of Doctor of Clinical Psychology to the University of Nottingham

SEPTEMBER 2013

Thesis Abstract

Introduction: The notion of mental health has been used to designate a range of concepts and a great deal of controversy surrounds discussions about the meaning of the construct. Despite its elusive nature, there is a growing body of research indicating that the ways in which healthcare professionals conceptualise mental health may have important clinical implications. It is argued that the quantitative methodologies employed by previous studies have not been able to capture the complexity of healthcare professionals' accounts.

Objective: This study aimed to explore clinical psychologists' accounts of mental health and its effects by using a qualitative methodology sensitive to the performative, variable and contextual aspects of discourse.

Design: A discursive psychological approach was taken in the analysis of data from semi-structured interviews.

Method: Data was collected from eleven interviews conducted with clinical psychologists in the East Midlands region of the UK.

Results: The findings demonstrated a wide range of constructions of mental health available to clinical psychologists, implying that their accounts are considerably more complex and flexible than previous quantitative studies have outlined. The study demonstrated how clinical psychologists use various discursive strategies to construct their accounts as credible and to manage issues of accountability. Clinical psychologists who constructed mental health in realist terms tended to draw on a biopsychosocial framework and employ discursive strategies such as case examples and stake inoculation to present their accounts as factual. Those who viewed mental health as a social construction focussed on the language associated with mental health and the implications of using this. This functioned to warrant a political analysis and to create a rationale for introducing alternative views of mental health. Participants drew on a discourse of moral concern for clients in considering the effects of their ideas about mental health on their clinical work thus allowing clinical psychologists' talk to be viewed from a moral framework where accountability could be managed within interactions.

Discussion: The study offers a novel approach to the exploration of mental health, highlighting the various difficulties that clinical psychologists face in negotiating this concept and its effects. The constructs and discursive strategies drawn on by clinical psychologists in this research were consistent with past discursively informed studies, showing a cross-topic relevance by demonstrating how clinicians rely on particular rhetorical devices to 'get things done' in verbal interactions. The results of this study suggests that there is a need for clinicians to be honest about the contingent and situated nature of their language and knowledge and to be mindful of the effects of their use of language on different stakeholders in talking about mental health. Clearly, if clinicians are not open about such issues there is a risk of service-users passively complying with a process that they do not understand or feel they benefit from, thereby ethically compromising clinical psychologists' practice.

Acknowledgements

To you who open and enter, eye-meeting

To you who unify and come to think of “hello” as something possible

To you the snow collectors who probably know that every winter is the last

To you with broken safes who rather use doors than locks

To you who give the person next to you on the bus a candy

To you who scream in public and believe in the weather

To you who sing in your kitchens and give someone a pound once in a while, an eye

To you who don't propose with words

but like the idiots

with lives

(Adapted from Hansson, 1998)

Statement of Contribution

I, Axel Lofgren, declare that this research is the product of my own original work conducted since my commencement of the Trent Doctorate in Clinical Psychology in 2010. The project design was developed in consultation with the research supervisors Dr. Roshan das Nair and Dr. Vanessa Hewitt, from whom I also received regular guidance and supervision. I have been the sole researcher, responsible for obtaining ethical approval, collecting and analysing the data, conducting the literature review and writing this thesis. Appropriate recognition has been given where reference is made to others.

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SYSTEMATIC REVIEW

Healthcare Professionals' Conceptualisations of Mental Health/Illness: A Systematic Review[1]

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Abstract

Whilst the impact of healthcare professionals' conceptualisations of mental health/illness on clinical practice is empirically well-based, the dimensions underlying such conceptualisations and the factors that influence them are less clear. Hence, the present systematic review sought to examine how healthcare professionals' conceptualisations of mental health/illness have been defined, measured and analysed in past research. A comprehensive literature search of databases, including Medline, Psycarticles, Psycinfo and Web of Knowledge from 1977 to 2011 was conducted. This was supplemented by a review of reference lists of all identified studies, reviews and commentary articles as well as citation tracking. Articles were included in the review if they explored conceptualisations of mental health and used healthcare professionals as participants. All identified studies were assessed for quality and data relating to study design, definitions of mental health/illness and measures of conceptualisations of mental health/illness were extracted. Of 267 identified studies, 7 met the inclusion criteria. Studies were conducted in France, USA and the UK. The included studies were generally of poor methodological quality with limited discussion of the dimensions and the factors implicated in conceptualisations of mental health/illness. The assessment instruments used to examine healthcare professionals' conceptualisations of mental health/illness were also fraught with methodological flaws. The present review has highlighted gaps in existing research and identified various points for future studies to take into consideration.

[1] The systematic review will be submitted to the Journal of Community Psychology.

1. Introduction

1.1 Background

There has been a long-standing debate about the ontological status of mental health/illness and the distinct positions taken by healthcare professionals has been argued to guide and inform their reasoning about mental health/illness and their approaches to assessment, formulation and intervention (Harland et al., 2009). It has therefore been suggested that healthcare professionals' conceptualisations of mental health/illness have important clinical implications for the work with service-users (Hugo, 2001). Since Engels introduced the biopsychosocial (BPS) model of mental health in 1977, which holds that mental health/illness is influenced by interactions of biological, psychological and environmental factors, a number of studies have been conducted investigating the clinical implications of conceptualising mental health/illness in terms of these factors. The most consistent findings of such studies have been that clinicians subscribing to a more biological perspective are less optimistic about treatment outcomes (Holmqvist, 2000), make more biased diagnostic decisions (Morey & Ochoa, 1989) and provide decreased quality of treatment (Wallach, 2004) compared to professionals who conceptualise mental health/illness in psychosocial terms. Conversely, healthcare professionals endorsing psychosocial explanations for mental health/illness have been shown to be more willing to involve service-users in the management of mental health services (Kent & Read, 1998), make more use of non-medical treatments (Cape, Antebi, Standen & Glazebrook, 1994) but also to be more likely to blame service-users for their behaviour (Miresco & Kirmayer, 2006) than clinicians endorsing a biological perspective of mental health/illness.

However, the findings from these studies need to be treated with caution because they have differed in the rigour with which they have attempted to define or measure healthcare professionals' conceptualisations of mental health/illness and in the extent to which they have controlled for variables that may affect such conceptualisations (Jorm, Korten, Jacomb, Christensen & Henderson, 1999). As a result, findings have often been inconclusive, inconsistent and in some cases contradictory. This has led researchers to criticise existing studies and the associated arguments may be broadly divided into the following points.

First, previous studies have relied upon the *a priori* assumption that mental health/illness is a consensual object of thought about which only attributions may vary. However, there is no clear definition of mental health or illness used in these studies and the two concepts are often used inter-changeably (Malek, 2004), thus limiting the validity of the research. Second, existing experimental studies have tended to offer participants a choice between biological and psychosocial conceptualisations of mental health/illness, thus leaving little or no room for more multifaceted and integrative conceptions of mental health/illness and potentially limiting respondents' viewpoints (Wyatt & Livson, 1994). Third, the methodologies (e.g. questionnaires, experimental designs) used to assess healthcare professionals' conceptualisations of mental health/illness have generally addressed the issue from a naturalist point of view, assuming that the boundaries between mental health and illness can be examined and determined through the use of rigorous scientific methods (Link, Yang, Phelan & Collins, 2004).

The aforementioned criticisms have led researchers to suggest that healthcare professionals' conceptualisations of mental health/illness warrant further study (Petrie, Broadbent & Kydd, 2008; Wahl, 2010). For the purpose of the present review, "conceptualisation" is operationally defined as a semantic structure that encodes knowledge constraining the structure of a piece of a domain such as mental health/illness[2]. As noted, there is extensive evidence suggesting healthcare professionals' conceptualisations of mental health/illness to have important clinical implications but only little is known about its components (Morant, 2006). The mental health field is characterised by its lack of consensus about what mental health/illness is. It has been noted that this has allowed multiple competing and sometimes contradictory paradigms of mental health/illness to coexist. In this way, explanations of the ”nature”, ”causes” and ”treatment”[3] of mental health problems may draw on cognitive, behavioural, social, biological, humanistic, psychodynamic and systemic frameworks of mental health/illness while offering little or no guidance on how to

[2] The terms “conceptualisation”, “model” and “representation” will be used inter-changeably in the present review to mean the same thing unless otherwise stated.

[3] Even the words used to describe a paradigm indicate its perspective (or bias;) depending on the ontological framework of the researcher or the therapist. Therefore, the ability to be ‘neutral’, even in this review, is problematic.

compare or choose between them (Morant, 2006). This heterogeneity of models of mental health/illness raises the question of how past research has attempted to define and measure healthcare professionals' conceptualisations of mental health/illness which, in themselves, seem fragmented. It was hoped that employing a systematic review methodology would lead to an increased understanding of how healthcare professionals' conceptualisations of mental health/illness have been defined, measured and analysed by past studies. It has been proposed that recent decades are an especially significant timeframe to explore healthcare professionals' representations of mental health/illness since historically taken-for-granted models have been challenged (Morant, 2006). Researchers have suggested that this shift in paradigms may help to access conceptualisations of mental health/illness that would previously have remained implicit or unverbalized (Gervais, Morant & Penn, 1999).

1.2 Definitions of Mental Health/Illness

Definitions of mental health/illness vary as a result of changes in historical conceptualisations and differences in the ontological framework subscribed to by individuals (Horwitz & Scheid, 1999). For instance, medical naturalism holds that an objective world of natural categories exists, and therefore defines mental health by distinguishing it from mental illness (Rogers & Pilgrim, 2009). More modern definitions tend to emphasise not only the absence of disease or infirmity but also physical, mental and social well-being (WHO, 2011). Social constructionists, on the other hand, suggest that the concept of mental health and illness is a socially constructed representation of the unknowable human condition and the result of a wider worldview reflecting the interest of society at large (Foucault, 1972). Schinnar, Rothbard, Kanter and Jung (1990) reviewed US literature and identified 17 different definitions of "severe and persistent mental illness". The authors found the prevalence rate of severe mental illness to vary from 4% to 88% in the general population depending on the definition used. This finding was used to emphasise the fact that healthcare professionals' understanding of concepts such as mental health/illness have important real-life implications but it also highlights how definitions of mental health are used differently depending on when it is used, where it is used and who is using it. However, given that definitions are culturally and

ontologically dependent (Horwitz & Scheid, 1999; Weare, 2000), the authors' own cultural and ontological frameworks are likely to have impacted on the inclusion criteria used and hence also their results. For the purpose of the current study, the generic terms "mental health/illness" will be used as if they were relatively consensual terms[4]. However, given the objectives of the present review, an *a priori* definition of mental health or mental illness will not be provided.

1.3 Objectives

The aim of the present systematic literature review was to examine how healthcare professionals' conceptualisations of mental health/illness have been defined, measured and analysed in past research. The present review will identify the current status of the methods used to systematically describe the conceptualisations of mental health/illness in order to identify gaps in the current literature and establish a research agenda for furthering our understanding of healthcare professionals' conceptualisations of mental health/illness.

[4] The use of these terms does not imply the adoption of any particular theoretical approach.

2. Method

A systematic review of social and medical science databases was carried out (see 'information sources') and two specific factors were adhered to in the design. Firstly, because of the broad nature of the research question, the methodology was designed to achieve a high degree of specificity to identify only studies examining healthcare professionals' conceptualisations of mental health/illness. For the purpose of the present review, the generic term 'healthcare professionals' refers to individuals qualified as psychiatrists, clinical psychologists, psychiatric nurses and social workers[5]. Given the large number of studies investigating conceptualisations of mental health/illness amongst the general public (e.g. Link, Phelan, Bresnahan, Stueve & Pescosolido, 1999), populations with mental health problems (e.g. Lam & Salkovskis, 2006) and carers of individuals with mental health problems (e.g. Barrowclough, Lobban, Hatton & Quinn, 2001), care was taken to maximise the sensitivity of search results towards studies using healthcare professionals as participants of research studies.

The current review adopted a critical realist variation of social constructionism, assuming that an objective world exists but that power, culture and our senses limit the extent to which we can know this world (Nightingale & Cromby, 1999). This framework was considered appropriate for the present review as it implies that truth claims may be evaluated against evidence while, at the same time, it holds that knowledge, and by virtue, language, is socially constructed. It was hoped that this would allow for a systematic review of the identified studies without compromising the complexity of the research question. Such epistemological disclosure is essential so as to provide the reader with the perspective from which the review is conducted, thus increasing the transparency of the study (Horwitz & Scheid, 1999).

2.1 Eligibility Criteria

The process of selecting appropriate studies included reading the titles and abstracts of all articles retrieved from the searches. In cases where the suitability of the study could not be determined from the title or the abstract alone, full-text copies of the

[5] The current review will refer to this population as mental health professionals or name specific professions in instances where studies have described them as such.

papers were obtained. The following inclusion and exclusion criteria were applied to all studies. Two main criteria were employed in considering articles to include in the review. Firstly, participants were healthcare professionals who had contact with service users as part of their work roles. Secondly, the aim of the studies was to explore conceptualisations of mental health or mental illness. This was done to maximise the sensitivity of results relevant to the research question, and because the terminology used to discuss mental health/illness has changed over time and across contexts (Weare, 2000), but also to exclude studies not investigating conceptualisations of mental health or illness.

Studies that had not been previously published in peer-reviewed journals, grey-literature and articles not available in English were excluded due to the limited resources available. To limit searches to more contemporary studies and to keep the search results manageable, articles published before 1977 were excluded. This period also relates to the introduction of the biopsychosocial model in 1977 (Engels, 1977) which has had a considerable impact on contemporary conceptualisations of mental health/illness (Fava & Sonino, 2008) as reflected in the fact that it is often described as the ideal model of clinical psychology in undergraduate textbooks (e.g. Davison & Neale, 2001). In addition, studies focussing on attitudes about particular aspects of mental health/illness such as stigma, and articles examining beliefs about specific mental health conditions such as schizophrenia were excluded since the review was concerned with healthcare professionals more general conceptualisations of “mental health/illness”. Given that conceptualisations of mental health/illness are culturally determined (Weare, 2000), studies conducted outside of Europe and North America were excluded. While this geographical marker of ‘culture’ is acknowledged to be problematic, it was chosen because of the parallels in both continents in terms of the use of comparable diagnostic systems such as the Diagnostic and Statistical Manual of Mental Disorders (APA, 1994) and intervention strategies. No studies were excluded on the basis of research design as this might have unnecessarily limited the potential number of articles.

2.2 Information Sources

Suitable studies were identified through searching the following databases using a predefined search string.

MEDLINE, 1977 – 2011, July Week 2

PsycARTICLES, 1977 – 2011, July Week 2

PsychINFO (Ovid), 1977 – 2011, July Week 1

Web of Knowledge, 1977 – 2011, August Week 2

All primary study articles were searched for references and this provided an additional search strategy. Conference reports, commentaries, book chapters and editorials were also scanned for references of other published studies, but they themselves were not included in the review.

2.3 Search Strategy

A systematic review of social and medical science databases was carried out. Search terms included 'mental health professional', 'healthcare professional', 'clinician', 'psychologist', 'psychiatrist', 'psychiatric nurse' AND 'conceptualisation', 'representation', 'model', 'belief', 'attitude'[6] AND 'mental health', 'mental illness', 'psychopathology', 'mental disease', 'mental disorder', 'mental health condition', mental health state'. Variations of these terms were also searched for by using truncation functions. The complete search strategy is available in Appendix A.

2.4 Assessment of Methodological Quality

The majority of quality rating scales have been designed to reduce the risk of bias in randomised controlled trials and as such appear inappropriate for the present review. Moreover, whether or how to make judgements of the quality of research is a widely contested issue and the use of formal appraisal tools has not been well supported by empirical research (Silverman, 2000). Nevertheless, there are a number of rating scales available that were not designed specifically for RCTs such as the Critical Appraisal Skills Programme (CASP, 2004), Long and Godfrey's (2004) tool designed to explore descriptive and evaluative elements of studies and the Newcastle-Ottawa

[6] Some terms like 'attitude' were included in the search to make it inclusive and to prevent missing studies that may have included some notion of conceptualisation.

Scale (NOS) (Wells et al., 2006) employed to assess the quality of non-randomised studies. Critics have pointed out that these quality assessment scales have not been fully validated nor have they been found to include criteria that are associated with outcome or effect size in studies (Juni, Witschi, Bloch & Egger, 1999). In terms of the present review, the NOS was considered the most appropriate scale for evaluating quantitative studies since it is recommended by the Cochrane Non-Randomized Studies Methods Working Group for appraising observational studies and it has also been partly validated (Wells et al., 2006). However, research suggests the scoring system that the NOS is based on to be unreliable, arbitrary and hard to interpret (Juni, Witschi, Bloch & Egger, 1999). Nevertheless, an adapted version of the NOS was employed to systematically assess the included quantitative studies' quality in terms of their selection of participants, design biases, definitions of mental health/illness and assessment of conceptualisations of mental health/illness. In line with the suggestion that assessing the quality of qualitative studies requires a separate set of procedures (Silverman, 2000), the Critical Appraisal Skills Program (CASP) was used as it is the most widely used quality assessment tool in the National Health Service (NHS) and it provides a methodological checklist with ten questions relating to rigour, credibility and relevance.

2.5 Data Extraction

Data about the author, date of publication, participants, demographics of the study population, definition of mental health/illness provided, the measure of conceptualisations of mental health employed and the main findings were extracted from all of the included studies. Because the broad nature of the research question could result in large heterogeneity across studies in terms of definitions and measures of conceptualisations of mental health/illness, a meta-analysis was not considered.

3. Results

By using the aforementioned search strategy, a total of 263 records were identified. Citation tracking and scanning of reference lists resulted in four additional studies being obtained that were not identified in the original search strategy.

3.1 Study Selection

Out of the 267 studies, only 7 fulfilled the inclusion criteria. The process of obtaining and identifying studies for inclusion in the present review is summarised in Figure 1 on the following page.

3.2 Study Characteristics

Six of the identified studies employed quantitative methodologies whereas one approached the research question using a qualitative design. The characteristics of the seven studies included in the present review are summarised in Table 1.

3.3 Study Location

Of the seven identified studies, four were conducted in the United States, two were carried out in the United Kingdom and one was conducted both in the UK and in France.

3.4 Participant Characteristics

Out of the seven included articles, two studies used qualified psychiatrists, clinical psychologists and social workers as participants (Ahn, Flanagan, Marsh & Sanislow, 2006; Ahn, Proctor & Flanagan, 2009). Two studies examined psychiatrists', clinical psychologists', psychiatric nurses' and social workers' conceptualisations of mental health/illness (Morant, 1995; Morrison & Hanson, 1978). The remaining studies used psychiatrists (Toone, Murray, Clare, Creed & Smith, 1979), trainee psychiatrists (Harland et al., 2009) and psychiatrists and clinical psychologists (Wyatt & Livson, 1994) as participants. The total number of participants of all the studies combined amounted to 539 healthcare professionals.

Figure 1. *Flow chart of the stages of identifying studies to be included in the literature review.*

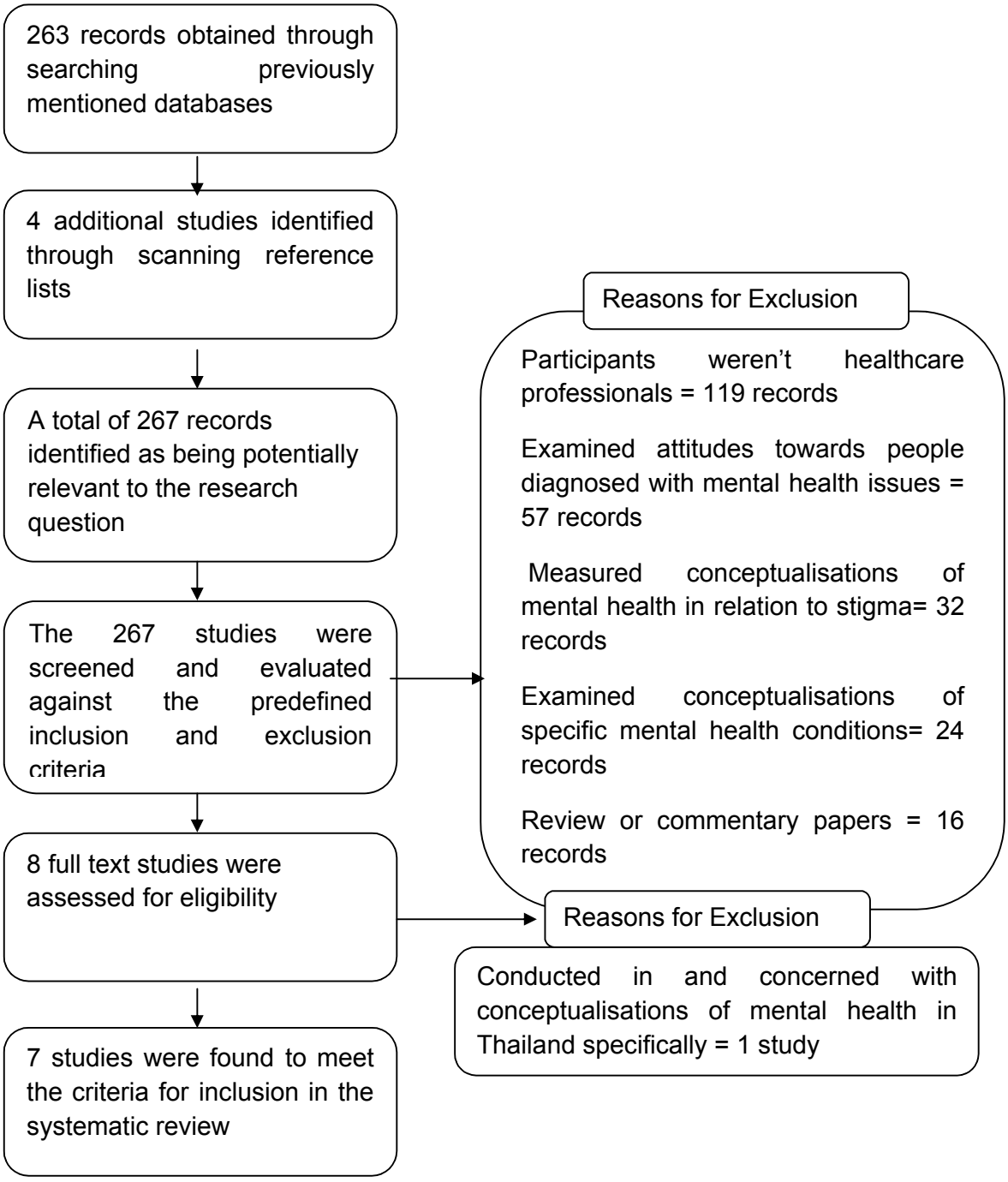

Table 1. *Characteristics and Main Findings of Identified Studies.*

Author, Year & Country	Sample Size	Population Studied	Mental Health/Illness Conceptualisation Measure(s)	Main Findings
Ahn, Flanagan, Marsh & Sanislow (2006), USA	30	10 psychiatrists, 10 clinical psychologists and 10 social workers	Bespoke measure of orientation (cognitive, behavioural, eclectic, psychoanalytic) and measure of participants' beliefs about whether mental and medical disorders naturally exist in the real world	Participants did not subscribe to categorical conceptualisations of mental health/illness that assume mental disorders to exist naturally in the world. Participants conceptualised mental disorders as being invented and decided upon by experts.
Ahn, Proctor & Flanagan (2009), USA	59 (This was a new sample of healthcare professionals, none of whom participated in the above study).	20 psychiatrists, 20 clinical psychologists and 19 social workers	Measure of believed causal basis of mental health issues using three dimensions (biological, psychological, social)	Participants tended to conceptualise different mental health states on a continuum, ranging from disorders of body to disorders of mind. Disorders that were thought to be strongly biological were considered to be only weakly psychological and environmental, and vice versa.
Harland, Antonova, Owen, Broome, Landau, Deeley & Murray (2009), U.K.	76	Psychiatrists	MAQ containing items formulated to probe psychiatrists' beliefs about mental illness. It divides each paradigm (biological, behavioural, cognitive, psychodynamic, social realist, social constructivist, nihilist and spiritualist) into four dimensions (aetiology, classification, research and treatment)	Most participants subscribed to the biological model of mental illness although this varied depending on the aspect of mental illness that was examined.
Wyatt & Livson (1994), USA	151	82 psychiatrists and 69 clinical psychologists	MHQ was used to evaluate participants' positions within the domains of psychosocial and medical models of mental illness, diagnosis, drug treatment and sociocultural values. Questionnaire items were derived from a survey of the literature on models of mental illness and included 105 items	Psychiatrists indicated a greater degree of acceptance for medical-model positions and less acceptance of psychosocial-model positions than did psychologists. More experienced psychiatrists and psychologists were more psychosocial-oriented and less medical-model oriented than their less experienced counterparts.

Table 1 (cont). *Characteristics and Main Findings of Identified Studies.*

Author, Year & Country	Sample Size	Population Studied	Mental Health/illness Conceptualisation Measure(s)	Main Findings
Morrison & Hanson (1978), USA	84	26 psychiatrists, 16 clinical psychologists, 23 psychiatric nurses and 25 social workers.	Adapted version of the CAQ-A, designed to assess the extent to which participants endorse or reject psychosocial and medical explanations of mental illness	Clinical psychologists were found to endorse the psychosocial model of mental health/illness whereas psychiatrists subscribed to the medical model
Toone, Murray, Clare, Creed & Smith (1979), U.K.	79	Psychiatrists	Amalgamation of two questionnaires used to create a bespoke tool consisting of 68 items purporting to measure models of mental illness	No support for any particular model of mental illness but higher age, senior status and more published papers were all associated with the endorsement of a biological model.
Morant (1995), France and U.K.	60	Psychiatrists, clinical psychologists, psychiatric nurses and social workers (the study did not specify the amount of participants belonging to each professional group)	Semi-structured interviews to explore mental health professionals' representations of mental illness, these were analysed using thematic content analysis	No one fixed understanding of mental illness dominates professionals' understandings of mental health/illness. Instead participants' conceptualisations were multiple and sometimes contradictory.

Abbreviations used in Table 1: (CAQ-A) Client Attitude Questionnaire, (MAQ) Maudsley Attitude Questionnaire, and (MHQ) Mental Health Questionnaire

3.5 Methodological Quality of Studies

The methodological quality of the quantitative studies was assessed using an adapted version of the Newcastle-Ottawa Scale (NOS), and was found to be varied across the included studies as presented in Table 2.

Quantitative Studies

Selection Methods

Although the studies selected participants from a wide range of sources, the reporting of selection and recruitment methods was generally found to be poor. Two of the six studies using a quantitative design provided no or very limited details about the selection and recruitment methods (Morrison & Hanson, 1978; Ahn, Flanagan, Marsh & Sanislow, 2006). Ahn, Proctor and Flanagan (2009), Toone, Murray, Clare, Creed and Smith (1978) and Harland et al., (2009) contacted all licensed healthcare professionals working in specific hospitals and healthcare trusts by post but provided little information about how these individuals were identified. Morrison and Hanson (1978) contacted mental health professionals that were personally known by the authors for participation in the study, and Wyatt and Livson (1994) randomly selected psychologists and psychiatrists working in "the San Francisco bay area" with no indication of how this process took place. The lack of detail about the selection and recruitment methods limits the extent to which these studies can be reproduced and generalised to different populations.

Design Biases

All of the included studies recorded participants' age and gender and so unless stated, it may be assumed that these was controlled for. The reviewed studies identified a number of confounding factors, with clinical experience being the most prevalent. Extensive research indicates that the amount of clinical experience, or contact with individuals with mental health problems, has an impact on people's conceptualisations of mental health/illness (Couture & Penn, 2003) and this was identified and controlled for in all but one of the studies. In Morrison and Hanson's

(1978) study the participants were personally known by the authors and so no demographic data other than age and gender was recorded in order to preserve the anonymity of participants.

Two studies (Ahn, Proctor & Flanagan, 2009; Wyatt & Livson, 1994) not only controlled for years of clinical experience, but also attempted to control for amount of client contact by including a measure of this. Three studies (Harland et al., 2009; Ahn, Proctor & Flanagan, 2009; Toone, Murray, Clare, Creed & Smith, 1978) also incorporated a measure of clinical research as this was hypothesised to influence healthcare professionals' conceptualisations of mental health/illness. However, the studies differed in their ways of measuring participants' clinical research experience with Harland et al., (2009) recording the number of peer-reviewed papers, Ahn, Proctor and Flanagan (2009) measuring years of clinical research and Toone, Murray, Clare, Creed and Smith (1978) controlling for the number of published journal papers. Only three of the six quantitative studies controlled for the setting of the participants workplace (Harland et al., 2009; Wyatt & Livson, 1994; Ahn, Proctor & Flanagan, 2009) which is noteworthy since the context in which people has contact with individuals with mental health issues has been found to influence their perceptions of mental health/illness (Zani, 2005). Of particular note is the lack of studies including participants' ethnicity into their design, with Ahn, Proctor and Flanagan's (2009) study being the only one to record this. Given that conceptualisations of mental health/illness are culturally determined (Weare, 2000), this may represent a potentially large confounding factor that has not been controlled for in the majority of the studies.

Definitions of Mental Health/Illness

None of the quantitative studies provided an explicit definition of mental health/illness but a range of different terminology was employed to describe the concept and various factors were referred to as being pertinent to the subject. Two of the studies (Toone et al., 1978; Morrison & Hanson, 1978) referred to mental illness as a unidimensional construct occurring on a linear continuum. In such definitions, medical and psychosocial explanations represent opposite poles on a single scale.

Unidimensional definitions have been widely criticised for being simplistic, and this has led to more multi-dimensional frameworks being developed such as the biopsychosocial model (Engels, 1977). In line with this, four of the studies suggested that mental disorders (Ahn et al., 2006; Ahn, Proctor & Flanagan, 2009) and mental illnesses (Wyatt & Livson, 1994; Harland et al., 2009) cannot be readily classified as either biological or psychological phenomena but instead should be thought of as complex multi-level phenomena. Ahn et al. (2006), Ahn, Proctor and Flanagan (2009) and Toone et al. (1978) discuss the impact of cultural context on conceptualisations of mental health/illness. Three of the studies (Harland et al., 2009; Wyatt & Livson, 1994; Ahn et al., 2006) also describe mental illness as a social construct based on a mistaken analogy between physical illness and psychological distress.

Measures of Mental Health/Illness Conceptualisations

The six quantitative studies all used questionnaires to measure participants' conceptualisations of mental health/illness, four of which had been tested for validity and internal consistency (Wyatt & Livson, 1994; Ahn et al., 2006; Toone et al., 1978; Harland et al., 2009). Most of the studies employed unidimensional measures of mental health/illness conceptualisations, such as the Maudsley Attitude Questionnaire (MAQ) (Harland et al., 2009) asking participants to rate the extent to which they agree with statements about mental illness, pertaining to the major conceptual paradigms in mental health/illness. Unidimensional measures have been criticised on the grounds that they neglect valuable information by not discerning underlying dimensions of constructs (Hattie, 1985), a limitation that may be particularly relevant to the field of mental health/illness given its broad nature.

To address these shortcomings, Wyatt and Livson (1994) employed a multidimensional instrument to evaluate healthcare professionals' positions within the domains of psychosocial and medical models of mental illness, diagnosis, drug treatment and sociocultural values. The authors suggested that this approach would allow for more multifaceted conceptualisations of mental illness to be recorded. However, such questionnaires may be criticised for their implicit demand to select a

single conceptualisation of mental health/illness, thus limiting the extent to which participants are allowed to express truly multi-faceted conceptions. Moreover, it is well-established that questionnaires may capture idealized rather than participants' actual conceptualisations of mental health/illness due to social desirability effects (Link et al., 2004). Moreover, there was no discussion of the potential influence and bias of the researcher on data collection or interpretation.

Qualitative Study

The only included qualitative article was Morant's (1995) study exploring representations of mental illness among British and French mental health professionals. The quality of the study was assessed using the Critical Appraisal Skills Program (CASP). The aims to explore mental health professionals' representations of mental illness in Britain and France and its relevance were explicitly stated and since the aim of the study was to explore mental health professionals' subjective representations of mental illness, the choice of methodology was deemed to be appropriate. There was little justification of the research design and no reference to the possibility of triangulation of methods. However, given the complexity the research issue, the use of semi-structured interviews seem appropriate as it allows participants' to express a wide range of potential conceptualisations of mental health/illness.

The study employed purposeful sampling to obtain a sample representative of the full range of mental health professionals working in the two countries but without mention of how they were selected. There was no discussion of participants' clinical experience despite this being known to impact on individuals' conceptualisations of mental health/illness (Couture & Penn, 2003). The authors provided some information about the procedure of the interviews and the themes explored. However, there was no justification of the form of data collection, no mention of the form of the data, no discussion of saturation of data and there was no reference to how/if methods were modified in the data collection process. Moreover, there was no indication of whether ethical standards were maintained, whether informed consent and ethics approval were sought and there was no discussion of how the researcher

handled the effects of the study on the participants. The study included a detailed description of the analysis process, how the themes were derived from the data and how quotes were selected to be included in the study. The article also integrated contradictory data and discussed the possible reasons for this along with its implications. However, there was a lack of reflexivity and no critical examination of the potential influence and bias of the researcher on data collection or interpretation. The findings of the study were explicitly stated and evidence for and against the findings were included and discussed in relation to the original research question. However, the study did not mention any tools used to verify findings such as triangulation or respondent validation. The contribution of the study to existing knowledge was considered in terms of its findings in relation to clinical practice and organisational policy. The findings were also discussed in relation to representations of mental health/illness held by lay people along with suggestions of how the findings may be transferred to other populations. In summary, Morant's (1995) use of semi-structured interviews is valuable as it allows participants' to express multifaceted and contradictory conceptualisations of mental health/illness. However, the study lacked a statement on reflexivity and a critical examination of the role of the researcher in selecting and analysing the data.

Table 2. *Assessment of Methodological Quality of Identified Studies.*

Primary Author & Year	Adequate Selection Methods	Design Biases Present	Definition and Discussion of Mental Health/illness	Assessment of Conceptualisations of Mental Health/illness
Ahn (2006)	Yes. Comprehensive details available in reference.	Yes. Controlled for years of clinical experience but no control for amount of client contact, setting of work or ethnicity.	Discussion of the impact of cultural factors on definitions of mental illness and mentions the social constructionist notion of mental illness as a myth.	Questionnaire measuring the extent to which participants' believe mental illnesses to be categorical or dimensional. A pilot study was carried out to ensure face validity of the instrument and it was also tested for its internal consistency.
Ahn (2009)	Unknown, insufficient information provided to ascertain sample.	Only study to control for participants' ethnicity. Also controlled for years of clinical experience, amount of client contact, setting of work and years of clinical research.	Describes mental disorders as complex, multi-level phenomena. Also discusses the impact of culture and ontological beliefs on definitions.	Measure of believed causal basis of mental health issues (biological, psychological, social). No details provided regarding the validity and reliability of the instrument.
Harland (2009)	Yes. Population and selection methods were well described.	Yes. Controlled for years of clinical experience, amount of research experience and setting of work. However, no control for amount of client contact or ethnicity.	Reference to how different ontological frameworks impact on definitions. Mention of the social constructionist notion of mental illness as a myth based on mistaken analogy between physical illness and psychological distress.	Questionnaire with different statements about mental illness pertaining to the major conceptual paradigms. Included a pilot study to ensure that the format was clear and a validation study but was not tested for internal consistency.
Wyatt (1994)	No. Population well described but details about the selection process and the contexts in which this took place were limited.	Yes. Controlled for years of clinical experience, amount of client contact and setting of work. No control for research experience or ethnicity.	Refers to mental illness as a multidimensional construct consisting of various poles. Also mentions the social constructionist notion of mental illness as a myth.	Multidimensional questionnaire used to evaluate healthcare professionals' positions within various domains of mental illness. Pretesting of questionnaire to ensure face validity. Highly reliable instrument as measured by the internal consistency of the items on the questionnaire (Cronbach's alpha = .93)

Table 2 (cont). *Assessment of Methodological Quality of Identified Studies.*

Primary Author & Year	Adequate Selection Methods	Design Biases Present	Adequate Definition and Discussion of Mental Health/illness	Adequate Assessment of Conceptualisations of Mental Health/illness
Morrison (1978)	No. Mental health professionals that were personally known by the authors were randomly contacted for participation in the study.	Yes. Did not control for any of the following potentially confounding variables: years of clinical experience, amount of client contact, setting of work or ethnicity of participants.	Describes mental illness as a unidimensional construct consisting of two poles; medical and psychosocial. Mention of mental illness as being an ineptly phrased concept as it gives proponents of a medical approach unwarranted moral and political power.	Adapted version of a unidimensional questionnaire designed to evaluate beliefs about mental illness. The instrument had previously been tested for reliability but not for validity.
Toone (1979)	Yes. Selection and recruitment methods were well described.	Yes. Controlled for years of clinical experience and amount of research experience but no control for amount of client contact, setting of work or ethnicity.	Describes mental illness as a unidimensional construct occurring on a linear continuum. Discussion of the impact of cultural factors on definitions of mental illness.	Unidimensional questionnaire consisting of items devised to measure models of mental illness. Half of the items consisted of propositions designed by the authors and were not tested for validity or reliability.
Morant (1995)	Very limited details about the sample, and the selection and recruitment methods.	Study employed a qualitative design but only provided limited demographical data about the participants and the factors believed to influence their representations of mental illness.	Refers to mental illness as a multidimensional construct consisting of multiple dimensions. Discusses the impact of culture and the ontological framework subscribed to on definitions of mental illness.	Semi-structured interviews analysed using thematic content analysis. There was little justification of the research design, no reference to the possibility of triangulation of methods and a lack of reflexivity.

3.6 Conceptualisations of Mental Health

Overall, there was a great amount of variation in the ways that the included studies' presented their findings and in what they found to be the conceptualisations of mental health/illness held by healthcare professionals. However, all studies included references to psychosocial and biological/medical explanations of mental health/illness. Amongst the first of studies conducted in this area was Morrison and Hanson's (1978) study assessing the extent to which psychologists and psychiatrists endorse and reject psychosocial and medical explanations of mental illness using the CAQ-A (Morrison & Hanson, 1978). This unidimensional measure places respondents on a continuum, with psychosocial positions at one end and medical-model positions at the other. The study found that psychiatrists endorse the medical model of mental illness whereas clinical psychologists endorse the psychosocial model. Similarly, other studies employing unidimensional measures of conceptualisations of mental health/illness found participants to endorse biological explanations of mental health/illness (Toone, Murray, Clare, Creed & Smith, 1978; Harland et al., 2009) or psychosocial models (Ahn, Proctor & Flanagan, 2009). However, as previously noted, since unidimensional measures are not capable of making multifaceted assessments of healthcare professionals' conceptualisations of mental health/illness they tend to homogenise groups and the results springing from such studies thus appear simplistic at best.

The only study using a multidimensional measure (MHQ, Wyatt & Livson, 1994) found that more experienced psychiatrists and psychologists are more psychosocial-oriented and less medical-model oriented than their less experienced counterparts. Moreover, although not statistically significant, psychologists subscribing to systemic models of mental illness tended to give more weight to psychosocial explanations compared to psychologists endorsing psychodynamic and cognitive-behavioural conceptualisations of mental health/illness. However, it is possible that this was an effect of the participants' amount of clinical training which the study did not control for. In the only included study to employ a qualitative methodology, Morant (1995), found that healthcare professionals' conceptualisations of mental illness are multiple and sometimes contradictory. The study's methodology allowed it to analyse the themes brought up by its participants as well as the language used to express these.

It was found that the participants made frequent use of terms derived from medical understandings of mental illness such as psychosis and neurosis. However, there were also regular references to mental illness as being an individual's inability to cope with aspects of personal or social life, which were interpreted by the authors as signifying psychosocial conceptualisations of mental illness in the participants. It was also found that themes of otherness and sameness coexist in healthcare professionals' conceptualisations of mental illness. Mental illness can thus be viewed as experiences that are different and not understandable (otherness) or as similar to other experiences (sameness). However, the study only provided limited demographical data about the participants which may have influenced these results. Moreover, the study failed to consider factors that may influence participants' representations of mental illness, such as years of experience, and the potential bias of the researcher on data collection or interpretation.

4. Discussion

4.1 Summary of Evidence

The present review identified seven studies that investigated healthcare professionals' conceptualisations of mental health/illness. The studies used a variety of measures such as questionnaires and semi-structured interviews, and assessed a range of aspects of healthcare professionals' conceptualisations of mental health/illness, including ontological frameworks and beliefs about aetiology, classification, research and treatment of mental health/illness. Because of the large heterogeneity across studies in terms of definitions and measures of conceptualisations of mental health/illness employed, no clear, discernable pattern between the studies' findings could be identified. The studies that used unidimensional measures of conceptualisations of mental health/illness found that healthcare professionals either endorsed or rejected psychosocial and biomedical explanations of mental health/illness. This is not a particularity surprising finding given that such unidimensional measures are not capable of making multifaceted assessments of conceptualisations of mental health/illness. To assume from these studies that, as in Morrison and Hanson's (1978) study, psychiatrists are more likely to conceptualise mental health/illness in biomedical terms than clinical psychologists

seems both imprecise and misleading. Indeed, a given healthcare professional may endorse a medical model in certain areas of practice, such as diagnosis, but adhere to psychosocial models in other areas, such as when planning and carrying out interventions. As such, the poor quality of these studies limits their applicability and the conclusions that can be drawn from them.

Whilst there were evident differences across the included studies, there were three points of particular pertinence. Firstly, Wyatt and Livson's (1994) use of a multidimensional measure capable of accounting for a greater complexity of conceptualisations of mental health/illness compared to unidimensional measures. Secondly, Morant's (1995) use of a qualitative methodology which allowed the author to record participants' multiple and contradictory conceptualisations of mental illness whilst paying attention to themes and the language employed to express these. Lastly, Ahn, Proctor and Flanagan (2009) being the only study to control for participants' ethnicity, despite evidence suggesting conceptualisations of mental health/illness to be culturally determined (Weare, 2000). This has two broad implications for the remaining studies. Firstly, conceptualisations of mental health/illness may be most appropriately assessed using multidimensional or qualitative measures. Secondly, ethnicity or culture may be a confounding variable that needs to be controlled for. However, in the 24 years of research reviewed in the present study, few studies have taken such factors into consideration.

4.2 Limitations

There are a number of limitations to this review. Firstly, the search strategy was designed with the aim of maximising the sensitivity of results relevant to conceptualisations of mental health/illness whilst maintaining high specificity to studies examining healthcare professionals' conceptualisations. Although the term "conceptualisation" has been extensively used in previous studies exploring representations of mental health/illness, it is possible that studies using different terminology were excluded on this basis. However, given the extensive search through reference lists and commentary papers in which such studies may have been identified, it is thought that this potential bias was limited. Secondly, the search strategy was intentionally kept broad in order to maximise the sensitivity of results

and this yielded a range of studies that considered various aspects of healthcare professionals' conceptualisations of mental health/illness. It is possible that by employing a search strategy focussing on more specific aspects of healthcare professionals' conceptualisations of mental health/illness would have resulted in additional studies relevant to the research question. Thirdly, the search strategy was also limited to published studies conducted in Europe and North America and presented in the English language. Given acknowledged cultural differences in conceptualisations of mental health/illness (Weare, 2000), the external validity of the findings is limited outside of this geographical area. The specificity of the search strategy may also represent a source of selection bias as well as potential publication bias. Moreover, given the large heterogeneity within groups of professionals, the fact that few of the studies controlled for demographics such as sexuality, ethnicity and area of work may further confounded the results signifies another limitation of previously conducted research.

4.3 Conclusion

This study has provided an overview of the manifold ways in which healthcare professionals' conceptualisations of mental health/illness have been measured and analysed in past empirical studies and a number of conclusions can be drawn from these. In terms of the various dimensions of healthcare professionals' conceptualisations of mental health/illness, there appears to be a fairly stable broad consensus as to the main concepts to be measured such the extent to which participants endorse biological and psychosocial explanations of mental health/illness. However, studies of healthcare professionals' conceptualisations of mental health/illness have remained descriptive with little rigorous research examining the underlying components of such conceptualisations. Moreover, there is no consensus about the set of measures to be used to assess conceptualisations of mental health/illness. Although the variety of measures is valuable as it approaches the complex question of conceptualisations of mental health/illness from a range of perspectives, it limits direct comparison of results and probably also contributes to the variation in the studies' findings and how these are presented.

4.4 Implications

There are a number of implications for future research in this area. Whilst existing studies have provided useful preliminary examinations of healthcare professionals' conceptualisations of mental health/illness, future studies need to build on the methodological flaws inherent in previous designs. Whilst the quantitative research is limited to questionnaire designs, this warrants greater control of confounding variables such as the impact of participants' ethnicity and amount of contact with individuals with mental health issues on conceptualisations. Further qualitative research will need to critically examine the role of the researcher in selecting and analysing data as well as make use of triangulation of methods where appropriate. From this review it is also apparent that the widely used unidimensional measures are not able to discern the underlying dimensions of conceptualisations of mental health/illness and future studies will therefore need to employ instruments capable of making multifaceted assessments and qualitative methodologies may be particularly useful for this purpose. It is a matter for further studies to explore whether assessments of healthcare professionals' conceptualisations of mental health/illness can be made more specific or whether the generality of the construct is what makes it so pertinent to clinical practice. However, as noted, there is no one measure of healthcare professionals' conceptualisations of mental health/illness that comprehensively addresses all the mentioned issues at present

The importance of the included studies for clinical practice is questionable. Although there is extensive evidence to suggest that healthcare professionals' conceptualisations of mental health/illness impact on their clinical practice, the studies in the present review shed limited light onto the complexities of assessing conceptualisations of mental health/illness. This is particularly true for unidimensional measures, which simplify the complex conceptualisations that practitioners draw on in clinical practice to such an extreme degree that they are misleading at best. However, the purpose of the present review has been to take a critical look at current concepts and assessments of healthcare professionals' conceptualisations of mental health/illness and as such has provided a valuable first step in identifying how the investigation of the research question should proceed in future research.

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Appendix A

The following search strategy was entered into Medline, Psycarticles, Psycinfo and Web of Knowledge independently.

1. exp mental health professional/
2. exp healthcare professional/
3. exp clinician/
4. exp psychologist/
5. exp psychiatrist/
6. exp psychiatric nurse/
7. or/1-6
8. exp conceptualisation
9. exp conceptualization
10. exp representation
11. exp causal belief/
12. exp model/
13. exp etiology/
14. exp explanatory model/
15. or/ 8-15
16. exp mental health/
17. exp mental illness/
18. exp psychopathology/
19. exp mental disorder/
20. exp mental disease/
21. or/ 16-20
22. (healthcare pro* or mental health pro* or conceptualisation or conceptualization or representation or belief* or attitude* or mental health or mental illness or mental disorder* or psychopathology).tw.
23. (healthcare pro* or mental health pro* or conceptualisation or conceptualization or representation or belief* or attitude* or mental health or mental illness or mental disorder* or psychopathology).mp.

JOURNAL PAPER

‘Doing Fence-sitting’: A Discursive Analysis of Clinical Psychologists’ Constructions of Mental Health and its Impact on their Work with Service-users[1]

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Abstract

The concept of mental health has been used to designate a range of concepts and a great deal of controversy surrounds the meaning of this construct. Despite its contested nature, there is a growing body of research indicating that the way healthcare professionals conceptualise mental health may have important clinical implications. This study adopted a discursive psychology approach, a method well suited to examine contested and variable concepts, to explore clinical psychologists’ accounts of mental health and its effects. Semi-structured interviews were conducted with eleven clinical psychologists in the East Midlands region of the UK. The participants constructed mental health through building up biological factors and psychosocial aspects as opposite ends of the same spectrum and then positioning themselves as distant from these extremes. This construction was used to manage issues of stake and accountability and to present their accounts as factual. The clinical psychologists drew on a discourse of moral concern for service-users to negotiate the implications of having different views of mental health to their service-users. This enabled participants to manage issues of accountability and to demonstrate their ability to be helpful to service-users. The results suggest that there is a need for clinicians to make the contingent and situated nature of their knowledge explicit and to be mindful of the effects of their use of language on different stakeholders in talking about mental health.

[1] The journal paper will be submitted to Social Science & Medicine.

Research highlights

- The first discursive psychological study of psychologists' accounts of mental health
- Clinicians avoided extremes of biological and social aspects of mental health
- Language was used to manage issues of stake and accountability and to present accounts as factual
- Clinicians should be honest about the contingent and situated nature of language and knowledge
- Clinicians should be mindful of the effects of language use regarding mental health

Keywords

Clinical psychologists, healthcare professionals, constructions, conceptualisations, mental health, fence-sitting, discursive psychology, discourse analysis.

Introduction

This paper adopts a discursive psychological approach to explore clinical psychologists' constructions of mental health and its perceived influence on their work with service-users. This approach is concerned with how language is used within social interactions to manage and create reality and as such represents a move away from the traditional cognitive psychology view of language as a tool to discover mental states (Elliott, Fischer & Rennie, 1999).

Since its inception over half a century ago, the notion of mental health has been used to designate a range of concepts including a psychological state, a dimension of health, and wider disciplines such as psychology and psychiatry. Given the variety of purposes for which the term has been adopted, it is not surprising that a great deal of controversy surrounds the meaning of mental health, with views reflecting the interests and values of the groups attempting to define the term. Indeed, a widely accepted definition of mental health remains absent from the literature and the concept is frequently dismissed as "too nebulous" to warrant serious exploration (Newton, 1988; Secker, 1998). Notably, the APA Dictionary of Psychology (2005) does not have an entry on mental health, whereas Campbell's Psychiatric Dictionary (2010) defines it as a synonym of mental hygiene and as a state of psychological well-being. The failure to provide a clear definition of mental health could be seen to imply that the concept has a self-evident validity. Moreover, it suggests a peculiar state of affairs since psychological literature rarely includes discussions about the general nature of mental health whilst, at the same time, asserts knowledge about the concept.

One consequence of the ambiguity about what constitutes mental health is a number of controversies regarding its ontological and epistemological status. A central point of contention is whether the concept of mental health is ever value-free and whether 'mental health' and 'mental illness' should be conceptualised as representing extreme ends of the same continuum (Kendell, 1995). Other researchers have suggested mental health to be qualitatively different from mental illness, implying that a person can be both mentally healthy and mentally ill at the same time (Secker, 1998). Indeed, these concepts are often used interchangeably in psychological

literature (Malek, 2004; Pickering, 2006), the boundaries between health and illness are drawn differently in different cultural contexts (Fernando, 2003), and the term 'mental health' is frequently employed to denote the management of mental illness (Vassilev & Pilgrim, 2007). Despite its elusive nature, there is a growing body of research indicating that the ways in which clinicians conceptualise mental health guide and inform their attitudes, reasoning and approaches to assessment, formulation, intervention and evaluation (Harland et al., 2009). Researchers therefore suggest that clinical psychologists' conceptualisations of mental health have significant clinical implications for their work with service-users (Hugo, 2001; Stevens & Harper, 2007).

Clinicians' conceptualisations of mental health and its effects

Research examining clinicians' conceptualisations of mental health and its implications comprise two main parts. The first is concerned with how conceptualisations influence attitudes and behaviours in relation to service-users. Such empirical studies have focussed on the consequences of endorsing biological and psychosocial conceptualisations which have been found to influence clinicians' attitudes (Bennett, Thirlaway & Murray, 2008), treatment decisions (Cape, Antebi, Standen & Glazebrook, 1994), engagement with service-users (Kent & Read, 1998), and the quality of treatment provided (Wallach, 2004). The second part includes studies concerned with the status of clinicians' ontological beliefs about mental health and the effects of these on their work with service-users. Such studies have found that psychiatrists and clinical psychologists are unwilling to accept mental disorders as real and natural categories (Ahn, Flanagan, Marsh & Sanislow, 2006), that ontological views about mental health influence clinicians' beliefs about the effectiveness of interventions and choice of treatment options, and that service-users' views about the aetiology of their condition are shaped by their clinicians (Ahn, Proctor & Flanagan, 2009). All these studies provide support for the notion that clinicians' conceptualisations of mental health have important clinical implications.

The problematisation of mental health

Whilst previous studies have been usefully applied, they appear conceptually and methodologically limited as they rest on the *a priori* assumption that mental health is

a consensual object of thought and that 'conceptualisations', 'beliefs' and 'attitudes' reside internally within individuals, that these remain relatively stable across contexts, and that they can be elicited through appropriate research methods. The notion that people's language reflects their underlying thoughts and feelings has been disputed by discursive psychologists such as Potter and Wetherell (1987), who argue that people construct accounts to serve different functions. In support of this, there is extensive research on health (Crossley, 2002) and beyond (Gilbert & Mulkay, 1984) suggesting that people are often inconsistent in their discussions of ideological dilemmas and that attitudes change even during the same interactions (Billig, 1999). This poses difficulties for quantitative methodologies, argued to be insensitive to the performative, variable and contextual aspects of people's accounts (Wetherell, Taylor & Yates, 2001). Instead, this research proposes that clinical psychologists' accounts of mental health and their effects can be productively explored by focussing on the ways in which these are discursively constructed through employing a social constructionist epistemology. Social constructionism holds a relativist position with regard to truth and thus views scientific inquiry not as an objective pursuit of truth but as a social institution which actively and systematically produces specific versions of reality and truth (Nightingale & Cromby, 1999). Taking this perspective, an examination of the various ways in which mental health is constructed, negotiated and authenticated and the implications of such accounts is made possible.

Methodology: discursive psychology

This study adopts the theory and methods of Potter and Wetherell's (1987) discursive psychology, which assumes that language is constitutive and that people's accounts are constructed to perform specific functions. The variability and inconsistency of people's accounts are considered to be the result of language being orientated towards different functions. For instance, researchers have described how accounts are constructed as factual in journal articles by minimising the agency of the scientist, thereby implicitly locating agency in the objects of research (Gilbert & Mulkay, 1984). It has been noted that speakers tend to draw on a range of rhetorical strategies when they have a stake in the outcome and in discussing contested issues, such as mental health (Harper, 1995). Through analysing the various discursive strategies that

speakers use to construct their accounts, the functions or interests served by these can thus be made more visible.

It is proposed that the application of a discursive psychological approach to the examination of clinical psychologists' constructions of mental health and its influence on their work with service-users enables an analysis of the processes through which mental health is *talked into being*. Through paying attention to the organisation and functions of such talk, the different issues attended to and how this talk is situated by the social and historical context in which it takes place, the adoption of this approach accommodates the variability and fluidity of clinical psychologists' accounts neglected by previous research. Discursive psychology has been used in previous studies to explore how professional accounts of psychiatric medication may be employed to serve rhetorical and persuasive functions in managing questions about its efficacy (Harper, 1999), to examine the ways in which psychiatric diagnoses are produced in professional discourse (Wooffitt & Allistone, 2005), and to study how the professional use of psychological terms can be the site of discursive struggle (McHoul & Rapley, 2005). As such, discursive psychology was considered to provide a framework well suited to the aim of this study: to explore clinical psychologists' constructions of mental health and its perceived impact on their work with service-users.

Method

The data for this study comprised audio recordings from eleven interviews with clinical psychologists in the East Midlands region of the United Kingdom.

Participants

This study received ethical approval from the Institute of Work, Health and Organisations at the University of Nottingham. A purposive maximum-variation sampling strategy was used as it was hoped that recruiting participants from various services would allow the range of positions and discourses available to speakers to be identified. Clinical psychologists known to the researchers were sent information packs containing information about the research through email. Eleven clinical psychologists volunteered to take part in the study, a sample size consistent with other published discursive studies designed to explore issues related to

professionals' accounts of mental health (e.g., Harper, 1995). Due to the small number of participants, demographic information is offered across the sample to protect confidentiality and minimise the risk of identification. The sample consisted of seven females and four males, six of whom had 0-10 years of clinical experience, two who had between 11-20 years, and three who had between 21-30 years of experience. The participants worked in a variety of services including: Primary and Secondary care, Forensic, Community, Neuropsychology, Residential and Child mental health services.

Interviews

The use of semi-structured interviews in discursive research is a contentious issue and 'naturally occurring talk' is frequently preferred (Potter & Hepburn, 2005). However, interviews enable researchers to purposely question a sample on the same issues, and were therefore considered to provide an appropriate framework for gathering data. The interviews were conducted by the first author, a trainee clinical psychologist, after informed consent was obtained that included permission to audio-record the interviews and to publish anonymised extracts. The interviews were aimed at eliciting a range of talk around mental health and were guided by an interview schedule covering participants' views of mental health and its effects on their work with service-users. The development of the interview schedule was informed by a literature review and pilot study.

Transcription and analysis

The interviews were recorded using a digital voice recorder and transcribed using a simplified form of Jeffersonian transcription notation (Rapley, 2007). Following Potter and Wetherell's (1987) suggestions, the analysis consisted of an iterative process whereby the transcripts were read a number of times whilst paying attention to patterns of language use in the data. Anonymised transcripts were also discussed in detail with the two other authors in a series of 'data sessions'. Extracts relating to the different categories were then transferred into data files that became the material for analysis. In particular, the different systematic ways in which 'mental health' was talked about, the various discursive strategies used by speakers to construct their

accounts as factual and cohesive, and the range of positions made available through the talk was considered.

Quality issues

As noted, this study adopted a social constructionist epistemology, thus rejecting the notion of 'absolute truth' that logical positivist research is measured against. This epistemological difference has considerable implications for evaluating the quality of the study since the reading of the data is viewed as only one out of a number of possible interpretations. In line with the suggestion that the quality of qualitative research should be evaluated by the logic of justification associated with the study's epistemology, this study aimed to meet the quality criteria set out by Madill, Jordan and Shirley (2000) for discursive psychological research. We urge the reader to keep these criteria in mind as they consider the study in terms of internal coherence, deviant case analysis, trustworthiness and openness to reader evaluation.

Analysis and discussion

The analysis focuses on two features of clinical psychologists' talk about mental health and the interests served by these constructions. First, the ways in which speakers construct mental health as psychological versus biological; and second, negotiating difference between their views and that of their clients. Both these aspects were salient and permeated the participants' talk and contained a wide range of the rhetorical strategies identified across the data corpus, suggesting that they were culturally available to the speakers. To aid reader evaluation, extracts from the interviews are used throughout the analysis to illustrate the presented arguments. The codes next to each extract refer to the interviewer (I) and the clinical psychologists who participated in the study (CP1, CP2 and so on).

Mental health as psychosocial vs. biological

Edwards and Potter (1992) noted that people frequently view others' accounts as invested to some extent and that there is therefore a risk that an account is discredited on this basis. In order to manage such dilemmas of stake or interest, people deploy discursive strategies to demonstrate that their accounts are justified or warranted by facts rather than biased or prejudiced. In the following two extracts,

accounts of mental health are constructed through building up biological factors and psychosocial aspects as opposite ends of the spectrum and speakers position themselves as distant from both these extremes. This is achieved through the use of a number of discursive strategies that help clinical psychologists to manage issues of stake, interest and accountability.

Extract 1

I: yes:: yes erm (.) it's a good opportunity to ask you what your understanding of mental health is?

CP2: erm (.) yes I mean it's funny because in the process of doing this I was kind of thinking what is my neat succinct answer to that question and I don't (.) ha:::ha I <u>can't</u> think of one at all.

I: ha ha.

CP2: erm I would have said that=well not historically but maybe for me there is I would really li::ke it would <u>really</u> satisfy me to be able to dismiss the notion of any kind of illness kind of conceptualisation

I: mmmm mmmm.

CP2: of and I am thinking about Psychosis in this case erm (.) it would really please me to be able to conclusively dismiss the fact that it's an illness and I think my approach is often informed by that drive

I: yes.

CP2: to kind of consider alternatives and think about (.) okay well let's think about this person's kind of psychological resources=how they have been nurtured=their developmental experiences=their attachment style=what life has dealt them because sometimes you know people just get dealt a crappy hand

I: sure

CP2: and erm so thinking about how they respond to kind of psychological burden erm but it's the caveat to that is that it's then tricky when someone sits in front of you and says but it is an illness (.) <u>to me it is</u>

I: mmmm

CP2: and I was well before (.) my medication has helped

27 I: yes
28 CP2: and actually in a way I am internally cursing them damn it ha:ha:ha:
29 I really wish I really had you know, because I suppose theoretically
30 it's satisfying to be able to conceptualise it purely in terms of
31 psycho-social? stuff (.) but I am not sure that we can and I think
32 maybe that's kind of a naïve erm its just (.) its that anti-psychiatry
33 thing of just not wanting them to be right
34 I: yes
35 CP2: erm (.) I think 90% they are not but there are times (.) particularly
36 post-qualification when I have had you kno:w when you think
37 actually you do:: have to consider factors like that

Interestingly, when asked about mental health, the speaker responds by constructing the dismissal of illness conceptualisations as an ideal to aspire to. This ideal is then explored by listing the "psychosocial stuff" which is presented as comprising the alternative to an illness conceptualisation of mental health and is finally dismissed through the introduction of a case example on line 23, which is used as a contrast to the psychosocial aspects of mental health. The use of such contrasts and lists has been noted to be powerful in producing factuality as it combines ideas eclectically from a range of theoretical viewpoints (Edwards & Potter, 1992). Similarly, through constructing her stake as counter to the illness conceptualisation represented by the case example, a discursive strategy known as stake inoculation, the speaker communicates that she has no stake in what she is saying and thereby positions herself as objective and constructs her account as factual (Potter & Hepburn, 2008). The speaker explains that it "would be theoretically satisfying" to conceptualise mental health purely in psychosocial terms but that, *through experience*, she has come to think of this as "naïve" and just "that anti-psychiatry thing of just not wanting them to be right". In this way, thinking of mental health in purely psychosocial terms is presented as a 'naive ideal' which the speaker distances herself from using case examples, creating a space between theory and practice and referring to the authority given by her experience as a clinical psychologist.

Horton-Salway (2001) suggested that rhetorical strategies are used precisely when there is a sensitive or contentious issue. It is therefore interesting that the case example is deployed following an account of psychosocial aspects of mental health, an aspect that is presented as incongruous with the illness conceptualisation which "it would really satisfy" the speaker to "conclusively dismiss". Edwards and Potter (1992) noted how such case-study format examples create the impression of a perceptual experience, i.e. as being factual and free from personal bias. The use of this example constructs the account as open to challenge and positions the speaker as reasonable. Indeed, if someone were to say that the speaker endorses an anti-psychosocial understanding of mental health, one could point to the comment that she views it as the ideal conceptualisation, which, if it weren't for her personal experiences of evidence to the contrary, she would embrace. In the last part of the extract the speaker makes use of various rhetorical strategies to account for the implication of biological factors in mental health and thus an illness conceptualisation. First, the use of the qualifier "I think" followed by the numerical approximation "90%" works to position the speaker as thoughtful and open to challenge whilst objectifying the implication of biological and psychosocial factors in mental health, thus giving them agency in their own right. The use of numbers is a common rhetorical device in empiricist accounts (Gilbert & Mulkay, 1984). Second, through referring to "post-qualification" the speaker's talk is constructed as coming from a category (qualified clinical psychologist) of knowledge and is thus presented as factual upgrade of knowledge. It is likely that the interviewer's position as a trainee clinical psychologist prompted the speaker to make use of this device, as it may not have carried the same epistemic weight in a conversation with another qualified or senior clinical psychologist. This rhetorical strategy has been named category entitlement by Edwards and Potter (1992) who demonstrated how some individuals (category members) are expected to possess or have access to certain knowledge or skills. Thus, through referring to such category membership, speakers are able to position themselves as 'possessing the truth'. Third, on line 36, the speaker describes how, not just her, but everyone else also needs to take such biological factors into account. Through characterising these events as having a predictable and sequential pattern, the speaker makes use of a discursive strategy referred to as script formulation by Edwards (1995). This helps to manage the speaker's accountability as

it ‘scripts’ the implication of biological aspects in mental health as an aspect that is to be expected or assumed and therefore not the responsibility of the speaker.

As in the previous excerpt, although asked about mental health, the speaker in extract 2 orientates towards a conceptualisation of mental *ill-health* and constructs mental health, mental illness and mental health problems as concepts that are taken to mean the same thing and can thus be used interchangeably, as indicated in the statement “whatever terminology you use” on line 44. Through utilising the impact of a scientific metaphor (“continuum”) along with the powerful nomenclature of a scientific and medicalised discourse (“psychosis, mood regulation issues”), mental health is then constructed as real and as existing regardless of the previously mentioned diagnostic categories.

Extract 2

38 I: that’s er (.) that’s a good point to lead into erm what your
39 understanding of mental health is I suppose.
40 CP1: I am very much erm mmm:: my starting point I suppose is that I see
41 most of the issues that people struggle with as being part of erm (.)
42 er: a continuum of human experience and obviously people who
43 have got a diagnosis of a mental illness or a mental health problem
44 (.) however whatever terminology you use tend to be people who
45 are <u>just</u> at the extreme ends of=of some continuum or other which
46 we are <u>all</u> on somewhere
47 I: yes
48 CP1: erm whether it’s erm obsessiveness or erm:: you know (.) sort of (.)
49 relationship erm (.) you know mood regulation type issues or
50 whether it’s erm anxiety or even psychosis?but I am not a (.) I don’t
51 have a sort of <u>radical</u> position on erm the sort of the construction
52 of=of mental illness in that I think it is legitimate for people for <u>us</u> to
53 consider and for people to consider themselves to have what might
54 be described as an illness with a kind of at least partially
55 physiological basis. I think there is evidence or a genetic basis you 56
know <u>there is</u> evidence that=that those factors are relevant

57 I: yes
58 CP1: however? I think that in general the medical approach to mental
59 illness is probably (.) erm in a sense the least important part of it
60 and of the psychological and social end of understanding of
61 somebody's experience and how their difficulties have sort of
62 manifested and understood, erm is kind of you know 75% of the (.)
63 of what's worth working with
64 I: yes
65 CP1: So=yes medication might be helpful yes it's important to bear in
66 mind there might be things that aren't going to change through
67 social or psychological interventions but I suspect on the whole in
68 mental health erm that that's the sort of the least important part of it
69 very often for a lot of people anyway.
70 I: yes.
71 CP1: erm so I suppose erm and I don't want to put a label on it I am
72 loathe to put a label on it but my position would be although I am
73 not a radical anti-psychiatry anti-medical I do:: think that that's not
74 where most of the important stuff goes on (.) I guess I would say
75 that
76 I: yes.
77 CP1: or I would say that because I am a Psychologist
78 I: yes
79 CP1: but:but that's I suppose where I position myself

In the second turn, the speaker positions herself as distant from any radical position before answering the question and corrects herself from "I *am* not a" to "I don't *have* a sort of radical position". This re-phrasing is noteworthy as it changes the intentionality of the statement from being one that defines the speaker (the verb *to be*) into a position of choice (the verb *to have*) thus giving agency to the intentional and flexible nature of the stance. This statement serves to distance the speaker from radical social constructionist views and works as a rhetorical disclaimer for the following sentence in which biological aspects of mental health are emphasised. In line 59, the speaker also distances herself from the "medical approach", instead

emphasising the importance of psychosocial aspects of mental health. The use of quantification to describe the extent to which psychosocial factors are implicated in mental health gives the account further epistemic weight. As in the previous extract, through constructing her stake as counter to the medical approach, stake inoculation is used to protect the speaker from accusations that her account is invested or biased.

As outlined, clinical psychologists produce accounts of mental health through presenting psychosocial and biological as representing opposite extremes and then distancing themselves from these poles. A feature of this type of account is that speakers note the influence of personal ideological commitment in distancing themselves from "that anti-psychiatry thing of just not wanting them not to be right" and the "medical approach" which "is the least important part of it". One effect of such constructions is to present a narrative that asserts the implication of biological aspects in mental health through distancing oneself from more radical understandings which, in turn, are constructed as naïve and narrow-minded.

Negotiating constructions: a moral discourse

The second aim of this study was concerned with how clinical psychologists construct the influence of their views of mental health on their work with service-users. As reflected in the following extracts, one prevalent feature of these accounts was clinical psychologists negotiating the implications of having different views of mental health to their service-users through drawing on a discourse of moral concern.

Extract 3

80 CP9: and just it doesn't matter? what I believe you know what matters is
81 the person's own view and their experience and I might be able to
82 share some helpful ideas
83 I: yes
84 CP9: about that and they may take them on board and you know they
85 might kind of buy into some of my theories around mental health (.)
86 erm or why they might be facing difficulties but they might reject
87 that and I suppose part of the way that I integrate it into my work is

by always making it clear that I have a kind of bit of a theory or a hypothesis and I make it very tentative

I: mmmm::

CP9: and I make it very gentle and I also invite people to reject it

I: yes

CP9: as much as I invite people to buy into it (.) so you know quite often in sessions it's not unusual for me to say you know I have got an idea or it might be wrong and tell me if I am completely off the mark or you know

I: yes

CP9: I think I am very=I am very keen for the client to know that <u>they</u> are the expert on them

Through the continuous use of the modal auxiliaries "might" and "may", the tentativeness of the speaker's subjective account is emphasised. These features give an impression of collaboration and function to position the speaker as a liberal and non-directive clinician whose primary concern is to empower service-users. In line with this, previous researchers have noted the need for clinicians to come across as open-minded and to take on the attitude of 'independent objective discussants' (Fowler, Garety & Kuipers, 1995).

Another feature of this discourse was to present oneself as a responsible professional through providing examples of authoritarian clinical psychologists and then distancing oneself from these. Potter and Wetherell (1987) noted that speakers do not only use discursive strategies to present particular versions of events in constructing their accounts, but also deploy rhetorical devices to undermine alternative versions that may pose a threat to how that person wants to be understood. Examples of such accounts can be seen in the following two excerpts in which speakers address the threat to themselves as non-collaborative clinicians through the deployment of case examples, thus enabling their talk to be viewed from a moral framework where accountability can be managed and allocated within interactions.

Extract 4

CP9: I suppose I manage it by and I always manage it by taking a kind of not knowing position and taking a position of not having any certainty

I: mmmm::

CP9: SO I would never impose on somebody that their view=you know their view is wrong or just because it's different to mine (.) I don't see myself as an expert who knows more about their experience than they do

I: right

CP9: erm and I think that's really dangerous and in fact I was having a conversation with a service-user not a client but someone who has used psychology services in the past recently and they were saying that they had a really awful. experience of going to a psychologist who was very insistent on what the formulation was

I: yes

CP9: of the problem and that things that she had seen in her life as good the psychologist turned that (.) so you know the formulation kind of made out that things had caused her problems that she actually didn't believe had caused her problems

I: mmmm::

CP9: and had never thought about it in a kind of negative way

I: yes

CP9: and you know I never want to be that psychologist basically you know I don't want to be someone that kind of imposes a view so I think if you take a position where you say let's think about what may have led to your current difficulties erm then you know (.) then you can co-construct something that's meaningful to the client?

In this extract, the expertise of the service-user is given agency through the assumption of a 'not knowing' position. This account is then corroborated through the use of a case example which is strengthened through vivid and detailed descriptions and by the authority of personal experience which positions the speaker as a credible

witness (Edwards & Potter, 1992). The deployment of the extreme case formulations "really dangerous" and "really awful" functions to further emphasise the seriousness of the example (Pomerantz, 1986). CP9 strongly distances herself from those clinical psychologists who "impose" their views on others and places evaluative moral force in the word "impose", which constructs the behaviour of such clinicians as morally unjustifiable and unethical. This distancing is also achieved through the use of the personal pronoun "you" and "you know" which works to co-opt the interviewer. The deployment of the word "co-construct" suggests a social constructionist discourse in which views about mental health may change depending on their situatedness. Indeed, the reluctance to make use of the word "truth" and the use of words such as "ideas" and "views" which do not imply a singular, fixed or neutral way of looking at things were a prevalent feature of clinical psychologists' talk about the effects of their views about mental health. Gilbert and Mulkay (1984) noted that although the activity performed by participants' constructions cannot be known by analysts, theories about the functions of such accounts can nevertheless be developed through familiarity with the data. It seems that through presenting views about mental health within a social constructionist ontology, clinical psychologists are able to resolve the potential dilemma of having conflicting views and instead emphasise their primary concern; their ability to be helpful to service-users through co-constructing narratives.

Extract 5

127 CP2: and also when someone tells you that that's how they view it (.)
128 who are <u>we?</u> to tell them that they are wrong?
129 I: yes
130 CP2: otherwise I am just pushing <u>my</u> agenda on them aren't I?
131 I: yes
132 CP2: by saying no=no it's all about stress=it's all about your
133 psychological resources (.) actually they don't want to hear that and
134 it's not necessarily useful
135 I: yes
136 CP2: if they want to think of it as an illness then. and do you know what
137 <u>really</u> annoys me about psychologists? actually who are=who do
138 that and I am only thinking of a couple I am not saying this is a

widespread occurrence but I do know a couple of psychologists who=who will push the psycho-social agenda on someone who views their experience as an illness because that's their agenda

I: mmmm:::

CP2: because they think that there is some inherent value in someone understanding it that way rather than that way and I always think that actually boils down to arrogance really

I: mmmmm:::

CP2: of thinking well no (.) my idea is better than yours.

I: yes (.) yes

CP2: and it's not for us to dictate is it (.) you know if someone think of themselves as ill and that=that's not fundamentally undermining their recovery (.) then why would we suggest that they are wrong?

As in the previous extract, the speaker uses a case example to position clinicians who 'push their own agendas' as irresponsible and arrogant. This strong moral discourse is highlighted both in the first and the last sentence in which rhetorical questions are asked as if to invoke common sense; why fix something that isn't broken? The use of consensus is a common discursive strategy to enhance facticity and functions to position the speaker as balanced and reasonable (Potter & Wetherell, 1987). As we have seen, clinicians' root their discourse and justify their decision not to challenge service-users' views about mental health in a discourse of moral concern. This concern is perhaps unsurprising given its integral role in the therapeutic relationship and that it is widely considered to be closely linked to clinicians' credibility (Gibson, 2006). Nevertheless, the explicit concern with not imposing views of mental health on service-users is interesting as most schools of therapy offer resources for challenging service-users' life-worlds. As described by Gergen (2009), if a client talks about issues of sexual perversion the psychoanalyst moves on to enquire about childhood experiences, and if a client speaks about how everyone is laughing at him the cognitive therapist asks if they could be laughing at something else. These therapeutic responses serve to challenge the reality of the service-user by communicating: 'you thought it was this, but it is (or could be) that'. Indeed, George Kelly (1969), doubting the alleged truths and insights resulting from

psychotherapy, concluded that insights occur only when service-users adopt the perspective of therapists. As noted throughout this analysis, the moral concern for service-users was a recurrent feature of the arguments and explanations that participants constructed in responding to the interview questions. The clinical psychologists presented this moral imperative as continuously guiding them in their considerations of the effects of their ideas about mental health on their clinical work thus allowing their talk to be viewed from a moral framework where accountability could be managed within interactions. As well as being professional, such accounts may also function to reflect aspects of clinicians' ethical self; their need to know that they are benefitting service-users rather than causing them harm.

General discussion

This study has presented a reading of clinical psychologists' accounts of mental health in which participants constructed biological factors and psychosocial aspects as opposite ends of the spectrum. By positioning themselves as distant from these extremes, participants were able to manage issues of stake and accountability and to present their accounts as credible. This construction legitimated the implication of biological factors whilst emphasising the primacy of psychosocial factors, which was helpful in managing cases where there was a lack of psychosocial evidence to explain a person's mental health. Consistent with Potter and Wetherell's (1987) observations, participants used a range of different rhetorical strategies to construct their accounts of mental health. In particular, stake inoculation, category entitlement, and case examples were used to present their constructions as factual and to manage issues of accountability. The discursive strategies deployed by the clinical psychologists in this study are consistent with past discursively-informed studies, showing a cross-topic relevance by demonstrating how clinicians rely on particular rhetorical devices to 'get things done' in verbal interactions. For example, research has outlined how clinicians use such discursive strategies to construct their accounts as credible (Harper, 1995; 1999), to meet challenges to their constructions (Harper, 1994), and to manage issues of professional accountability in clinical interactions (Robertson, Paterson, Lauder, Fenton & Gavin, 2010). This study was also concerned with how clinical psychologists construct the influence of their views of mental health on their work with service-users. One prevalent feature of these

accounts was participants negotiating the implications of having different views of mental health to their service-users through drawing on a discourse of moral concern, which functioned to manage issues of accountability. Power and collaboration is common dilemma in psychotherapy (Frank, 1973) and, in line with this data corpus, previous discursive studies have demonstrated how clinicians' manage the implications of challenging service-users' beliefs through drawing on a discourse of collaboration (Messari & Hallam, 2003).

This study has shown various assumptions implicit in professionals' accounts and analysed the consequences of these accounts, in particular for how clinicians and service-users are positioned. As outlined in the literature review, clinicians' views and assumptions about mental health have been found to guide and inform their approaches to assessment, formulation and intervention (Harland et al., 2009) and shape service-users' views about their conditions (Ahn, Proctor & Flanagan, 2009). This implies that there is a need for clinicians to be honest about the contingent and situated nature of their knowledge and language, to make their assumptions about mental health explicit, and to be mindful of the effects of their use of language on different stakeholders in talking about mental health. Clearly, if clinicians are not open about such issues there may be a risk of service-users passively complying with a process that they do not understand or feel they benefit from, thereby ethically compromising clinicians' practice. Moreover, such open and honest conversations are likely to strengthen the therapeutic alliance, a factor associated with positive outcomes (Martin, Garske & Davis, 2000) and service-user satisfaction (Roberts & Holmes, 1998) across therapies. On a theoretical level, the findings demonstrate that there is a range of constructions of mental health available to clinical psychologists and the analysis highlighted the variability and ambiguity of the participants' accounts. This highlights how the concept of mental health is highly contested and that, rather than relying on the *a priori* assumption that mental health is a consensual object of thought, future studies should be designed to capture this complexity. Lastly, on a methodological level, this research represents the first discursive psychological examination of clinical psychologists' constructions of mental health and its effects on their work with service-users. As such, not only does it fill a gap in DA literature by examining the topic of mental health as an action-orientated

discursive practice but it also offers a discursive space to examine the interactive actions performed in other controversial and contested issues.

Limitations and suggestions for future research

The use of this novel approach is not without its limitations. In particular, the use of 'artificial data' has been argued to decrease the ecological validity of findings (Potter & Hepburn, 2005). Although not epistemologically problematic, the method of data collection is likely to have impacted on the variability of the data. Given that mental health is an ambiguous and contested term, participants may have been conscious of how they would be perceived in constructing their accounts. The presence of the interviewer is likely to have influenced the ways in which the clinical psychologists did professional accountability and how they defended their constructions of mental health and the choices made in clinical practice. As such, the views and constructions of the participants could be argued to be intersubjective, taking into account what they perceived to be the interviewer's views of mental health. Further studies might therefore consider how clinical psychologists present and negotiate constructions of mental health with service-users and other professionals in clinical settings, thus providing the opportunity to compare the data from this study with naturally occurring talk. This study focused specifically on clinical psychologists' constructions of mental health and its perceived effects. One question which has been left unanswered is how service-users construct mental health and their experiences of how views of mental health are negotiated in their interactions with clinicians, which would be an interesting extension to this study.

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EXTENDED PAPER

Part One: Extended Background

1.1. Section introduction

The central interest of this thesis is clinical psychologists'[2] constructions of mental health and its effects on their work with service-users. In order to offer a context to the study, it is important to begin by situating it within a wider picture and to review the literature that has influenced the understanding of the psychological construct of 'mental health'[3]. For this reason, I start with introducing the history of the evolving concept of mental health and review the importance of the construct in psychology. To provide a background to the current study, the ways in which CPs' accounts of mental health have been studied in the past will then be explored. In particular, studies examining the association between professionals' conceptualisations of mental health with factors linked to interactions with service-users will be considered. Thirdly, the methodological limitations of previous research will be reviewed and used to provide a focus and rationale for the present study. Lastly, an alternative approach to the exploration of the construct of mental health and its implications than has been taken historically will be advocated and the epistemological implications of this approach will be reviewed along with empirical studies adopting a similar approach.

1.2 History of the concept of mental health

The history of the concept of mental health is complex, arguably in part due to the idea that any formulation of the construct is entangled within particular social and historical contexts (Bracken & Thomas, 2005). References to mental health and the corresponding concept of 'mental hygiene' can be found in the English language long before the 20th century. Indeed in 1843, one of the founders of the American Psychiatric Association, Isaac Ray, referred to it as "the art of preserving the mind against all incidents and influences calculated to deteriorate its qualities, impair its energies, or derange its movements" (Rossi, 1962, p.78). It was not until 1946, however, when the World Health Organization (WHO) was established in New York that technical references to the concept of mental health were made (Bertolote,

[2] The abbreviation CP will be used throughout this thesis to denote the professional group of clinical psychologists.

[3] Throughout this study I aim to problematise the concept of mental health. The use of inverted commas to signal this may be irritating or confusing for readers and so the term mental health will be employed pragmatically despite the risk that I may end up inadvertently reifying it.

2008). In 1951, WHO's Expert Committee on Mental Health defined the concept as a "condition, subject to fluctuations due to biological and social factors, which enables the individual to achieve a satisfactory synthesis of his own potentially conflicting, instinctive drives; to form and maintain harmonious relations with others; and to participate in constructive changes in his social and physical environment". Since its inception over half a century ago with its clear psychodynamic references, notions of mental health have been used to designate a range of concepts including a psychological state, a dimension of health, and wider disciplines such as psychology and psychiatry. Given the variety of purposes for which the term has been adopted, it is not surprising that a great deal of controversy surrounds discussions about the meaning of mental health as outlined in the journal paper. In an attempt to overcome the dichotomies of physical/psychic and body/mind, the WHO stresses a more holistic and positive dimension of mental health in the widely referenced preamble to its constitution: (mental) "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2001).

1.3 Mental health and psychology

Because of its polysemic nature, the delimitation of mental health in relation to psychology is not always clear and it is therefore useful to consider the social context in which the modern discipline of psychology has developed, as this may illuminate some of the social interests at work in creating and maintaining discourses around mental health. Psychology has its roots in the nineteenth century when principles of science were increasingly being applied to the study of human beings in the hope that this would enable predictions about human behaviour to be made (Milton, Craven & Coyle, 2010). Gergen (1991) suggested that the discipline of psychology grew out of four overarching epistemological suppositions that are now embedded in the discipline. Firstly, psychology adopted the belief in a knowable world and thus a basic subject matter to be examined. Secondly, this supposition implies a belief in the existence of underlying essences and universal properties. Thirdly, it subscribed to the idea that, through the use of the scientific method, obdurate truths can be discovered about such essences and thereby reveal laws or principles that apply to other instances across time, individuals and situations. This point is evident in taxonomic systems such as the International Classification of Diseases (ICD) (World

Health Organization, 2008) and the Diagnostic and Statistical Manual of Mental Disorders (DSM) (American Psychiatric Association, 2000), which assume that the concepts of mental health and illness and their boundaries are matters of natural fact to be examined and determined using scientific methods, and best diagnosed by healthcare professionals and experts. Under this assumption, therefore, the specific personal theories that individual clinicians hold about mental health and illness would be irrelevant to the truth yet to be discovered. Indeed, as noted by Ahn and Kim (2008), to suggest that these are relevant might sound as bizarre as proposing that the periodic table should be revised to fit the way chemists reason about elements. Lastly, there is a belief in the progressive nature of the research enterprise resulting in the illumination of the fundamental character of its subject matter (Gergen, 1991).

These realist assumptions are challenged by the alternative social constructionist idea that understandings of mental health and illness do not represent 'truths' but rather that they are ideologically shaped and culturally reinforced constructions (McNamee & Gergen, 1992). From this perspective, in order to make sense of 'mental health', an account of what constitutes 'mental ill-health' is required and it is argued that such categories are embedded within broader social systems and reflect existing beliefs regarding what is socially acceptable and normative (Milton, 2010). As pointed out by the French philosopher Michel Foucault (1967), conceptualisations of 'madness' at any given point in history are necessarily reflective of normality, as indicated by the additions and deletions of mental health conditions in the ICD and DSM which could be argued to reflect changes in the way that mental health is perceived over time. Mental health from this perspective is therefore viewed as a concept constructed through a range of socio-cultural factors including scientific concepts prevalent in society, ideas regarding an ideal and healthy lifestyle as well as dominant causal beliefs and explanations about illness conditions. This stance implies that the ways in which professionals reason about mental health is crucial in building an understanding of the concept. The reasons for why such an understanding is important will be considered in greater detail following an outline of one of the prevalent contemporary frameworks of mental health; the biopsychosocial model.

1.4 The biopsychosocial model of mental health

In 1977, a psychiatrist named Engel highlighted the inadequacies of biological explanations of mental illness and instead proposed a biopsychosocial framework of mental health which holds that mental illness is caused by interactions of biological, psychological and environmental factors. The model was warmly welcomed by social scientists as it affirmed the importance of psychosocial factors and has since had considerable impact on the scientific community (Yardley, 1996). In particular, the introduction of the model led to a vast expansion of research concerned with the biopsychosocial determinants of mental health and illness. In line with Engel's (1977) suggestions, such studies have tended to produce quantitative measures of psychosocial variables and correlated these with assumed signs of mental health and illness. The consequences of this wave of biopsychosocial studies have been multiple; psychological research has won acceptance from medical clinicians, the implication of psychosocial factors on mental health has become increasingly acknowledged in medical circles and CPs have been given a more substantial role to play in the provision of mental health services (Yardley, 1996). Indeed, the Health Professions Council (HPC), the statutory regulator for psychologists, has included a conceptualisation of mental health in biological, psychological and social terms in the core definition of CPs' competencies (Health Professions Council, 2009). Similarly, the British Psychological Society (BPS) has argued this framework to be crucial to psychologists' understanding of mental health (Kinderman & Tai, 2009). The biopsychosocial model has thus become established as a prevalent narrative within psychology and researchers have noted that the model is an important conceptual framework that guides clinicians in their everyday work with service-users (Fava & Sonino, 2008). As such, it is likely to inform the perspective that psychologists adopt when considering the concept of mental health.

1.5 Relevance of constructions of mental health

There are two distinct branches of literature into the implications of CPs' constructions of mental health. The first is concerned with how CPs' ideas about mental health shape and maintain the discourses held by service-users and wider society in general. The second focuses on the influence of CPs' constructions of

mental health on their attitudes and clinical decision-making and each of these will now be reviewed in turn.

1.5.1 Constructions of mental health and dominant discourse

As previously outlined, it could be argued that mental health is constructed in the context of social and cultural settings (Gergen, 2001). From this perspective, beliefs about mental health are not necessarily acquired from direct experience but derived through the complexity of constructive processes of communication and interaction in a particular setting that is itself situated in a broader historical, social, political, and cultural context (Foucault, 2006). In line with this, it has been demonstrated that the meaning of mental health is formed in everyday conversations (Daniels & White, 1994), is influenced by cultural and social norms (Dixit, 2005; Leventhal et al., 1997) and that the concept may thus be understood as an intersubjective linguistic creation (Guterman, 1994). Because of their role in society as 'practical experts', mental health professionals such as CPs are charged with the job of assessing people's mental health and deciding what care should be provided. As such, CPs play a major role in the provision of mental health services and in the social constructive processes through which contemporary representations of mental health evolve. This implies that CPs hold the power to construct and maintain discourses and to position themselves and others in ways that may have significant consequences. Indeed, the work of CPs guides and informs the mental health theory that influences government policy of care, which, in turn, is used to shape the tangible practices made available to service-users. In this way, CPs' constructions of mental health are filtered into the existing stock of common sense knowledge about mental health. Consistent with this account, service-users' views about the aetiology of their diagnosis have been found to be shaped by their clinicians (Ahn, Proctor & Flanagan, 2009) and CPs' attitudes and behaviours have been argued to inform and influence future caregivers (Servais & Saunders, 2007). Given their powerful role in constructing the contemporary social reality of mental health, it is thus important to gain an understanding of CPs' discourse of mental health and how this relates to their work with service-users.

1.5.2 Constructions of mental health as implicated in clinical decision-making

The distinct positions taken by healthcare professionals in relation to mental health have also been argued to guide and inform their reasoning and their approaches to assessment, formulation and intervention (Harland et al., 2009). Although CPs' professional bodies emphasise the importance of focussing and attending to the difficulties experienced by individual service-users in order for clinical care to be client-centred (HPC, 2009), clinicians also need to think more generally about what the science suggests, about any similar problems assessed before and what interventions may be helpful in making clinical decisions. It may be that CPs do not consider the larger concept of mental health in day-to-day practice, but focus instead on the sets of symptoms or concerns that service-users present with. However, such judgements are likely to be influenced by the ways in which CPs' construct mental health as these constructions position their service-users in particular ways and may therefore markedly impact on the processes of referral, assessment, formulation and intervention (Harper, 1999b). Indeed, critics have long argued that clinicians rely on intuitive thinking in predicting outcomes and making diagnoses for service-users rather than drawing on scientifically established findings (e.g., Dawes, 1994; Garb, 1998; Kahnemann, Slovix & Tvwersky, 1982; Meehl, 1954).

As previously noted, the construct of mental health can be viewed as a value position regarding what is appropriate, desirable or normal in contemporary life and the ways in which different therapeutic schools of thought define the concept may reflect such value judgements. Drawing heavily on the medical model, the traditional view of the aim of therapeutic change has been to replace a state of illness with a state of health (Milton, 2010). Similarly, the aim for Freudians may be to replace repression by ego control, for Jungians to realise self-hood and for cognitive therapists to replace dysfunctional thoughts with reality-based thoughts. In this way, successful therapy replaces dysfunctional or unhelpful orientations with new realities, narratives or insights, a process that carries with it value judgements about what mental health entails. It is noteworthy that not only is there a lack of clear definitions of mental health but there is also no device or technique that can verify an individual's mental health. Instead such verification processes involve clinical judgements. Mental health may thus be viewed as an arena of discursive encounters as it involves the negotiation of assumptions and values (Yardley, 1996) and previous studies have

demonstrated various ways in which clinicians' decision-making is discursively constructed (Barrett, 1988; Harper, 1994). It thus seems that there are a range of ways in which professionals' constructions of mental health may be implicated in clinical decision-making, an observation that has led researchers to suggest that the topic warrant further investigation (Hugo, 2001; Petrie, Broadbent & Kydd, 2008; Stevens & Harper, 2007; Wahl & Aroesty-Cohen, 2010).

1.6 Review of the literature on healthcare professionals' conceptualisations of mental health

One of the most well established findings in cognitive psychology is that people's expectations can influence their attention (e.g., Sarter, Givens & Bruno, 2001), perception (e.g., Rolls, 2008), categorisation (e.g., Delorme, Rousselet, Macé & Fabre-Thorpe, 2004) and memory (e.g., Rutman, Clapp, Chadick & Gazzaley, 2009). Such expectations can be elicited by anything ranging from the theories and beliefs that the person brings to the situation to cues in the environment. This notion of top-down processing has provided the basis for a wealth of literature examining healthcare professionals' conceptualisations of mental health and its implications. This body of research comprises two main parts; the first concerned with how healthcare professionals' conceptualisations of mental health influence their attitudes and behaviours in relation to service-users. Such empirical studies have focussed on the consequences of endorsing biological and psychosocial conceptualisations of mental health (Wahl & Aroesty-Cohen, 2010). In addition to this branch of research, there is a more recent wave of studies concerned with the status of mental health professionals' ontological beliefs about mental health/illness and the effects of these on their work with service-users. These two branches of research will now be considered and critiqued in turn. Previous studies have generally used samples consisting of different mental health professionals and thus the following sections reviewing this evidence will also treat this group as unitary. Moreover, the terms 'mental health', 'mental illness' and 'mental disorder' have been used interchangeably in past research and as such appear inextricably linked (Malek, 2004; Pickering, 2006). Therefore, studies employing these terms were considered relevant and were consequently included in this review.

1.6.1 Effects of healthcare professionals' conceptualisations of mental health on attitudes and behaviours

The most consistent findings of studies examining the consequences of endorsing biological and psychosocial conceptualisations of mental health[4] have been that clinicians subscribing to a more biological perspective perceive service-users as more pathological (Langer & Abelson, 1974), more dangerous (Bennett, Thirlaway & Murray, 2008) and are more likely to perceive mental health problems as untreatable (Herrman, 2001) than those conceptualising mental health in psychosocial terms. Such attitudes held by mental health professionals have been found to be associated with biased diagnostic decisions (Morey & Ochoa, 1989), less optimism about treatment outcomes (Holmqvist, 2000) and decreased quality of treatment (Wallach, 2004). Conversely, healthcare professionals endorsing a psychosocial perspective of mental health have been shown to be more willing to involve service-users in the management of mental health services (Kent & Read, 1998), make more use of non-medical treatments (Cape, Antebi, Standen & Glazebrook, 1994) but also to be more likely to blame service-users for their behaviour (Miresco & Kirmayer, 2006) than clinicians endorsing a biological perspective of mental health.

These findings support the notion that CPs' conceptualisations of mental health have important clinical implications in terms of influencing their attitudes, beliefs and behaviours when working with service-users. However, as outlined, findings have often been inconclusive, inconsistent and in some cases contradictory. This has led researchers to criticise existing studies and the associated arguments may be broadly divided into the following four points. First, previous research has relied upon the *a priori* assumption that mental health is a consensual object of thought about which only attributions may vary. Second, existing experimental studies have tended to offer participants a choice between biological and psychosocial conceptualisations of mental health, thus leaving little or no room for more multifaceted and integrative conceptions of mental health and potentially limiting respondents' viewpoints (Wyatt & Livson, 1994). Third, past studies have tended to employ questionnaires and vignettes, methodologies widely recognised to capture idealised rather than actual

[4] A comprehensive account of the literature examining the implications of clinicians' subscription to biological and psychosocial conceptualisations of mental health is beyond the scope of this literature review but is available elsewhere (e.g., Schulze, 2007; Wahl & Aroesty-Cohen, 2010).

attitudes due to social desirability effects (Link, Yang, Phelan & Collins, 2004). Finally, the methodologies used to assess healthcare professionals' conceptualisations of mental health have addressed the issue from a naturalist point of view, assuming that the boundaries between mental health and illness are matters of natural fact that can be examined and determined through the use of rigorous scientific methods. This assumption appears inconsistent with findings from more recent research suggesting that some CPs are unwilling to accept mental disorders as real and natural categories, which will now be reviewed.

1.6.2 The ontological status of healthcare professionals' beliefs about mental health and its effects on their work with service-users

Ahn, Flanagan, Marsh and Sanislow (2006) set out to investigate whether and to what extent clinicians believe that mental disorders, compared to medical disorders, are real and possess an 'essence'. The participants were asked to judge whether mental and medical disorders naturally exist in the world or whether they are invented by culture and whether disorders are categorical or dimensional. Participants were also asked to rate the extent to which they believed that each disorder has a defining feature, whether they believed that those features cause symptoms of disorders and whether one needs to target the defining features in order to treat the disorders. The study concluded that clinicians are unwilling to commit to essentialist beliefs and endorse mental disorders as naturally existing concepts, that is, categories to be discovered in the world. The authors speculated that clinicians' unwillingness to subscribe to essentialist accounts might shield them from stigmatising people diagnosed with mental disorders since such categories were viewed as being socially constructed.

Employing a similar methodology, Ahn, Proctor and Flanagan (2009) examined mental health clinicians' ontological beliefs about the mental disorders listed in DSM-IV and the consequences for judging treatment effectiveness. In the first part of the study the authors asked clinicians to rate the extent to which they believed each individual disorder to be biologically based, psychologically based and environmentally based. In the latter part, participants rated the extent to which they felt that psychotherapy or medication would be able to "improve, control, or manage"

the various disorders. The study found that clinicians conceptualise mental disorders along a continuum spanning from non-biological disorders (e.g., adjustment disorders) to biological disorders (e.g., autistic disorders) and that clinicians believe psychotherapy to be more effective for psychosocially based mental disorders and medication more effective for biologically based mental disorders. It was thus concluded that clinicians' ontological beliefs about mental health influence their beliefs about the effectiveness of medication and psychotherapy as well as their choice of treatment options. Kim and Ahn (2002) found that clinicians' concepts of mental disorders are theory based rather than theory-neutral and that they are better at recalling symptoms associated with their individual theories of mental health than symptoms not related to their theories. The authors concluded that clinicians may be biased to falsely remember symptoms central to their theory and that their conceptualisations may thus influence informal initial diagnoses, which in turn may impact on the way in which clinicians perceive and interact with their service-users. For instance, the authors argued, clinicians may be inclined to focus their attention on detecting symptoms that are central to their theories about mental health, an issue of particular importance given that symptoms are often ambiguous.

These studies contribute to knowledge by examining healthcare professionals' conceptualisations of mental health and provide further support for the notion that CPs' conceptualisations of mental health have a range of clinical implications. This is important since similarities between service-users' and mental health professionals' values are associated with therapeutic improvement (e.g., Beutler & Clarkin, 1990; Castonguay & Beutler, 2006) and service-users' views of their difficulties have been found to be shaped by their clinicians (Ahn, Proctor & Flanagan, 2009). Moreover, shared conceptualisations of mental health may help to strengthen the therapeutic alliance, a factor associated with positive outcomes (Martin, Garske & Davis, 2000) and service-user satisfaction (Roberts & Holmes, 1998) across therapies.

1.6.3 Concerns with mental health as a consensual object of thought and the methods used to explore it.

The underlying assumptions of past studies have clearly informed the methods used to collect data, the type of data and results obtained, as well as their perceived

implications and these assumptions will now be considered. One of the implicit assumptions of previous research is that attitudes and beliefs reside internally within individuals and that these can be elicited through appropriate research methods. The studies employed vignettes and questionnaires to explore clinicians' beliefs about mental health and their role in interactions with service-users. This methodology is ideal for obtaining individualistic and categorical data that can be assigned an attitude. However, it may also be criticised for its implicit demand to either endorse or reject a limited list of prescribed responses, leaving little room for articulation of multifaceted beliefs. Through the use of these methodologies, data that does not answer the questions in the predefined format, such as talk or free text comments, is not regarded as suitable for inclusion in the primary analysis. It could thus be argued that through directing participants to express their beliefs about mental health using forced choice attitude scales, the occasioned and variable nature of professionals' conceptualisations of mental health and its effects is obscured and restricted. Indeed, any variability would present difficulties for categorisation and so points to the limitations of conceptualising attitudes or beliefs as inner stable cognitive entities.

It seems that the reviewed studies' assumption regarding the straightforward connection between participants' responses and their beliefs have resulted in a lack of discussion about the context in which participants' accounts are produced. It could be argued that past studies' focus on attitudes as the core unit of analysis have worked to construct an epistemology that produces particular sets of categorical statements about clinicians' beliefs about mental health and the ways that these influence their work with service-users. The methodologies employed could be seen to reinforce the unit of analysis and to dismiss any contextual challenges to its methods as mere contingencies. In this way, individual clinicians are constructed as the core source of meaning and as holding discrete sets of rational attitudes and beliefs that are relatively stable across settings. At the same time, the function of the talk and the impact of social, cultural and situational factors on clinicians' conceptualisations of mental health are marginalised as random contextual and contingent factors external to their beliefs. These issues indicate that past research has failed to explore the performative and contextual aspects of the discourses used by CPs to conceptualise mental health and the perceived effects of these on their

work with service-users.

As previously noted, healthcare professionals' conceptualisations of mental health and their implications have been routinely measured, compared and theorised from a variety of perspectives whilst relying upon the *a priori* assumption that mental health is a consensual object of thought. In this way, even though people hold different attitudes and attributions in relation to mental health the concept itself is not disputed. However, as outlined, the vagueness of the phrase mental health, its multiple uses and contested nature implies that it is very difficult to differentiate its meaning to one individual from another. This raises the potentially controversial question of how it is that people can work as 'mental health professionals' or be diagnosed as having a 'mental health problem' when mental health itself seems to be a conceptually fuzzy and highly ramified term? Moreover, the methodologies employed by past studies have not been sensitive to features of ambivalence, ambiguity and uncertainty in clinicians' sense-making processes, thus potentially simplifying the complex beliefs about mental health that practitioners draw on. These issues raise important questions about the appropriateness and the solidity of the epistemological assumptions that past research has relied on in studying healthcare professionals' ideas about mental health and its influence on their work with service-users.

Furthermore, whilst clinicians' beliefs about mental health and their effects are referred to as an association, the beliefs are also implicitly presented as a causal variable in influencing practitioners' attitudes towards service-users (Wahl & Aroesty-Cohen, 2010), their beliefs about intervention efficacy (Ahn, Proctor & Flanagan, 2009), and the informal initial diagnoses they assign service-users (Kim & Ahn, 2002). The use of standardised and validated questionnaires with demographic tables outlining participants' representativeness of the broader population and complex statistical analyses serves to authenticate the objectivity of the research. Such rhetorical features are typical of an empiricist repertoire (Gilbert & Mulkay, 1984) and, through their use, even though categorisations such as mental health and mental illness may be referred to as 'biopsychosocial entities' or even 'hypothetical constructs', the data involving these categorisations is collected, analysed and

disseminated as if though it exists in the social and psychological world independently of any particular categorisations.

Whilst existing studies have been usefully applied, they appear to have missed domains central to the research question which may help to explain some of their contradictory findings since healthcare professionals' conceptualisations of mental health may not be consistent across social contexts, or indeed, over time. There is extensive research on health (Crossley, 2002; Gillies & Willig, 1997) and beyond (Gilbert & Mulkay, 1984) suggesting that attitudes change even during the same interactions. Such arguments have led researchers to suggest that the variation in the definitions and conceptualisations of mental health appear to represent the different contexts of its reification (Bracken & Thomas, 2005). The observation that people are often inconsistent in their discussions of ideological dilemmas (Billig, 1999), poses difficulties for quantitative methodologies, argued to be insensitive to variability in participants' accounts (Wetherell, Taylor & Yates, 2001). The present study is not suggesting that the naturalist assumptions that previous research has relied on are inherently wrong. Instead, it is proposing that it is necessary to examine the assumptions that underpin CPs' conceptualisations of mental health in order to gain a better understanding of the function of these and the effect they may have on their work with service-users. For this purpose, it is argued that the examination of mental health requires a radically different methodological framework from the positivist approach that has been applied historically to explore healthcare professionals' conceptualisations of mental health. In particular, it will be suggested that CPs' accounts of mental health and their effects can be productively explored by focussing on the ways in which these are discursively constructed through employing a social constructionist epistemology, which will be considered next[5].

1.7 Mental health from a social constructionist lens

In recent years, there has been a general shift towards qualitative research; a shift

[5] It seems useful at this stage to draw a distinction between critique and deconstruction: critique challenges statements by working within the same world of assumptions; deconstruction, in contrast, explores those very assumptions (Spivak, 1990). This thesis is deconstructive in the sense that rather than assuming that the entity of mental health exists, it seeks to understand how the concept is produced.

largely fuelled by the postmodernist critique of positivism and it is increasingly acknowledged that such a framework provides a useful alternative to quantitative research in the study of psychological processes (e.g., McLeod, 2001; Toukmainian & Rennie, 1992). In particular, there has been a move towards developing research approaches drawing on social constructionism, which suggests that all aspects of human functioning are produced and reproduced through social interactions in specific cultural and historical contexts (Burr, 1995). Social constructionism holds a relativist position with regard to truth, implying that knowledge is never value-neutral as it is considered to be located within and constrained by particular historical and sociocultural contexts. Social constructionism therefore considers scientific enquiry not as an objective pursuit of truth but rather as a social institution that actively and systematically constructs particular versions of truth and reality. The approach thus assumes a critical stance towards taken-for-granted or 'common sense' knowledge and is committed to analysing and problematising the naturalisation of such discourses through the process of active deconstruction (Frosh, Burck, Stricklan-Clark & Morgan, 1996) (see section 2.1 for a more comprehensive account of social constructionism and the epistemological assumptions of this study). As such, it is concerned with the social and interpersonal categories that individuals bring into existence in talking about their minds to others (Edwards & Potter, 1992).

There appears to be a number of advantages of employing a social constructionist framework in the study of CPs' constructions of mental health and its effects. First, because language is not viewed as representing truth or the real experience of the speaker, adopting a social constructionist position implies that rather than attempting to establish 'correct' or 'true' accounts, it allows for the examination of what is achieved in talk and how versions of truth are constructed, argued and authenticated in discourse (Willig, 2008). This focus on the performative aspects of discourse suggests that rather than being seen as a consistent and accurate representation of individuals' attitudes, talk may instead be viewed as produced to meet particular interactional demands. Second, because talk is viewed as oriented towards social action, it changes according to time, function and the social conditions in which it is situated. This means that instead of viewing CPs' accounts of mental health as being located in the individual and as separate from their context, accounts can be viewed

from within the complexity of social interactions in which it takes place. The study of mental health 'itself' is thus replaced by a study of the ways in which CPs represent or construct mental health through their use of language in particular contexts. Lastly, as implicitly implied by the first two assumptions, attitudinal variability is viewed as an inherent property of accounts since people perform different conversational actions with their talk depending on the contexts in which they are speaking (Austin, 1962). The approach thus aims to facilitate variability, disagreement and contradiction in people's accounts as this is considered to provide important clues about the contextual, functional, and argumentative features of the discourse being analysed, not as a problem to be solved, controlled or avoided as assumed in traditional cognitive research (Potter & Wetherell, 1987).

1.8 New wave of social constructionist studies

In response to the call for a change in methodology, there is a new wave of studies underpinned by a shared recognition of the role of context and language in negotiating, confirming and challenging social realities. The majority of such studies have focussed on the therapist - service-user interaction and the ways in which therapy is performed including the rhetorical strategies used by therapists and the effects of interventions on service-users' narratives (see Avdi & Georgaca, 2007 for a review). However, there is also an increasing body of social constructionist research concerned with the ways in which psychological discourses constitute and regulate 'mental health' (Foucault, 1967; Guterman, 1994; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Zeeman & Simons, 2011) and its specific diagnostic categories such as 'eating disorders' (Malson, Finn, Treasure, Clarke & Anderson, 2004), 'schizophrenia' (Boyle, 2002) and 'depression' (Stoppard, 2000). In particular there is a wave of empirical studies informed by social constructionist ideas concerned with the accounts of health professionals (e.g., Griffiths & Hughes, 2000; Parker, Georgaca, Harper, McLaughlin & Stowell-Smith, 1995; Soyland, 1995). Given their methodological focus on the inherent variability of accounts, such studies have focussed on the ways in which contested issues are constructed by professionals. Examples of these studies include an analysis of how professional scientific rhetoric is employed to construct recipients of electro-convulsive therapy as severely ill (Stevens & Harper, 2007), an examination of how professional accounts of

psychiatric medication may be employed to serve rhetorical and persuasive functions in managing questions about its efficacy (Harper, 1999a), a critique of how the definition of mental disorder is constructed in the DSM-IV and its implications for how normality is constructed (Crowe, 2000), a study of how psychiatric diagnoses are produced in professional discourse (Wooffitt & Allistone, 2005), and an exploration of the ways in which the professional use of psychological terms and production of a psychiatric diagnosis can be the site of discursive struggle (McHoul & Rapley, 2005). These studies comprise the background to the present thesis, which itself forms part of a broader 'discursive turn' within mental health (Gergen, 1990; Harre & Gillet, 1994; Radley & Billig, 1996).

1.9 Section summary

The literature reviewed in this introduction has outlined the ways in which professional discourse on mental health and its effects is characterised by conflicts and confusion, reflecting the inherent complexity of the topic. CPs' conceptualisations of mental health and its effects on their work with service-users have been found to be diverse and reflective of the biasing filters of the methods used to make sense of the topic. In particular, it has been argued that the methodologies employed by past studies have not been sensitive to the function, variability and context of participants' accounts and that an alternative methodology drawing on social constructionist ideas is therefore more suitable. It has been suggested that the adoption of such an approach enables the exploration of the research question whilst paying attention to the functions of CPs' talk, the different issues attended to and the ways in which their talk is situated by the social and historical context in which it takes place. These issues will be further discussed in the extended methodology. The aim of this study was thus to explore CPs' constructions of mental health and its impact on their work with service-users.

Part Two: Extended Methodology

2.1 Section introduction

In the literature review, the ways in which conceptualisations of mental health have differed across time and contexts were identified and I outlined how I came to appreciate the great variability in the definition of mental health. This variability has been regarded as problematic by past research approaching the issue from a positivist framework[6] seeking to construct a generalised version of participants' accounts where consistency is seen as evidence of generalisability. It has been argued that because psychological constructs such as mental health are represented through linguistic labels, which are bound by time and culture and reified through their use, they are thus intrinsically variable. An alternative approach sensitive to variability and people's use of language was therefore proposed and this section will detail the epistemology and methodology that is being used. This will be followed by an outline of methods employed, the procedure of the study, ethical considerations and a discussion of quality issues in qualitative research.

2.2 Epistemology: social constructionism

Throughout my training in psychology with its clear emphasis on empiricism I was taught that there are innate discoverable psychological essences or 'truths' that we as researchers can come to know through the process of carrying out carefully designed experiments. However, my study of conceptualisations of mental health has opened my eyes to an alternative framework which views our understanding of the world as derived not from an objective reality but from other people (Burr, 1995). From such a social constructionist perspective, variability is not viewed as an obstacle but as the central feature of interest. Similarly, language is not thought of as a tool to discover mental states as proposed in cognitive psychology but rather as a social action used to manage and create reality (Elliott, Fischer & Rennie, 1999). This is in line with Burr's assertion that 'knowledge is, therefore, seen not as something that a person has (or does not have), but as something that people do together' (1995, p.8). This study adopts a social constructionist epistemology assuming that people come to understand the world in terms of their views, and that these are

[6] Positivist frameworks are based on the assumption that there is an objective 'reality' which researchers can come to know through the use of traditional empirical methods.

interactionally and communicatively produced (Gergen, 1999). From this perspective, the various possible accounts of the 'nature of the world' are viewed as constructions in themselves and are therefore best understood in terms of their functional nature in specific contexts. Since the aim study of this study was to explore CPs' constructions of mental health and its effects, a methodology sensitive to variability through the medium of language was favoured to explore how such constructions are represented.

2.3 Methodology

A number of different approaches including Interpretative Phenomenological Analysis (IPA), Conversation Analysis (CA) and Discourse Analysis (DA) were considered in the process of designing this study. IPA is concerned with producing accounts of individuals' subjective experiences of the world and this research was less interested in CP's subjective experiences and more with how they produced or constructed their accounts of mental health and its effects (Smith, Flowers, & Larkin, 2009). CA is mainly focussed on the micro-features of conversation whereas this research aimed to situate the data within its wider context and so for these reasons DA was deemed the most appropriate framework (Potter & Wetherell, 1987; Sacks, Schegloff & Jefferson, 1974).

2.3.1 Discourse analysis

Discourse analysis (DA) is a blanket term for various different frameworks[7] that developed through a critique of the ideas of cognitivism and the notion that people's language reflects their underlying thoughts and feelings (Willig, 2008). Instead, language is viewed as a device used to manage social interactions and construct social realities and DA enables questions to be asked about the actions performed by the use of language. In short, discourse analysts are concerned with how descriptions, accounts and arguments are organised and what is gained by these constructions (Potter & Wetherell, 1987). This has led Billig (1997, p.43) to suggest

[7] These include, amongst others, Foucauldian DA (FDA), Critical DA (CDA) and Discursive Psychology (DP). An in-depth review of DA approaches is beyond the scope of this study but can be found elsewhere (e.g., Cameron, 2001; Rapley, 2007; Wetherell, Taylor & Yates, 2001; Willig, 2008)

that DA is not only a methodology as "it involves a theoretical way of understanding the nature of discourse and the nature of psychological phenomena".

2.3.2 Discursive psychology

This study adopted the theory and methods of discursive psychology (DP), which differs from other forms of discourse analytic approaches in its emphasis on how psychological themes are utilised and has been described as "the application of discourse analytic principles to psychological topics" (Edwards & Potter, 2001, p.12). The approach stresses the primacy of discourse as a medium for action and draws on the principles of ethnomethodology[8] (Garfinkel, 1967), conversation analysis (CA) (Sacks, Schegloff & Jefferson, 1974) and Wittgenstein's (1967) philosophy of mind. Discursive psychology differs from more traditional psychological approaches that view discourse as representative of a form of communication that takes place between minds that exist *a priori*. Rather than conceptualising discourse as neutral mirrors of reality or as confounding variables that need to be controlled, discursive psychology views discourse as something worthy of study in itself without regard to any presumed underlying representation or structure. The discursive psychology approach taken in this study focusses on how meaning is created through the use of language within social interaction and assumes that discourse is action-orientated, situated and constructed and each of these features will now be considered in turn (Edwards & Potter, 2001).

Action-oriented

The discursive psychological approach to language is informed by Wittgenstein's notion of "language-games" (1967) in that it recognises the importance of considering the different actions performed by the infinite variety of statements that people can make in any given context (Potter, 1996). Language is viewed as active, constitutive and committed to a purpose rather than as a path to discover how users of language think or feel about something. Specifically, the approach is concerned with how individuals construct what they say in order to serve particular interests or perform certain functions (Potter & Wetherell, 1987).

[8] Within the approach, discourse is generally conceptualised as all forms of spoken interaction and written text (Potter & Wetherell, 1987).

Situated

Given the potentially infinite variability of discourse, the context to which it is bound, or situated within, has been argued to be central to its understanding (Hepburn & Potter, 2003). Discourse may be situated in a number of different ways. Firstly, rather than being neutral descriptions of the way things actually are, people's accounts are often made in relation to other possible alternatives and so are constructed to consider the risks of being viewed as contentious or false (Edwards, 1997). Therefore, the discursive psychological approach emphasises the importance of paying attention to the rhetorical organisation of discourse (Billig, 1987). Secondly, the approach concurs with the conversation analytic notion that discourse can be a function of its social setting and sequential positioning and the interactional framework of the discourse thus needs to be taken into account (Sacks, Schegloff & Jefferson, 1974). Lastly, not only the discourse produced in any given context but also what might be omitted or "what could have been said" should be considered in order to understand its meaning (Potter & Wetherell, 1987).

Constructed

Discursive psychology assumes an epistemic rather than an ontological position with regard to social constructionism and therefore differs from other constructionist approaches (Potter & Edwards, 2003). In this way, the central feature of interest is the constructive nature of accounts as opposed to what might exist beyond them. Thus, in considering conceptualisations of mental health, the approach considers these to be constructed rather than representing an accurate description of individuals' inner mental states. Discursive psychology enables an exploration of how people utilise language to perform social actions and may thus offer an increased understanding of the processes by which mental health is 'talked into being' (Antaki & Widdicombe, 1998; Willig, 2008). However, as noted by Wittgenstein, "interpretations by themselves do not determine meaning" (1967, p.198) and the constructive nature of the current study and the ways in which the interpretation and analysis of the data are, in themselves, constructed to achieve particular aims must consequently be acknowledged.

2.3.4 Discursive psychology and constructions of mental health

A discursive psychology approach was adopted to explore variability in CP's constructions of mental health in order to gain an increased understanding of patterns of meaning and interpretation in their accounts. Discursive psychology is concerned with the different manners in which mental health may be talked about and the implications of such variations and therefore differs from previous research, which has tended to be of a quantitative nature. Since conceptualisations of mental health are produced almost entirely within language, it is argued that adopting a discursive psychology approach is particularly appropriate for the present purpose. The approach allows for the variability and fluidity of CPs' discourse to be captured while paying attention to the contextual nature of mental health accounts (Seymour-Smith, 2008). As noted by Edwards and Potter (1992), rather than being viewed as an explanatory resource, discursive psychology enables an examination of how language is used for specific purposes in talking about contested issues. Mental health is one such issue and a discursive examination was thus used to shed light on the communicative practices, verbal strategies and common assumptions drawn on by CPs in producing their accounts of mental health and its perceived impact on their work with service-users. In line with its epistemological position, the aim of this study was not to produce knowledge of what mental health is or isn't but rather to gain an increased understanding of the processes by which mental health is talked into being. Indeed, Harper (1994) suggested that discursive approaches are useful in deconstructing discourses as they allow for an examination of implicit oppositions in people's accounts, such as between the normal and the pathological. Moreover, there is an increasing amount of discourse analytical studies concerned with contested issues within psychology to which this research aims to contribute.

Critics of discursive approaches have argued that its analyses aren't sufficiently grounded and that DA studies thereby risk over-interpreting data. In response to such arguments, researchers have proposed that all semantic phenomena have multiple causes and that studies rooted in a logical positivist tradition may thus be over-determining data (Burman & Parker, 1993). Indeed, the social constructionist epistemology associated with discursive approaches rejects the notion of any completely grounded 'final' version of reality and discursive writers are careful not to

assert that their interpretations or findings represent universal and timeless truths. However, rather than arguing that everything is relative and that 'anything goes', it has been suggested that it may be a case of 'nothing goes' in that all alternatives have both inherent possibilities and dangers (Stenner & Eccleston, 1994). Thus, instead of subscribing to the extreme relativist argument that no comparative evaluations can be made, discursive analysts aim to elaborate and problematise the criteria against which the quality of analyses is measured (Harper, 1999b). This issue is given further consideration in section 2.7.

2.4 Methods

2.4.1 Design

To allow for the varied and contested accounts of mental health to be explored, a qualitative research design sensitive to participants' language use was considered the most appropriate. The details of the methods employed in this study will be outlined in the following five sections: collection of data through semi-structured interviews, recruitment, sample size, sample and materials.

2.4.2 Semi-structured interviews

The appropriateness of using semi-structured interviews in discursive research has been debated and "naturally occurring talk" is frequently preferred, although the meaning of this term is a contentious issue[9] (Potter & Hepburn, 2005).

In particular, it has been argued that the use of interviews produce a certain kind of interaction as participants invariably orient towards the interview situation thus revealing more about the manners in which participants manage their stakes as interviewees than about the discursive strategies used in everyday life (Willig, 2008). However, it has also been suggested that semi-structured interviews are able to identify more informal use of discursive resources (Gilbert & Mulkay, 1984) and enable researchers to purposely question a sample on the same issues rendering it a good way of generating rich data about the social world (Gubrium & Holstein, 2003). The aim of the current study was to examine CPs' conceptualisations of mental

[9] Critics have argued that research-prompted data is a contrived artefact and that the process of obtaining informed consent and using recording equipment by its very nature contaminate the purity of naturally occurring data, thus rendering the concept meaningless (Speer, 2002).

health and its perceived effect on their work with service-users, a topic that participants might not have felt comfortable discussing if a different methodology was employed (such as focus groups). As such, semi-structured interviews were thought to provide participants with a safe, confidential and flexible space sensitive to complexity and variability in participants' accounts. One-to-one semi-structured interviews are also the most commonly employed method of capturing individuals' discourse in DA research (Wetherell, Taylor & Yates, 2001). On this basis, semi-structured interviews were considered to be most appropriate method for gathering data. Consistent with the epistemological framework, the interviews are not regarded as accurate descriptions or truth claims but rather as important in constructing the data in itself. In line with this, the interviewer and interviewee are viewed as co-constructing the contingent sense-making and the interviews are thus considered as conversations rather than elicitations (Willig, 2008) (see Part 5 and Appendix I for statements on reflexivity). However, taking into account Cameron's (2001) suggestion that participants respond to questions on the basis of what they perceive the researcher's motive to be, my involvement in the interviews in terms of questions and prompts was intentionally kept to a minimum and a facilitative rather than a argumentative style was adopted.

2.4.3 Recruitment

This project was interested in CPs' constructions of mental health and its influence on their work with service-users and the study thus sought to recruit accredited CPs with direct contact with service-users as part of their work role. Participants who did not meet this standard were excluded based on their answers to the following questions: "Are you registered as a Clinical Psychologist with the HPC?" and "Do you have direct contact with service-users as part of your current role?"

A purposive maximum-variation sampling strategy (Pickard, 2007) was used in that CPs working in a variety of different settings were invited to take part in the study. In line with Merriam's (1998) suggestion that purposive sampling enables researchers to ensure that participants add different perspectives, it was hoped that recruiting participants from various services would allow the different positions and discourses about mental health available to CPs to be identified. After gaining ethical approval

(see section 2.6), CPs in the East Midlands region known to the researchers were sent an email inviting them to take part in the study. The respondents expressing an interest were then sent information packs containing information about the research through email and the practical arrangements for the interviews were agreed on. Before the start of the interviews participants were reminded of the research aims, the interview process and the equipment being used to record the interviews. Prior to completing the consent forms, participants were also asked if they had any questions about the research and whether they had understood the aims of the study.

2.4.4 Sample size

It has been suggested that because extensive variations in linguistic patterning can emerge from a small amount of people, a large sample size may not add to the analytic outcomes but instead render the process of analysis unmanageable (Potter & Wetherell, 1987). Indeed, a number of researchers have noted that discursive psychology methods require smaller sample sizes compared to quantitative approaches since the success of such studies are dependent not on the amount of data but on the research question asked and depth of the analysis carried out (Potter & Wetherell, 1987; Seymour-Smith, 2008). Previous published studies employing discursive approaches have tended to use sample sizes of between five and fifteen participants and so a sample size of ten CPs was deemed appropriate (Madill, Gough, Lawton & Stratton, 2005). This sample size is also consistent with previous discursive research specifically designed to explore issues related to professionals' accounts of mental health (e.g., Harper, 1995).

2.4.5 Sample

Eleven semi-structured interviews were conducted with CPs who volunteered to take part in the study and who self-identified as working directly with service-users. Overall, the sample represented diversity with regard to service-user groups, clinical settings and length of clinical experience as detailed in the journal paper.

2.4.6 Materials: interview schedule

The development of the interview schedule was informed by the literature review, the pilot study and discussions with the research supervisors and current government

policy on mental health such as “No Health Without Mental Health” (Department of Health, 2011). The interview schedule was designed to broadly cover five areas related to the research question in order to elicit a range of talk around mental health whilst still allowing the participants to elaborate and introduce new aspects to the study (see Appendix D). These areas included participants’ understandings of mental health and how these related to their service context and colleagues’ clinical practice, the factors perceived to be associated with conceptualisations of mental health and the ways in which views about mental health were considered to influence participants’ work with service-users. Due to the exploratory nature of the study, the questions were intentionally kept broad and were revised in line with the iterative process of the methodology (Potter & Wetherell, 1987). Cameron (2001) suggested that researchers need to maintain a degree of control during interviews whilst giving participants the opportunity to redefine the research topic as this may generate new insights. Taking this into account, open-ended questions were used to provide a flexible interview space within which the participants could communicate different representations and introduce new directions to the interviews other than those directly addressed by the researcher.

2.4.7 Materials: demographic information sheet

It has been argued that including basic demographic information in studies using discursive approaches allows readers to situate the sample and to evaluate the relevance of findings (Elliott, Fischer & Rennie, 1999). For this reason, a demographic information form was included to collect the following data using self-completion questionnaires: age, gender, area of work, years since qualification, the number of hours spent providing supervision every month and the number of hours of the work-week spent in direct contact with service-users (see Appendix C).

2.4.8 Materials: recording and transcription equipment

The interviews were recorded on an Olympus DS-30 digital voice recorder and transferred to a personal computer. The interviews were then transcribed using an Olympus AS-2300 transcription kit as well as an external transcription service.

2.5 Procedure

2.5.1 Interview preparation

Prior to conducting the interviews, participants were given the opportunity to go through the information sheet again and to raise any questions or concerns. A consent form (see Appendix B) stating the potential risks of study participation, participants' rights to withdraw from the study without penalty, and the anonymous nature of their responses was then distributed to be signed prior to participation and this was the only item containing personally identifiable information. The consent forms were stored in a locked cabinet following the interviews. A demographic questionnaire asking participants to indicate their age, gender, area of work, years since qualifying and the number of hours spent in direct contact with service-users and providing supervision was then completed and these were stored separate from the consent forms. The demographic forms were anonymised using individual identification codes and these were also employed in the transcription of the digital recordings of the interviews. Lastly, participants were reminded of the research aims, the interview process and the equipment being used to record the interviews.

2.5.2 Pilot study

In order to examine whether the interview schedule achieved its aim it was piloted using two one-to-one interviews. These interviews were then transcribed and discussed with the research supervisors and it was agreed that the interview schedule was able to capture participants' responses in a manner relevant to the research aims. However, throughout the pilot interviews I found myself repeatedly prompting the participants and thereby potentially closing down the avenues available to interviewees in responding to my questions. For this reason, ways to minimise the extent to which I was steering the direction of participants' accounts were discussed with the research supervisors in an effort to generate richer data in further interviews.

2.5.3 Semi-structured interviews

In line with the notion that naturalistic settings are to be favoured when using discursive psychology (Potter & Hepburn, 2005), the interviews were conducted in settings familiar to the participants wherever possible. The interviews were carried out over a five-month period in 2012 (February to June). The duration of the

interviews ranged from approximately 40 minutes to 110 minutes (with an average session duration of about 72 minutes).

2.5.4 Interview schedule

In order to afford a greater degree of comparability and to make the task of coding and searching through the transcripts for variations and patterns in responses more manageable, all participants were asked a similar set of questions. However, the development of the discussion depended on participants' replies and so the sequence of questioning varied somewhat from interview to interview in order to allow participants to expand on their ideas informally. My known and accepted position as a trainee CP, and consequent interest in learning from other CPs was used to facilitate this process. In line with the epistemological position adopted, the interviews were viewed as an opportunity to explore participants' discursive practices rather than as a means to access veridical accounts. The progress through the interview schedule was informed by changes in the interactional nature of the interview and questioning techniques included probing for in-depth details, clarification and asking follow-up questions in order to generate data rich in variation and diversity, considered integral to the epistemology of DP (Potter & Wetherell, 1987; Silverman, 2001). Again, it needs to be noted that in eliciting diverse responses from participants I inevitably influenced the interactive process although this impact was kept to a minimum through limiting my responses where appropriate.

2.5.5 Transcription and analysis

Based on Willig's (2008) suggestion that the process of transcription inevitably transforms the interview data as the transcripts can never be an exact representation of the interviews themselves, I transcribed five of the recordings myself. This allowed me to engage with the process of transcribing the data and to reflect on it and as such may be viewed as a first stage of analysis (Cameron, 2001). An external transcription service was also used to transcribe the interviews and the quality of these was then evaluated against the audio recordings and my original transcripts. Since the aim of the analysis was to explore rhetorical function and discourse, a simplified form of Jeffersonian transcription notation was used (Rapley, 2007; Appendix E). This system is commonly employed by discourse analysts as it can be adapted in accordance with the amount of detail required (Kitzinger & Frith, 2001).

The audio recordings of the interviews were transcribed verbatim using 10-20 hours per one hour of interview and the transcripts were headed with participants' pseudonyms and numbered for reference purposes.

The focus of the analysis was on the language used by CPs in talking about their ideas around mental health and its influence on their work with service-users and the constructions used to evaluate this link. As such, the analysis focussed on how participants' talk was organised, the constructions produced in the talk and the discourses and discursive strategies drawn on (Horton-Salway, 2001). In order to make the process of analysis more manageable, the discourses generated in the talk related to the interview questions were first saved in a data file. As part of this process, conversational talk before and after the interview concerning issues not relevant to the research was eliminated. It is at this point important to keep in mind that in discursive examinations of data, consistency is relevant only in the context of recognising patterns in language use (Potter & Wetherell, 1987). Indeed, consistency in responses may indicate that there is a limited set of discursive resources available to participants. However, the primary focus of the analysis is on the variation in responses. As noted by Potter and Wetherell (1987), analysis of discourse should not be carried out mechanically but rather involves reading and re-reading transcripts whilst paying particular attention to patterns of language use in the data. In order to orient my reading and guide the analysis of the interviews, I developed a template listing a number of analytic questions based on past researchers' suggestions (see Appendix G). The data corpus was read twice, coded and systematically explored using this analytic framework paying particular attention to how the text constructed its objects and subjects (context) and how such constructs varied across discursive contexts (variability). The attention of the analysis to the dimensions of context and variability allowed me to trace the effects of participants' accounts of mental health (action orientation) (Potter & Wetherell, 1987). The analysis assumed that 'mental health' was not simply talked about by participants but also constituted through their discourse., Throughout the analytic process I asked myself; why am I reading the text in this way, what is being assumed in the passage and what discursive features produce this reading (see Appendix H for a more detailed account of the analytic process).

2.6 Ethical considerations

This study obtained ethical approval from the Institute of Work, Health and Organisations at the University of Nottingham, United Kingdom on the 2nd December 2011 (see Appendix F).

2.6.1 Confidentiality

Given that studies employing qualitative methodologies frequently contain detailed descriptions of participants' experiences, confidentiality was given considerable consideration throughout the research process. Ethical considerations such as the recording of the interviews, the use of direct quotes in the write-up and the storage of data were discussed with participants before the interviews and also outlined on the information sheet and detailed on the consent form. Participants were also informed that any identifiable information (e.g., names of people and places) would be altered to maintain anonymity.

2.6.2 Informed consent

Prior to signing the informed consent form, participants were asked if they had any questions about the research and whether they had understood the aims of the research. The consent form explained the voluntary nature of participation, the right to withdraw or stop being a part of the study up to two weeks after the date of the interview and that anonymous direct quotes from the interviews may be used in the study reports and future publications (see Appendix B).

2.6.3 Risk of harm

Given the general nature of the questions, it was considered unlikely that the study would cause distress to participants. However, as explained on the information sheet, there was an option to request additional support from the research supervisors who are qualified health professionals for participants experiencing distress as a result of participation.

2.7 Quality issues

As outlined, this study adopted a social constructionist epistemology, which favours the existence of multiple, equally valid interpretations of knowledge thus rejecting the

notion of 'absolute truth' that logical positivist research is measured against. This epistemological difference has considerable implications for evaluating the quality of the study. For instance, since the researcher and the participants are not viewed as independent entities, the absence of bias or the notion of objectivity is not considered a meaningful criterion for determining its quality. Researchers have noted that applying quantitative measures such as validity and reliability to evaluate qualitative studies that approach knowledge from a relativist viewpoint is contradictory to its epistemological assumptions and thus meaningless (Reicher, 2000). Given that research adopting a relativist epistemology cannot be evaluated using the same, established standards of quality employed within realist frameworks, some researchers have questioned the validity of discursive psychology examinations (Elliott, Fischer & Rennie, 1999). Such methodological controversies has led to the development of various frameworks with which to evaluate the quality of qualitative research (Willig, 2008), although to date no unitary approach exists, arguably reflecting the various epistemologies employed within the qualitative paradigm (Taylor, 2001). Madill, Jordan and Shirley (2000) suggested that because there is no such thing as a unified qualitative paradigm, the quality of qualitative research should be evaluated by the logic of justification associated with the study's epistemology. Clearly, in order to evaluate the contribution to knowledge of a piece of qualitative research, the objectives of the study and the type of knowledge that it aims to produce must be taken into account.

The epistemological position adopted in this study assumes that knowledge is necessarily contextual with the implication that, depending on their context and background, different people may interpret the same talk differently (Seale, 1998). The notion that research methods are able to access entities such as thoughts, feelings and experiences[10] is thus rejected and quality criteria concerned with the reliability, accuracy or authenticity of perspectives are therefore considered meaningless. Importantly, this is not the same as proposing that "any interpretation is as good as another" (Madill, Jordan & Shirley, 2000 p. 13). The focus of discourse analysis is to explore an interpretation of discourse and the discursive practices that

[10] It is noteworthy that within DP, the category of 'experience' is commonly viewed as a discursive move by which speakers refer to their 'experiences' to validate their claims.

constitute knowledge (Phillips & Hardy, 2002). It has been noted that such research needs to be evaluated on its own terms (Reicher, 2000) and that discursive examinations are best evaluated by assessing the quality of the accounts they produce (Willig, 2008). For this purpose, criteria of internal coherence, deviant case analysis, openness to reader evaluation and trustworthiness have been introduced as meaningful ways of evaluating the quality of discursive research and each of these will now be considered in turn (Madill, Jordan & Shirley, 2000).

2.7.1 Internal coherence

Internal coherence refers to the degree to which the analysis of the study 'hangs together' and does not contain major contradictions. However, as noted, since mental health is assumed to be socially constructed, I would not expect consistency in the way that CPs' talk about their understanding of mental health and its impact on their work with service-users. Rather, the analytical claims made in the study about the discourse should in a coherent manner demonstrate how CPs deploy discursive strategies to construct mental health and its effect on their clinical practice. It must however be acknowledged that I, as a researcher, may alter my understanding of what the data is doing through the process of completing this thesis. This, in turn, may result in inconsistencies, an issue that has led Madill, Jordan and Shirley (2000) to propose an alternative criterion for demonstrating internal coherency through "the absence of abhorrent contradictions" (p. 13).

2.7.2 Deviant case analysis

The quality criterion of deviant case analysis refers to the process of seeking out material that seems to challenge the developing theory or pose exceptions to the analytical scheme (Potter & Hepburn, 2005). It has been suggested that engaging in deviant case analysis allows the researcher to further demonstrate the coherency of the study (Potter & Hepburn, 2005; Potter & Wetherell, 1987). It was for this reason that CPs working in a diverse range of settings were recruited to the study so that potentially contrary cases would be included to aid in testing and qualifying the findings of the study. In this study, there were a number of exceptions to the prevalent discourses in CPs accounts of mental health and its effect on their clinical practice. These deviant cases are given further attention in the results section to

validate the analytical claims being made (see section 3.8).

2.7.3 Openness to reader evaluation

The validity of discursive research is commonly referred to as the extent to which it demonstrates systematic transparency and openness to reader evaluation (Potter & Wetherell, 1987). To address this point, I avoided assuming a neutral stance through disclosing my own epistemological underpinnings, assumptions and biases. The ways in which the analytic process was affected by my perspective was considered throughout the study by adding a reflexivity section and it was also my reason for writing in first person as it has been argued that the researcher becomes detached from the research process by using the third person[11] (Parker, 1998). In line with Burr's (1995) suggestions for increasing the transparency of discursive examinations, the methodological processes and analytic procedure were described in detail, including exceptions and variations and acknowledging novel questions that these brought to the research. In order to enable readers to evaluate the arguments presented and to facilitate their own interpretations, all findings were based in the data and extracts from the text were also offered alongside each discussion point (Potter & Wetherell, 1987). All of these measures were taken to encourage a reflexive exchange about the interpretative procedures and the methods of analysis (Flick, 2006). It was hoped that this transparency will enable readers to interpret the steps of the analysis, to think of possible alternative interpretations, and to assess the fit between the data and the researcher's interpretations.

2.7.4 Trustworthiness

In line with Yardley's (2000) recommendations for increasing the credibility of qualitative research, my interpretations of the transcripts and the analysis were discussed in detail with the research supervisors who were experienced in discourse analysis. These regular supervision sessions functioned as a sounding board to see whether my supervisors were able to follow my reading of the data, thereby indicating the extent to which my analyses were linked to the actual data. As noted by Harper (1999b), by assuming that another researcher could come along and provide the

[11] Indeed, from a discursive point of view, the use of the third person may be viewed as a rhetorical device that works to obscure the context of research and to reify the product of the research.

same analysis there is a danger of creeping positivism as it ignores the impact of my own background and my detailed reading of the literature prior to the analysis. This criterion was therefore conceptualised as the extent to which my reading of the data could be followed, not that it could be repeated. The issue of subjectivity was also managed through the use of a reflexive diary. In addition, as suggested by Hayes and Oppenheim (1997), an “audit trail” was employed throughout the research process to account for changes to methodology and strategy in order to increase its trustworthiness. This study adopted a social constructionist stance assuming multiple, equally valid interpretations of knowledge implying that different people might produce different readings of the data. For this reason, member-checking, or evaluating the accuracy of the results with participants following the analysis, was not deemed an appropriate quality criterion.

Part Three: Extended Analysis and Discussion

3.1 Section introduction

In order to orientate the reader and contextualise the analysis and discussion presented in this section[12], the findings presented in the journal paper will be discussed briefly. In the journal paper two aspects of CPs' talk that were pervasive across the data were presented. First, the ways in which CPs construct accounts of mental health through building up biological factors and psychosocial aspects as opposite ends of the spectrum, and positioning themselves as distant from both extremes to manage issues of stake and accountability were considered. Second, how drawing on a discourse of moral concern for service-users allows CPs to negotiate the implications of having different views of mental health, thus demonstrating their ability to be helpful to service-users was analysed. In this section, these two topics will be expanded on and other findings that were identified in CPs' talk about mental health will also be discussed. In doing so, I will first analyse and discuss the dominant constructions of mental health that arose in the interviews. These include 'multifactorial accounts of mental health', 'mental health as a physical illness' and 'mental health as a social construction'. Second, I will examine the issues evident in CPs' talk about the effects of their views about mental health on their work with service-users. In this section the dilemmas of whether to disclose views about mental health and whether to challenge service-users' assumptions will be discussed. It is hoped that this will further elucidate the features of CPs' constructions of mental health and its influence on their clinical work and the variability that occurred within the talk.

The aim of this section is to outline and describe some of the constructions and resources CPs use in their talk about mental health. These have been mapped out from the reading and re-reading of the data corpus whilst drawing on wider research literature. I am not suggesting that this section includes all of the possible stories and positions available to CPs about mental health. To the contrary, the large magnitude of data collected for this thesis and the limited word count has meant that I as a (novice) researcher have had to be necessarily selective in what is presented. Nor

[12] As is common practice in discursive research, discussion will be included alongside the analysis in this section (e.g., Seymour-Smith, 2008; Stevens & Harper, 2007; Taylor, 2001).

am I suggesting that this is the only possible reading of the data. Clearly, a different researcher may notice different features of the data and so produce a very different analysis. It is also likely that if I were to re-visit the data in the future, I might find very different things. Instead, it is hoped that this section offers a way into an analysis of CPs' talk about mental health thus serving a hermeneutic value as well as providing a starting point for 'troubling' talk about mental health (Harper, 1999b).

A recurrent feature of CPs' talk was that they appeared surprised and confounded by my question about their understanding of mental health as indicated by laughter, clarifications and repetitions of the question. This occurred frequently across the interviews, which is noteworthy since all participants were told that they would be asked about their ideas about mental health before agreeing to take part in the study. A possible interpretation of these responses is that mental health, as indicated in the literature review, is such a vague and ambiguous term that it poses difficulties for people attempting to explain it. It is also possible that participants felt nervous or threatened since, in their role as mental health professionals, they might be expected to be able to answer this question in an authoritative manner. Indeed, such features of accounts have been suggested to be typical of talk about sensitive and difficult topics (van Dijk, 1984).

3.2 Multifactorial accounts and the biopsychosocial model

Potter and Wetherell (1987) argued that accounts are constructed to perform certain functions or serve particular interests and that these can become more visible through delineating the different positions that we take up in our use of language. However, not only do we position ourselves but we are also positioned by others (for instance, by me as an interviewer) and by the wider discourses and institutions available at any given time (Davies & Harré, 1990). Therefore, to avoid falling into the trap of viewing CPs' accounts as merely matters of individual intentions and effects[13], the dominant narratives within which the speakers are positioned also need to be considered.

[13] Indeed, the analyst remains agnostic with regard to such aspects (Heritage, 1984).

As reflected in the frequent references to biological and psychosocial factors by participants, their accounts could be argued to be positioned within a biopsychosocial model (Engel, 1977) of mental health, a dominant narrative within Clinical Psychology. From a social constructionist perspective, it may be assumed that CPs' professional credibility is associated with the extent to which they subscribe to the rules that govern their professional bodies, such as the HPC and the BPS. As noted in the introduction, the discourse supported by these powerful professional institutions is to conceptualise mental health in biological, psychological and social terms. By continuously referring to mental health in biopsychosocial terms, this view becomes legitimated, taken for granted and 'epistemologised' while linked to powerful institutional practices (Foucault, 1972). In the journal paper, we saw how speakers re-stated their positioning as distant from both anti-psychiatric and medical understandings of mental health and then made reference to this positioning as being the dominant narrative within Clinical Psychology. Through voicing and acknowledging this dominant discourse, speakers thus introduced their own personal agency and subjectivity into the narrative. This script formulation functions to construct accounts as ones that are to be expected from any CP whilst emphasising personal agency, thus positioning speakers as thoughtful, balanced and reasonable. In the following extract CP1 draws on a similar account in explaining the factors that have impacted on his views of mental health.

Extract 6

152 I: what (.) ehmm::: would you say has influenced <u>your understanding</u>
153 of mental health?
154 CP1: erm you know I suppose I am somebody who tends to think that
155 most things are partly true just as almost everything is partly wrong
156 as well
157 I: yes
158 CP1: it's the kind of models and ideas that we think of that (.) you know I
159 find it difficult to entirely reject any erm but difficult to entirely
160 embrace any:
161 I: sure (.) yes
162 CP1: at the expense of others if you see what=I=mean so I am kind of a
163 (.) a natural erm (.) fence-sitter or fudger or so ha::ha:: erm

164 I: ha::ha
165 CP1: but I suppose I defend that on the basis that I think that's how=I
166 think that's how it really works
167 I: yes::
168 CP1: you know I think we are a (.) and the experiences that we have
169 including the difficult ones=the dramatic ones that we seek help for
170 I: mmmm
171 CP1: are a combination of you know (..) what we are (.) you know
172 biologically evolutionary speaking erm (.) as well as our more
173 immediate erm (.) circumstances you know (.) our psychological
174 and emotional history our attachment histories

The speaker asserts that he subscribes to a variety of frameworks of mental health. Whilst this response implies that such a multi-factorial account simply represents the way things really work it can also be viewed as a rhetorical strategy and thus be examined for the effect that it achieves in talk. On line 172, a range of theoretical frameworks of mental health is presented in a five-part list, a discursive strategy argued to be effective in constructing factual accounts (Edwards & Potter, 1992). Through eclectically combining ideas from various theoretical viewpoints the account is given a degree of flexibility, which can be used to manage potential challenges, a feature described by Harper (1999a) in his analysis of psychiatrists' accounts of the efficacy of medication. In this way, if the influence of biological factors on mental health were questioned on the basis that medical interventions have not had an effect on a person's mental health, then other frameworks can be drawn on as an explanation. An example of how such a 'fence-sitting account' can be used to manage challenges is given in the following extract in which CP9 refers to biological factors to explain a person's mental health when psychosocial aspects do not seem sufficient.

Extract 7

175 CP9: so I don't you know (.) I don't usually kind of buy into it as a
176 biological illness, I don't buy into an illness model particularly erm I
177 think it's more about people's adaptive responses to their

experiences and that's why you may get mental health problems or be mentally healthy and well

I: yes::

CP9: erm but having=said that I suppose. I meet a few people where I just think there is no obvious other explanation? other than it being an illness.

I: yes

CP9: so there have been a few people that have kind of challenged my thinking that it's all about kind of experience and past events

I: yes.

CP9: and you never know obviously when someone comes to you (.) you never know somebody's history

I: no

CP9: sometimes you get 15 volumes of files that go into it in great detail

I: yes.

CP9: you know you think how somebody that comes with little information about their background erm but they don't make any connections and I don't always think that's about kind of a lack of insight or a lack of awareness I mean it's sometimes people haven't had necessarily kind of traumatic events or difficult pasts and yet somehow find themselves facing real difficulties

I: yes:: and how do you make sense of that=I mean when you see those exceptions from the kind of past experiences explaining current mental health?

CP9: I suppose I mean I suppose one erm (.) one way of making sense of that is by thinking right you know the bio-psycho-social model

I: yes

CP9: and in a way that=that as a model makes sense to me because I think you know (.) I don't know much very much about biology and kind of biological factors that might lead to people having mental health problems other than their kind of immediate sleep and you know diet and things like that but in terms of longer-term and you know obviously there is lots of kind of genetic research that goes on

that hasn't yet proven much I don't think to my knowledge but erm (.) certainly lots of people kind of cling onto that idea erm:: and obviously there is going to be psychological factors that sort of impact on whether you are well or not and there is going to be social so I suppose sometimes I see that as a way of explaining it but actually a more critical approach () saying that's just a real cop out and there is no () because it covers everything

I: right

CP9: it's completely non-specific so of course you can apply that approach to anybody

I: yes::

CP9: erm (.) but it doesn't really give you an answer it just kind of gives you a catch all saying=and you know I work with lots of people who=who want to know when they have therapy why has this happened to me

In the above extract, the challenge to a purely psychosocial explanation posed by its inability to explain a person's mental health in terms of his/her history even when you get "15 volumes of files that go into it in great detail" is met by a move to a biopsychosocial account of mental health which allows the speaker to explain the person's state in biological terms. If CP9 had constructed mental health in solely psychosocial terms, a solution to this might have been difficult. In this way, therefore, a biopsychosocial model of mental health allows speakers to manage such dilemmas, responding flexibly to challenges to a psychosocial account by referring to biological theories.

3.3 Fence-sitting and resistance

Fence-sitting accounts such as these rest on the liberal assumption that all points of view have some utility and therefore appear to be open to criticisms. However, whilst utilising a rhetoric of eclecticism and balance, they have also been argued to assimilate criticisms and thereby function to maintain the status quo (Billig, 1987). In the previous extract CP9 does not simply re-state the dominant biopsychosocial narrative of mental health but she also demonstrates through her positioning that she

resists aspects of this narrative by referring to it as a non-specific “cop out” which “doesn’t really give you an answer”. Indeed, one of the effects of fence-sitting accounts is that they can present a range of theories as equally valid but as fixed within a hierarchy. For example, Harper (1999a) outlined how such accounts allowed psychiatrists to construct biology at the ‘core’ of mental health problems, and to position psychological and social issues as the mere effects of underlying biological mechanisms.

Extract 8

CP4: erm (.) and I don’t know you know maybe that’s true and I suppose that’s another example of something that challenges my reluctance to kind of engage in biological models of illness

I: mmmmm::

CP4: and kind of chemical imbalances and all those kinds of things because I meet people where medication really works for them

I: yes

CP4: and makes the difference and therefore I can’t say there is nothing in it erm (.) but I also think that you have to be really cautious around that so you know (.) of course somebody appears better if they are sedated

I: yes

CP4: I erm (.) yes I remember a service-user saying to me once that you know of course you know (.) of course he was more tranquil because he was having massive amounts of tranquilliser but it didn’t mean that things had changed for him necessarily

I: no

CP4: it just meant that they were managed on a very surface level and as yet, I suppose alongside those people who I see take medication it seems to be really really helpful for them

I: yes

CP4: I also see a lot of people on a lot of medication who have been taking it for a long time and nothing has changed for them

I: yes

250 CP4: and you know=so I always have that (.) I suppose it's not really a
251 dilemma but I <u>always</u> have that kind of mixed view of <u>maybe</u> there
252 is something in the biology. but maybe there isn't?

In this extract CP4 manages the dilemma of accounting for the efficacy of medication and thus the implication of biological factors after having constructed mental health in terms of psychosocial factors. This is achieved through presenting medication as being able to manage people's mental health on a 'very surface level'. Such metaphors of depth are a common feature of empiricist accounts and function to position CPs as 'experts' with specific knowledge about the 'realm below the surface'. Since this form of knowledge cannot be verified but only assumed through paying attention to symptoms or surface signs, it functions as a type of category entitlement. Through constructing a multi-factorial account of mental health, then, CP4 is able to account for the varying efficacy of medication and thus the implication of biological factors whilst the primacy of psychosocial factors remains unthreatened. Clearly, if the speaker would have constructed mental health in purely psychosocial terms, she might have struggled to offer a solution to such challenges. In this way, such multifactorial accounts are able to neutralise challenges to a psychosocial account through the use of biological theories. Moreover, because the account is not tied to any particular theoretical model, it can be changed depending on the circumstances, thus further increasing its flexibility.

In the above extracts, mental health was constructed in biopsychosocial terms, allowing CPs to implicate biological factors whilst maintaining the primacy of psychosocial factors in mental health. These accounts draw on elements of 'eclecticism' and 'balance' to appear flexible and to position CPs as open-minded, liberal and thoughtful professionals who weigh up arguments for and against in a balanced and rational manner. However, as outlined, such accounts may also paradoxically work to relativise challenges and criticisms and thereby function to maintain current practice. These criticisms of the discursive effects of fence-sitting accounts are also echoed in the literature concerned with the implications of adopting a biopsychosocial model of mental health (Stainton-Rogers, 1991; Yardley, 1996). Engel (1977, p.132) suggested that a 'rational scientific approach to behavioural and

psychosocial data' should be adopted to create standardised psychosocial measures comparable to biological variables. From this point of view, concepts such as 'cognitions' and 'personality' are to be seen as objective and value-free entities representational of an underlying psychological reality. In this manner, the biopsychosocial model is able to incorporate and assimilate psychosocial aspects of mental health whilst retaining an essentially biological perspective. Rather than analysing psychosocial aspects of mental health in biomedical terms, critics of the biopsychosocial model have proposed that the biological realm should be reinterpreted from a psychosocial viewpoint. From this perspective, mental health and biopsychosocial concepts are viewed as changeable notions that are constructed and maintained by social relationships, roles and practices. For example through the practices of CPs who advocate selective ideas about what mental health really is by outlining the 'underlying' causes of the conditions that service-users present with in clinical practice (Yardley, 1996).

As previously noted, discursive psychology holds that constructing mental health as a biopsychosocial phenomena is doing something beyond the words used; it is performing an activity and detailed reading of the data allows for various interpretations of the possible function of such constructions to be made (Potter & Wetherell, 1987). The reading of the CPs' construal of mental health in biopsychosocial terms was that it legitimated the implication of biological factors whilst emphasising the primacy of psychosocial factors which was helpful in managing dilemmas around the efficacy of medication and cases where there was a lack of psychosocial evidence to explain a person's mental health.

3.4 Mental health as physical illness

In this kind of account, which was not particularly well represented in the interviews, mental health is portrayed as a physical illness and agency is given to the universal and biological features of mental health.

Extract 9

253 I: erm:: (.) what is your understanding of mental health?

CP5: Oh my goodness? Ha::ha (.) erm my understanding of mental health(..) I mean I=I see it as something that=that like anything else in terms of kind of erm life and situations and things (.) I think its something that can happen to anybody (.) I don't think=erm I don't think anybody's excluded from the reaches of having difficulties with mental health at some point in their life and particularly erm working in services where people are going through very traumatic things and I think that just reminds you of how (.) how vulnerable we all are erm to sort of struggling with things at certain points so (..) erm (..) I am trying to think how can I I don't know erm (…) I am just trying to (.) sorry go on

I: no::

CP5: I thought you were going to say something (..) I don't really know what I guess=do you mean sort of like how I understand it as a concept or is that?

I: erm (..) yes=yes?

CP5: yes erm (.) I think in a lot of ways I would look at mental health in a way that you'd look at any kind of sort of illness that people can have at any point so erm on a sort a bit of a spectrum I guess like cancers and tumours and things like that they are obviously you know very extreme erm and they are very few thank goodness? in the world (.) whereas something like a common cold everybody will have at some stage and it will perhaps impact on you differently depending on whether you are run down or whether you are you know sort of struggling with other things

The speaker describes mental health as a mental illness that is similar to, if not the same as, physical illnesses. Mental health is positioned in the same category as 'cancers', 'tumours' and 'the common cold' and is thereby reified as an 'illness' which everyone is vulnerable to and which will impact differently on different people. This implies that the concepts of mental health and illness and their boundaries are matters of natural fact that can be determined, examined and ultimately treated in the same ways as physical illnesses. Such 'physical illness accounts' have been noted to

locate the management of the 'illness' within the realm of the psy-complex[14] whilst disqualifying non-expert understandings (Foucault, 1972; Rose, 1985). Through establishing mental health as a physical illness, the account gives agency to expert knowledge and thus presents mental health professionals as having the know-how and the responsibility of treating service-users who are positioned as passive and powerless. Despite these power implications, the language used in the extract does not position the speaker as an authoritarian CP. Instead, the account is presented in simple everyday language with numerous qualifiers such as 'I think', 'I would' and 'I guess' which work to position the speaker as thoughtful and open-minded as well as leaving the account open to challenge. The repetitive use of qualifiers introduces a sense of vagueness, ambiguity and tentativeness to the narrative. Similarly, through clarifying whether I am asking about her understanding of mental health 'as a concept', the speaker further distances herself from her account thus enabling less ownership. These discursive strategies are useful since they allow any challenge to the speaker's account of mental health to be met with the response that it was only a tentative hypothesis. Physical illness accounts are frequently used by psychiatrists to present 'symptoms' as if they had agency in and of themselves thus positioning mental health problems as somehow disconnected from the individual experiencing them. It has been highlighted how this functions to warrant the need for medical interventions as reflected in phrases such as 'a pill for every ill' (Harper, 1999a). However, in this extract, the universality ("how vulnerable we all are") and the context of mental health ("it will perhaps impact on you differently depending on whether you are run down or whether you are you know, sort of struggling with other things") are emphasised by the speaker. This is unsurprising given CPs' concern with the psychosocial dimensions of people's experiences. Through giving agency to these two aspects of mental health the speaker could therefore be viewed as managing the categorical implications of illness constructions and reaffirming the need for psychosocial interventions.

3.5 Mental health as a social construction

In the previous sections CPs have constructed mental health as reflecting a 'real' category, which was treated as a 'given' of the world by focussing on the biological,

[14] A term used by Foucault (1967) to denote the set of professionals dealing with the psyche.

psychological and social aspects hypothesised to influence it. However, a number of participants also presented mental health as a social construction. A feature of this type of account was that biological and psychological factors were either minimised or seen as caused by social and political influences. Instead, participants constructing mental health in this way tended to focus on the language and categories associated with mental health and the effects and implications of using these.

Extract 10

279 CP8: the concept of mental health or diagnosis is clearly socially
280 constructed
281 I: mmmm::
282 CP8: And you know just how do they help us and the sort of people that
283 we are dealing with like you know (..) I am not sure that they do
284 I: yes::
285 CP8: but we all (.) well you know lots of people just seem to have
286 adopted this kind of pseudo-medical view of the world
287 I: yes
288 CP8: which (.) and you know the other thing which is I think a social
289 which you see in modern practices is because of the way that
290 services are set up you know these labels are often used as means
291 of excluding people from services and reducing waiting lists rather
292 than helping people
293 I: yes::
294 CP8: so I think they are dysfunctional in many ways (.)
295 I: mmmm
296 CP8: so I resist it

The speaker opens this excerpt by presenting mental health as a category, which, like psychiatric diagnoses, is socially constructed. To strengthen his argument, CP8 refers to the moral concern for service-users as guiding his reasoning by providing an evaluative assessment on line 283, thus reminding me of CPs' primary orientation; to be helpful to service-users. Through the inclusive use of "us", "we" and "you know", I

am assigned moral agency and responsibility by the speaker, a common discursive strategy in managing accountability issues (Edwards, 1997). This is also evident on line 285, which CP8 starts by saying “but we all” and then amends to “well you know lots of people”. This re-phrasing is noteworthy as it reduces the speaker’s investment in his construction, positioning him as someone who, just as everyone else, is aware of people who adopt this view without necessarily doing so himself. One implication of presenting mental health as socially constructed is that it leads speakers to give agency to the usefulness or the consequences of adopting a particular language. An effect of such accounts is to warrant a political analysis in the construction of mental health. This is consistent with a wider social constructionist narrative, which posits that the reluctance to challenge or probe the objects and categories that we encounter is a political act as it affirms these as ‘givens’ of the world without considering how this status was achieved or whose interests they serve (Sampson, 1993). In the excerpt, resistance to mental health labels is constructed linguistically through drawing on Foucauldian ideas around power. This is presented through commenting on the manner in which services rely on such categories to position individuals as legitimate or illegitimate service-users and the material interests served by these discourses (“reducing waiting lists”).

3.5.1 Resistance to mental health as labelling

A common feature of the CPs’ construction of a resistance to the categorical understandings of mental health was the use of the evocative metaphor of “label”, a word that was not given as part of the interview questions. This vivid physical image was used by participants to highlight how although the label of mental health may be useful, it is imposed by someone external to the object and does not comprise an intrinsic part of the item and therefore communicates only minimal information. Again, the use of the word “label” functions to emphasise the social construction of mental health since people in different contexts, at different times and with different opinions may label the same item differently for a variety of purposes. In the following extract CP11 uses humour to highlight this variability with the question mark indicating the voice rising at the end of the sentence in the manner of an ironic rhetorical question.

Extract 11

297 CP11: mmmm:: because I mean=I think you know you think about how
298 mental health erm (.) I don't know when I think mental health I think
299 you know this is people talking about DSM or ICD 10 you know I
300 think that's what they are referring to (.) the labels that have fitted
301 within those books (..)
302 I: yes:: yes.
303 CP11: you know ha::ha: and I think about how they evolve and you know
304 these groups of people who sit down and decide
305 I: yes
306 CP11: you know=what language shall we use to describe this group of
307 people today?? you know ha::ha: that's erm (..) you know it's so
308 temporal you know it changes through time
309 I: Mmmm::
310 CP11: and erm:: (.) you know that=that in itself I think is quite interesting

Instead of criticising mental health as labelling directly, the speaker ironically uses the first person plural to present the process of labelling as unreliable "what language shall *we* use to describe this group of people *today*" and to position herself as not belonging to "these groups of people". The use of the word label was repeatedly associated with phrases such as 'stuck', 'attached' and 'hard to remove' throughout the interviews. These linguistic devices may also be understood as constructing resistance to the categorical implications of realist constructions of mental health, which in turn has a later function: the legitimisation of an alternative construction.

3.5.2 Mental health as a discourse of ambivalence

Rather than constructing the effects of using mental health terminology in purely negative terms, the CPs varied in their accounts, drawing on ambivalent and sometimes contradictory constructions. This discourse of ambivalence was repeatedly indicated by the common discourse marker 'but' (Schiffrin, 1987), allowing speakers to include the other side of the coin. This is both seen on line 285 in excerpt 10 as well as in the following extract on line 333.

Extract 12

311 I: erm (.) how do you view mental health?
312 CP8: I don't
313 I: right (.) okay erm:: (.) do you accept it as a=as a concept?
314 CP8: erm well I accept it as a concept which is banded around
315 I: right
316 CP8: I accept it as a concept yes I mean it's a hypothetical construct
317 I: and (.) I mean how would you describe that=that construct what
318 does it entail?
319 CP8: what does mental health entail as a hypothetical construct (.) erm
320 (.) broadly it would involve the absence of attracting unfortunate
321 mental health diagnoses and behaving in a way which enables you
322 to sustain relationships roles jobs whatever (.) which bring a degree
323 of (.) hopefully happiness
324 I: right and what is your rationale for not engaging with that?
325 CP8: Erm what it my rationale for not engaging with it (.) erm well
326 although the term mental health is meant to be positive it is
327 essentially used in terms of the absence of mental ill health isn't it?
328 I: mmmm
329 CP8: erm I resist you know=we have to speak the language of diagnosis
330 because you know it's like being in France and not being able to
331 speak French
332 I: yes:
333 CP8: you have to be able to speak the language (.) but I erm I don't like
334 the language of diagnosis I can see that it makes some people
335 behave in ways which are broadly similar but if you look at the role
336 of diagnosis and what it's used for generally I am not sure its terribly
337 helpful you know, the systems which are in place have huge
338 amounts of variation (.) very low degrees of reliability.

In this extract, mental health is first rejected on the basis that it is a hypothetical construct but is then accepted and constructed as signifying both the absence of attracting a diagnosis and behaving in a functional way. This construction is interesting because although the speaker distances himself from the assumption that

mental health problems originate within individuals through referring to it as “a concept which is banded around”, it is then presented as an individual’s ability to function. Through constructing mental health as a hypothetical construct, CP8 is perhaps able to assign conceptual distance from his response and thereby manage issues of accountability. The account starts by focussing on the usefulness of the language and then shifts to giving agency to mental health at the level of the individual, similar to the realist constructions that were discussed in the previous section. As such, the speaker shifts between drawing on a social constructionist ontology in which mental health is constructed externally and changeably and a realist ontology in which mental health is constructed as a concept characterising aspects of the person. The ways in which speakers draw on such contradictory discourses to achieve certain goals have been highlighted in previous discourse analytic work (Bilić & Georgaca, 2007). By alternating between social constructionist and realist constructions, CP8 obtains a certain amount of discursive space for manoeuvring as his construction of mental health can change as a function of the effects that he wants to achieve or the context in which he speaks thus allowing him to present his account in a flexible manner.

3.5.3 Constructing an alternative

As outlined, CPs espousing social constructionist accounts of mental health constructed resistance to realist discourses through challenging its scientific correctness and questioning its social implications. As well as downgrading realist accounts of mental health as a resource, one of the functions of social constructionist accounts is to provide and legitimise an alternative construction. Clearly, if realist accounts are constructed as unhelpful and problematic for service-users then the introduction of novel constructions becomes ethically necessary.

Extract 13

339 CP10: I think in a sense of (.) broader sense of practice it’s about trying to
340 erm::: allow discussion and debate in different forums so not just in
341 terms of working with individuals but also thinking about in team
342 meetings:: in wider service discussions:: allowing erm discussion
343 and debate to occur really I think=I think that’s really important erm

and that people feel they:: can question and critique you know erm what might appear to be sort of erm dominant narratives (..) I think that's something that should be erm encouraged really.

I: yes:

CP10: erm and that mental health the whole field of mental health or mental ill health is contested that's a very important thing (.) I think people should have a sense that it's an ongoing debate that it is a contested arena

I: yes

CP10: and erm (.) I think that's how it will always be=I don't think there will be a point to which it arrives at a view a sort of a truth (.) I think it's ongoing discussion because I think for me it's a reflection again of this wider issue about what sort of world we want to live in what sort of society we have mental health is a reflection of that so the fact that we have large numbers of people experiencing distress at the moment I think is indicative of that we aren't at ease as a society=I mean that's just one indication you could say why do we lock up so many people in prison why do we you know erm (.) have such rates high rates of obesity I mean these aren't symptoms of a healthy society I'd say they are indicative of a society that's got problems

I: yes

CP10: so I think this is part of a bigger debate

I: yes

CP10: and I think mental health is part of that debate and really it would be=it's much better to sort of allow that debate to happen I think it's interesting that by putting it into the arena of a medical individualised problem (.) individualising the problem I think kind of suppresses that debate a bit because it locates the problem inside individuals rather than outside=as something needing more sort of social discussion (.) more social change really

In this excerpt the speaker presents an alternative construction of mental health as one that is reflective of wider issues and thus necessarily contextual, varying and

changeable. This construction highlights the importance of examining the different positions that are being made available or denied through various conceptualisations of mental health as well as considering what the alternatives might be. Through continuously referring to mental health as a concept that is 'contested' and which should be open to 'discussion' and 'debate', this account serves to relativise the power of realist constructions of mental health such as the biopsychosocial model by positioning it as merely one out of many possible frameworks. Moreover, the speaker gives agency to the social constructionist tenet of language's action orientation in constructing how the dominant narrative acts to put mental health "in the arena of a medicalised individualised problem".

As outlined in this section, CPs adopting a social constructionist stance resisted and challenged realist constructions of mental health on the basis of a moral concern for service-users and through positioning themselves as outside of the dominant discourse. Through resisting the dominant individualising narrative of mental health, an alternative construction of mental health sensitive to variability was introduced, based on the idea that mental health is constructed in our relationships with others and with society. As this view of mental health gives agency to social issues and the constructive elements of language, one effect of this kind of account was to warrant a form of political analysis.

The effects of CPs constructions of mental health

3.6 Disclosing views: a moral dilemma

As well as examining how CPs construct mental health, the current study was concerned with the ways in which CPs construct the influence of their views of mental health on their work with service-users. One of the issues that arose in this talk was whether service-users are aware of clinicians' conceptualisations and whether these ideas should be made explicit.

Extract 14

374 I: ermm do you think that your (.) the service-users that you see that
375 they come away with erm (.) an idea about your views about mental
376 health?

377 CP6: I would hope so yes yes:: I think I would hope that they would come
378 away with an understanding of how I view it (.) I would also hope
379 they'd come away with an understanding that I am equally open
380 and interested to know about their understanding of it and that the
381 two even if the two positions are different then that doesn't mean
382 that that's a problem
383 I: mmmmm::
384 CP6: and that that's okay
385 I: yes
386 CP6: erm (.) so I think it's equally I would want them to come away with a
387 clear understanding of how I view things so that they can disagree
388 or not and likewise I would want them to go away with a very clear
389 view that I am keen to know what their understanding is
390 I: yes=yes
391 CP6: of it and whether our views match or whether they don't
392 I: mmmm
393 CP6: and if that's a problem for working together or if it's not but I (.) I am
394 a believer in being very explicit about these things

In this excerpt the speaker presents the issue of service-users coming away with an idea of her construction of mental health as something desired, an ideal to be aspired to whilst highlighting her interest in the service-user's understanding. This view is justified through giving agency to the expertise of service-users since if they are aware of their clinicians' views; they are also able to disagree with them. The speaker emphasises that although conversing views of mental health could present problems, it wouldn't necessarily do so.

Extract 15

395 CP7: errm so that informs that so I guess I try and=and I suppose that
396 partly informs why I give people information about my views on
397 mental health (.) I don't I like to think I impose them but I think that
398 kind of if you can give it to people in an accessible way then they
399 are able to make choices so actually you know I think they can put
400 them (.) that erm elevates their knowledge and when people have

401 knowledge they can make better choices I think for themselves
402 I: yes
403 CP7: so I suppose that's partly thinking back to your earlier question
404 about why do I how do people I see end up knowing what I think
405 erm: I do think that does influence my practice that I am trying if you
406 like lay bare the assumptions behind what people do erm (.) just so
407 that then clients can make better choices about the kinds of help
408 they want and have a bit more agency in their care

CP7 draws on a similar discourse of moral concern for service-users in accounting for his decision to disclose his position. This is evident in the numerous benefits to service-users that the speaker argues that such disclosures lead to and the way in which he distances himself from "imposing" his views. The implication of this account is that clinicians who do not disclose their ideas deprive service-users from having these choices. These constructions therefore give agency to service-users' expertise and their right to make their own decisions regarding their care through emphasising the importance of being transparent as a clinician. Moreover, as noted in the above extract, they also warrant the challenging of clinicians' accounts, thereby constructing service-users as active agents. In this way, the disclosure of CPs' views of mental health to service-users is presented as a moral necessity, an action performed out of respect for service-users' autonomy. By presenting the need to disclose views in a manner which position them as responsible clinicians, CPs are thus able to manage the dilemma of self-presentation or impression management (Potter & Wetherell, 1987). Interestingly, through constructing the issue of whether to disclose one's views of mental health to service-users in moral terms, the decision is converted from a neutral idea into a value-laden judgement call. This, in turn, was evident in the many explanations and justifications that CPs offered for their decisions as reflected in the following excerpt.

Extract 16

409 CP7: and I would have to explain myself to a client to some extent and I
410 think that probably marks me (.) I'd be surprised if many clinical
411 psychologists erm are that clear about it you know (.) I mean=I think

412 there is an analogy to me you know when a CBT therapist
413 socialises someone in to the model (.) I don't really see there is
414 anything different in what they are doing from what I am doing (.)
415 it's just that we have different <u>beliefs</u> I mean somebody who fully
416 signs up to CBT that is a satisfactory model of a person and of
417 course they have a good ethical base in doing it because it's
418 grounded in quite a lot of empirical support so they can easily
419 <u>defend themselves</u> and say well what I am doing is telling people
420 what's scientifically true about persons erm:
421 I: yes::
422 CP7: erm (.) so all I am=ermm=so that technically I'm giving them
423 information erm (.) and I guess my views on people are you know
424 (.) not the same as that but I guess you know=you <u>always</u> give
425 some information about your views as part of the practice I think it's
426 <u>unavoidable</u>

CP7 first positions himself as different to other CPs and then likens his decision to disclose her views about mental health to CBT therapists socialising service-users to the model. This analogy could be seen as working to equate the speaker's actions with those prescribed by the socially sanctioned, evidence-based framework of CBT, thus presenting it as more acceptable and as something that "anyone would do". This account, then, functions to legitimise the speaker's initial positioning as different from the norm. On line 422, CP7 corrects himself from "so all I am" to "so that technically". These starts are noteworthy as they minimise the speaker's decision to disclose his views and highlights the need for justification. Finally, CP7 introduces the idea that views are always shared, whether we like it or not. This construction may be viewed as allowing the speaker to manage issues of accountability since, if someone were to question his rationale for disclosing his views on the basis of it being similar to socialising service-users to a CBT model, he could refer to his response that it is unavoidable to transmit some ideas.

3.7 Constructions of mental health as controllable

Another feature of CPs' talk about the influence of their constructions of mental health on their work with service-users was to present the effect of their views as a factor that could and needed to be controlled and regulated in interactions with service-users.

Extract 17

427 CP2: so erm (.) so yes I have got my conceptualisation of mental health
428 but you have to put that to one side and not let it rule your decisions
429 about what you do with someone.
430 I: mmmm yes:: erm we are just kind of hinting at it but you think it's
431 possible to put our conceptualisations aside in interactions with
432 other people?
433 CP2: yes=yes I think you hold them yourself
434 I: mmmm
435 CP2: but I think you have=yes you do I think definitely you do have to be
436 able to put them aside you have to be able to control the amount to
437 which it goes into your work with a client.
438 I: yes
439 CP2: either it will fully inform it and drive the work in a certain direction
440 but you have to be able to spin that and sometimes withhold it and
441 hold it and go okay there is little bits that I can use here
442 I: mmmm::
443 CP2: but actually you know I have to mediate the influence of my
444 conceptualisation on what I am doing with clients

In this excerpt, views about mental health are presented as something that "rules" clinical decision-making, almost as if it, unless controlled, would take on a life of its own. This is provided as a rationale for the importance of controlling the influence of these in interactions with service-users. Through the use of the personal pronoun "you" and "you have to be able", the speaker introduces a moral force into her account since those CPs who aren't able to put their conceptualisations of mental health aside are constructed as ruled by their views and not by what their service-users' bring to the interaction. On line 435 the speaker says "but I think you have", and then rephrases using an extreme case formulation (ECF, Pomerantz, 1986) "yes

you do, I think definitely you do have to be able to put them aside". The deployment of this discursive strategy is commonly associated with 'doing the rhetorical business' of portraying accounts as compelling and believable (Potter & Wetherell, 1987). This account is interesting as it constructs views of mental health as potentially clouding clinical decision-making, thus separating such views from the 'real world' and implying that decisions are best made in a vacuum free from such biases.

3.8 Deviant case analysis

Thus far, the need to disclose one's views about mental health and the importance of not imposing these on service-users have been constructed by drawing on a discourse of moral concern. These were presented within a social constructionist ontology which functioned to highlight how, despite having different views about mental health, the CPs were nevertheless able to work with service-users to co-construct narratives. In addition to these accounts, some CPs emphasised the importance of challenging service-users' views of mental health and other CPs constructed the effects of their views of mental health as sometimes being an obstacle to their work with service-users, thus providing interesting variability to the data corpus. In quantitative research such instances might be regarded as 'outliers' and thus be discarded. However, as noted in the methodology section (see section 2.7.2), from a discursive perspective such deviant cases are viewed as forming part of a larger collage and are therefore included in the analysis (Potter & Hepburn, 2005; Potter & Wetherell, 1987).

Extract 18

445 I: you mentioned before as well about sometimes maybe challenging
446 people's conceptualisations of mental health could be helpful in
447 some situations.
448 CP2: yes:: I think it is times when you feel like psychological factors or
449 social factors are so powerful
450 I: mmmm
451 CP2: and yet un-acknowledged that the person is left not understanding
452 why they are ill=so they view it like that they perhaps view it as an
453 illness but you look at it and you see a huge influence of other

factors maybe relationship kind of developmental factors social stuff disadvantage=things like that.

I: yes::

CP2: and the person is saying to you I don't understand why I am ill I don't understand why this happened to me.

I: mmmm

CP2: then I think that might be a case where I would try and introduce another framework for understanding their experiences

I: right

CP2: not to knock out their one but just to kind of go alongside it because fundamentally if someone doesn't understand themselves I think that impedes recovery

I: mmm

CP2: so their explanation is not actually helping them to feel kind of satisfied then I think we have a duty to make and offer other explanations alongside that

I: yes

CP2: or perhaps where someone's' understanding of their own mental health difficulties is overpowering them I think that's (.) so if someone is=if someone's' explanation of their experiences is fuelling a self-critical drive or a self-destructive drive

I: yes::

CP2: it's actually feeding into it then I think therapeutically you have to challenge that because actually it's something that's contributing to the problem

In this extract I enquire about challenging someone's view of mental health as this topic was previously introduced by the speaker who goes on to describe several factors that might influence the choice to do so. In this account agency is given to CPs' "duty" to act in such situations, which, again, appears to draw on a discourse of moral concern for the service-users. This is also highlighted in the speaker's clarification that this new framework would not knock out the service-user's understanding of mental health but rather go alongside it. Through this discursive

construction CP2 is positioned as a responsible yet respectful clinician who, rather than pushing her own agenda, accompanies and supports service-users in working out their own healing. This is important since CP2's decision to challenge her service-user's views is a value-laden and subjective judgement call that is likely to be based on her own views of mental health. This puts the speaker at risk of being positioned as an authoritarian, non-collaborative CP, which she carefully manages through her construction. Power and collaboration is common dilemma in psychotherapy (Frank, 1973) and, as indicated in this data corpus, previous discursive studies have also noted a conflict between therapists' wish to persuade service-users to modify their beliefs and their beliefs in collaboration (Messari & Hallam, 2003).

Extract 19

479 CP7: one of my clients once asked me for a personality assessment (.)
480 well I felt incredibly uncomfortable about it
481 I: yes
482 CP7: you know=I did what I had to do in the end but I think she was very
483 disappointed because she was expecting some really big
484 personality inventory but because I am so sceptical about it and
485 therefore unfamiliar with the area
486 I: right
487 CP7: and uncomfortable with it=you know I gave her a fairly brief and
488 erm (.) you know <u>tentative</u> erm interpretation of the findings so you
489 know <u>definitely</u> if you checked my clinical practice that way I would
490 never
491 I: no=and did you tell her kind of your views about mental health?
492 CP7: Erm I don't think I told her totally (.) I mean I told her that I had=you
493 know=I think I probably just said I don't=you know=I think I have
494 some problems with it (.) to be honest <u>any</u> client who works with me
495 for any period of time probably knows my views because erm I
496 mean it's clearly not my role to impose them on people but it will
497 crop up from time to time because often clients are concerned with
498 judgements or measuring themselves against certain norms

499 I: mmmmm
500 CP7: erm:: or trying to find their true self and you know where I just don't
501 believe such things exist.
502 I: right
503 CP7: I have got to be=I do it in a communicable way but I have got to
504 kind of try and put clients in a kind of in the picture of where I stand
505 on that because otherwis::e
506 I: yes
507 CP7: we'd be working at cross purposes and that wouldn't be really
508 helpful for them and they could say I don't want to work with you
509 because you have got stupid ideas=do you know what I mean they
510 couldn't easily do that I guess but er:: that's: so I don't think there is
511 any surprise to my clients to know that I'm sceptical about that and I
512 think that's a problem you know if she is a big believer in that and
513 that's a problem that means we don't work probably as well as
514 maybe somebody else I think she benefits from working with me in
515 some ways but clearly in other ways (.) you know she would benefit
516 seeing somebody who deals in a lot more certainty with erm (.) er
517 kind of those ideas.

In this excerpt, the speaker gives an example of how his ideas about mental health could present problems when working with service-users who view the construct differently. This could be seen to present an interesting dilemma for CP7 since, if he chooses to disclose his views and these pose an obstacle to working effectively with a service-user, is he then responding to his own needs or to those of the service-user? To manage this, the speaker draws on a discourse of client-centeredness as he constructs the decision to communicate his views as informed by service-user need and the desire to be as helpful as possible. Moreover, personal accountability is managed by presenting reflections on the situation and some of the associated difficulties, thereby anticipating and dissolving potential criticism (Potter & Wetherell, 1987). Similar to the way in which we saw clinicians drawing on a discourse of moral concern for service-users in justifying disclosing their views of mental health, one effect of this account is to present service-users as rational and autonomous

decision-makers with regard to their care. This concern is again demonstrated when the speaker corrects himself in recognising that service-users may not feel able to challenge healthcare professionals' views of mental health when they do not agree with them. Through constructing his decision to be open about his views about mental health as informed by concern for service-users, the speaker is able to avoid being forced into the position of a non-collaborative clinician whilst acknowledging the possibility that conflicting views may pose a problem in clinical practice. This extract could also be seen to provide an example of the tension that emerges when CPs who chooses a social constructionist view of mental health try to resist the dominant scientific discourses informed by positivist epistemologies in their clinical work.

The two exceptions noted in this section are part of a larger picture in which CPs' negotiate the influence of their views of mental health on their work with service-users through drawing on a discourse of moral concern. As noted throughout this analysis, this discourse was recurrent in the arguments and explanations that CPs constructed in responding to my questions and it allowed their talk to be viewed from a moral framework where accountability could be managed within interactions.

3.9 Section summary

This section has been concerned with analysing how CPs construct mental health and how these views influence their work with service-users. Rather than evaluating to what extent these accounts may be considered 'accurate' from a naïve realist perspective, this analysis have examined the effects of these accounts and how the accounts are constructed to achieve these effects. In the course of this examination, I have argued that CPs draw on a number of rhetorical devices. In particular, I have focussed on how speakers manage issues of accountability in presenting their accounts of mental health and how a discourse of moral concern is drawn on in constructing the effects of their views on their work with service-users.

Part Four: General Discussion

4.1 Section introduction

This discussion section is organised into three subsections: a summary of the findings; implications of the results and an evaluation of the study with suggestions for future research.

4.2 Summary of the findings

The objective of this study was to explore how CPs construct mental health and its effects on their work with service-users and to generate hypotheses about the effects of these constructions. The findings of this study show that there is a range of constructions of mental health available to CPs and that these are used for a variety of purposes. This implies that clinicians' views of mental health are considerably more complex and flexible than previous quantitative studies have demonstrated. Consistent with Potter and Wetherell (1987), CPs constructed various versions of mental health through the use of different rhetorical strategies. In particular, CPs who constructed mental health in realist terms tended to draw on a biopsychosocial framework and employ discursive strategies such as case examples and stake inoculation to present their accounts as credible. The CPs who viewed mental health as a social construction tended to focus on the language associated with mental health and the implications of using this. This functioned to warrant a political analysis and to create a rationale for introducing alternative views of mental health. From a realist perspective, this diversity of discourses occupied by participants may be viewed as evidence of confusion about what mental health is. However, from a social constructionist viewpoint, this diversity may be seen as a reverberation of the controversy and contradiction that surrounds the concept. Central to this research is the notion that rather than simply reflecting reality, language is active and constructive, thus allowing CPs accounts to be analysed for the effects that they achieve in talk. The discursive strategies deployed by CPs in this study were consistent with past discursively informed studies, showing a cross-topic relevance by demonstrating how clinicians rely on particular rhetorical devices to 'get things done' in verbal interactions. For instance, past research has outlined how clinicians use such discursive strategies to construct their accounts as credible (Harper, 1995; 1999a), to meet challenges to their constructions (Harper, 1994), and to manage

professional accountability through their talk in clinical interactions (Robertson, Paterson, Lauder, Fenton & Gavin, 2010).

As well as examining how CPs construct mental health, this research examined the ways in which CPs construct the influence of their views of mental health on their work with service-users. One prevalent feature of these accounts was CPs negotiating the implications of having different views of mental health to their service-users through drawing on a discourse of moral concern, which functioned to manage issues of accountability. In line with this, previous discursive studies have demonstrated how clinicians' manage the implications of challenging service-users' beliefs through drawing on a discourse of collaboration (Messari & Hallam, 2003)**.** Another issue that was brought up by a number of participants was the ethical need to disclose views about mental health to service-users so as to enable them to make informed choices in their interactions with services. This narrative is echoed by both the recovery movement (Andresen, Oades & Caputi, 2011) and the Department of Health (2010), which have argued such transparency to be key to the empowerment of service-users' and clinicians' professional accountability, respectively.

4.3 Implications of the study

Researchers have noted the epistemological challenges associated with applying findings from discursive studies as they emphasise the contextual nature of knowledge and do not seek to generate 'truths' (Willig, 2008). However, if it is not able to offer anything, research is rendered futile and becomes ethically compromised. The positivist notion of applying research has been argued to be constrained by a linear and mechanistic opposition between theory and practice by critics who have suggested that studies should instead be considered in terms of their usefulness (Harper, 1999b). In this section I will suggest some theoretical, methodological and practical implications consistent with the analysis whilst reminding readers to keep the discursively positioned nature of the research context in mind.

Theoretical

This study has demonstrated how clinicians manage professional accountability and therefore the personal credibility of their practice through their constructions of

mental health. By analysing clinicians' accounts of mental health from a discursive point of view, this study has offered a valuable theoretical contribution to the topic of mental health as an action-orientated discursive practice. The findings demonstrate that there are a range of constructions of mental health available to CPs and this thesis has outlined some of the assumptions and oppositions implicit in clinicians' accounts and their effects (e.g., between health and illness). On a theoretical level, this is of use to researchers concerned with the implications of subscribing to particular models of mental health as it highlights how the concept of mental health is highly contested in itself. This suggests that, rather than relying on the *a priori* assumption that mental health is a consensual object of thought, future studies should be designed so as to allow clinicians to articulate multi-faceted conceptions. As outlined, ambiguity, uncertainty and ambivalence were important features of CPs' accounts in constructing mental health and future research will therefore need to capture this complexity.

Methodological

This research represents the first discursive psychological examination of CPs' constructions of mental health and its effects on their work with service-users. By showing how CPs present their accounts as credible and the effects of these through the use of a wide range of discursive strategies, this study has produced novel findings of clinical relevance, a criterion argued to be indicative of good quality discursive research (Potter & Wetherell, 1987). As such, not only does this thesis fill a gap in DA literature, but it also offers a discursive space to examine the interactive actions performed in other contested issues.

Practical

As outlined in the literature review (section 1.5) CPs' constructions of mental health may have important clinical implications. This study has shown a range of assumptions implicit in professionals' accounts and analysed the consequences of these accounts, in particular for how clinicians and service-users are positioned. The results of this study suggests that there is a need for clinicians to be honest about the contingent and situated nature of their language and knowledge, to make their assumptions about mental health explicit and to be mindful of the effects of their use

of language on different stakeholders in talking about mental health. Clearly, if clinicians are not open about such issues there may be a risk of service-users passively complying with a process that they do not understand or feel they benefit from, thereby ethically compromising CPs' practice. This is particularly important in interactions with service-users who, given the inherent power imbalance in the therapeutic relationship, may not feel able to express their wishes or needs. Indeed, such open and honest conversations might allow service-users and other professionals to recognise that CPs' accounts of mental health is only one possible interpretation of the situation and empower stakeholders to ask more questions about CPs' views and alternative constructions. Moreover, such transparency is likely to strengthen the therapeutic alliance, a factor associated with positive outcomes (Martin, Garske & Davis, 2000) and service-user satisfaction (Roberts & Holmes, 1998) across therapies.

The findings of this study provided novel insights into the issues of accountability at stake during CPs' verbal interactions. The analysis demonstrated how CPs position themselves as liberal and thoughtful clinicians through giving agency to service-users and drawing on a discourse of moral concern, thereby helping clinicians to manage issues of accountability and to provide a rationale for potentially contentious choices in clinical practice. It may be possible to draw on some of the findings from this study to develop training packages to help CPs to reflect upon and engage in debate about the different positions they can adopt, that they may be forced into or place others in as well as the various functions served by such positions and discourses. In line with this, past research has outlined how therapists have been trained to help them to identify the discourses and positions that they and service-users adopt in therapy (McKenzie & Monk, 1997). This might help to increase CPs' levels of reflexivity in considering the choices that they make and the positions that they assume and give others in clinical practice.

This study has shown that CPs draw on a number of unarticulated assumptions about mental health and that certain discourses, such as the biopsychosocial model, are privileged which leads to certain consequences. There is a need to further examine the implications of these implicit assumptions and for clinicians to explore how the negative effects of the dominance of some of these assumptions can be

challenged. Hare-Mustin (1994) urged clinicians to be reflexively aware of the dominant and limited nature of certain discourses so that they can "challenge the assumptions of dominant discourses rather than merely going along with them" (p.33). It has been argued that such a process will provide space for subjugated discourses, thus giving a voice to alternative conceptions of mental health (White, 1995). Indeed, this study has revealed a wider diversity of constructions of mental health and associated dilemmas than one might expect having read policy documents, journal articles and textbooks.

4.4 Evaluation and suggestions for future research

The quality criteria that this thesis sought to meet were outlined in section 2.7, which the reader has been able to use in evaluating the study and I will reflect on the main considerations here. Research employing discourse analysis has been criticised for presuming that the findings or resultant discourses are representative of the population studied (Hammersley, 2003). As noted, rather than adopting a representational view of language, discourse analysts view language as action oriented and as being affected by a range of contextual factors. In this study mental health was conceptualised as a contested arena of competing discourses and all of the constructions expressed by CPs in my analysis are part of this discourse and thus of undeniable significance. I am not suggesting that this study was able to capture all of the possible constructions of mental health in circulation but rather some of the many discourses of mental health available to CPs. Whilst the idiosyncrasy of this research may be viewed as a limiting factor, it also carries many benefits as it is sensitive to the multiple voices, contradictions and variability that has been largely neglected by previous research. Although it is not possible to claim that the constructions outlined in this study are representative of CPs, this does not imply that the study of discourse remain only at the individual level. Indeed, this study has demonstrated some of the 'rules' of discourse followed by CPs in talking about mental health and outlined the sort of things that can and cannot be said from their positions.

Another criticism often levelled at qualitative studies is the supposed lack of clear criteria for identifying discourses and that the analysis is entirely dependent on the

competence of the researcher, and thus subject to human inconsistencies (Miles & Huberman, 1994). In line with Burr's (2005, p.152) suggestion that 'no human being can step outside of their humanity and view the world from no position at all' it is acknowledged that the work reported here inarguably reflects my own judgements and biases as well as contextual factors such as the limited word count. However, I have endeavoured to present the research process and the findings of this study with sufficient clarity and transparency to assure readers of the consistency employed throughout all stages of this process. As noted by Stainton-Rogers (1991, p.10), I am not telling it 'like it is', but instead suggesting 'look at it this way'. Thus, it is hoped that my openness in outlining the stages that led to the findings of this study will establish sufficient confidence that these were not simply the result of personal inclinations. Potter and Wetherell (1987) discuss research validity in terms of systematic transparency. Consistent with this idea, data extracts were included to demonstrate how the results were grounded in the data (Taylor, 2001), other researchers were consulted to discuss the analytical procedures and alternative interpretations of the data (Elliott, Fischer & Rennie, 2000), and a neutral stance was avoided by stating my own values, biases and situatedness. The question then becomes, 'are my analyses and implications persuasive, taking what you know of my assumptions into consideration?' (Harper, 1999b).

Nevertheless, there are limitations associated with my amateur status as a discourse analyst. In particular, although I tried to avoid *a priori* thinking when reading for discourses in the data, I wonder about the extent to which my own beliefs about mental health influenced what I chose to draw from the texts. Moreover, I am curious about what Edwards and Potter (1992) have called the 'interactional consequences', namely how my views of mental health affected what participants felt able to disclose in the interviews. Clearly, it is possible that their views and constructions were intersubjective, taking into account what they perceived to be my views of mental health. This issue is associated with the use of 'artificial data' in this study, which has been argued to decrease the ecological validity of findings (Potter & Hepburn, 2005). Although not epistemologically problematic, the method of data collection is likely to have impacted on the variability of the data. Given that mental health is an ambiguous and contested term, CPs may have been conscious of how they would be

perceived in constructing their accounts. For instance, my presence as a trainee CP is certain to have influenced the ways in which the CPs did professional accountability and how they defended their constructions of mental health and the choices made in clinical practice. However, such issues of self-presentation also reflect participants' assumptions and the positions that are 'taken-for-granted'. As such, the interviews provided a medium through which these could be explored in detail and, at times, be challenged, thereby offering a useful framework for examining variability in CPs' accounts.

Further studies might consider how CPs present and negotiate constructions of mental health with service-users and other professionals in clinical settings, thus providing the opportunity to compare the data from this study with naturally occurring talk. Given the possibility that assumptions about mental health influence clinicians' judgement of whether to challenge service-users' beliefs or not, there is also a need for further study of the influences on such decisions. Moreover, there is a need for research into service-users' constructions of mental health and their experiences of how views of mental health are negotiated in their interactions with clinicians so as to explore whether they see this process as open and collaborative as the CPs in this study presented it. It might also be fruitful for future research to conduct a discourse analysis of relevant policy documents and influential psychology texts that CPs use in training and clinical practice to examine the culturally available constructions of mental health within Clinical Psychology. The results of this study demonstrated how CPs frequently draw on the culturally available biopsychosocial discourse in constructing their accounts. Whilst the influence of cultural context was highlighted in analysing the actions performed by CPs' talk, it did not focus on wider contextual issues as much as a different form of DA might. For instance, undertaking this study using Foucauldian DA would enable a more thorough consideration of the impact of historical and cultural context on CPs' discourse. Such an approach might help to identify and document the disciplinary discourses used by CPs to construct mental health and its effects, which would be helpful as it might lead to a rethinking of CPs' conceptual underpinnings in relation to mental health.

Part Five: Reflexive Section

5.1 Section introduction

In traditional empirical research, the supposed neutrality of numerical data pre-empts the necessity of reflexivity. However, from a social constructionist viewpoint, all knowledge is considered to be influenced by the epistemology and ontology of the researcher, and is therefore value laden. As such, the relationship between the content of the research and the researcher's theoretical and methodological positioning must be understood reflexively (Potter & Wetherell, 1987). The prime concern of this reflexive section is the continuous decision-making processes that has led to the contents of this thesis. These reflections are informed by the reflective journal kept throughout the research process as well as other forms of research record keeping such as supervision notes and analytic memos. This section aims to make my personal and theoretical biases explicit in order to enable readers to evaluate and redefine the multiple established claims and counter-claims made in the study. In line with previous studies highlighting the importance of paying attention to reflexivity issues, it is hoped that the process of describing, explaining and reflecting on the various stages of the research will further add to the rigour and trustworthiness of the study (Flick, 2006).

5.2 Reflexivity – epistemology and methodology

The epistemogical assumptions of this research and the use of a DP framework highlighted the difficulties of conceptualising talk within context. This study remained at the discursive level and only looked at the consequences of CPs' talk to the extent that these were evident in the discourse. The neglect of wider contexts in DP has led critical theorists to point out that DP analyses are only able to demonstrate how people talk about subjects but not, crucially, the contextual consequences of doing so (e.g., van Dijk, 1997). Throughout the research I found myself drawn towards explaining CPs' constructions of mental health and its effects as the outcome of dominant discourses. This is noteworthy since this study was not concerned with the macro level of talk and did not, for instance, analyse policy documents as one might have done using a different form of DA such as FDA. As such, I wonder about the extent to which my preconceptions about what might constitute the dominant discourses for CPs caused me to seek for confirmatory evidence to support these

ideas. Moreover, at the start of this process I had considerably less knowledge about DA and it therefore has to be acknowledged that there may be more complex ways of answering the research question. However, in line with its epistemological assumptions, this study allowed me to channel my idiosyncratic constructions of the world into the research and its subjective nature could thus be viewed as a strength. In addition, through learning more about alternative frameworks for analysing discourse such as FDA I have come to appreciate the value of DP and how it allows researchers to stay close to the data thereby constructing, in my view, more grounded and convincing arguments for possible effects of talk.

5.3 Reflexivity – interviews

The social constructionist epistemology of this research implies that I, as a researcher, need to be sensitive to the role that I played in generating the data. The interviews represented a particular power dynamic as, through the authority afforded to me by my role as the researcher, I controlled the research, the direction of the conversations and the analyses that followed. This interview dynamic is likely to have positioned the CPs in different ways and influenced what they felt able to say. Indeed, Gilbert (1980) described how such dynamics creates roles such as confessant and student for participants. The interviews were also characterised by my role as a trainee CP which may have given me what Taylor (2001) calls 'inside status' in my interactions with the CPs as I was part of the same system that I sought to examine but who, in a work situation, would have more power than me. This context may both have worked to complement and undermine the research process as, although the language culturally available to the participants and myself may have been the same, I was often drawn towards accepting CPs' accounts and found myself wanting to be less critical. This issue made me reflect on how when we as professionals position ourselves as protective of our collegues we may in part be protecting ourselves from being undermined by others. Clearly, such acts of protection are problematic as they may result in oppressive practices remaining unchallenged. Other researchers have commented on how a similar professional status can give researchers an increased awareness of what it might be like to be in the participants' shoes and therefore help to maintain a respectful curiosity in interviews (Cecchin, 1987). Throughout the interviews I adopted a conversational

interviewing style and tried to strike a balance between what was interesting to the participants and what was interesting to me as a researcher with the aim of providing a context for linguistic variation (Potter & Wetherell, 1987). Although I was at times tempted to see myself as 'neutral' in the interviews, it is recognised that even my questions, which demonstrated that I was not taking things for granted, were likely to have communicated to participants that I was coming from a particular position. These factors unavoidably contributed to constructing a particular framework for the interviewees' accounts and, as such, it is acknowledged that alternative findings might have been produced if the research was undertaken in a different context.

5.4 Reflexivity – analysis and write-up

Throughout the process of reading and analysing the data I often felt at sea, arguably in part because explicit guides to conducting discourse analyses are not available as it is considered to be a matter of developing a particular analytic mentality and tacit expertise gained through careful reflective reading (e.g., Potter & Wetherell, 1987; Willig, 2008). This general vagueness about the process of choosing themes added to my awareness of how the choices that I made in focussing on particular analytic themes were my own constructions. This caused me to question whether these were at all grounded in the data, an issue which became especially apparent when I read the data to find instances consistent with the devices that I had constructed. In the end I made a selection of themes that felt justified in light of the data, the aims of the study and wider literature whilst recognising my personal influence on these choices. Hollway (1989) commented on the dual danger of representing the analysis as more matter-of-fact than it actually was or to construct it as completely open-ended and thus arbitrary. Taking this into account, I am hoping to communicate that the process of analysing the data and writing up the research was a struggle. I am not doing so in order to confess my limitations as a discourse analyst but rather to outline the methodological processes through which this analysis was arrived at, a feature lacking in much of DA research (Harper, 1999b). Another aspect of this process that is worthy of some reflection is the way in which I have, throughout this thesis, used specialist language, quotes from other researchers and various other discursive strategies to construct my account as credible. As such, this thesis is not so much a systematic record of facts as it is a complex social accomplishment (Gergen, 1999;

Harper, 1999b). The rationale for highlighting these ideas is not to reject empiricism or realism but to emphasise the constructive nature of language and the complex contextual factors that have influenced this research.

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APPENDICES

APPENDIX A: PARTICIPANT INFORMATION PACK

INFORMATION ABOUT THE RESEARCH

Clinical Psychologists' Conceptualisations of Mental Health and its Perceived Effect on their Work with Service-users

Researchers: Axel Lofgren, Dr. Roshan das Nair and Dr. Vanessa Dale-Hewitt

Invitation to take part in a research study on conceptualisations of mental health

You are being invited to take part in a research study. This study will go towards the completion of the Doctorate in Clinical Psychology for the study co-ordinator, Axel Lofgren.

This information sheet will tell you why the research is being done and what participation involves. Please take time to read the following information carefully and consider whether you would like to participate in this research.

What is the purpose of the study?

The aim of the current study is to examine Clinical Psychologists' conceptualisations of mental health and its perceived effect on their work with service-users. Therefore, we are interested in speaking to you and other clinicians to explore how you as a clinical psychologist think about mental health and the implications (if any) of these conceptualisations.

Participation in the research will involve taking part in a semi-structured interview with the study co-ordinator. You will also be requested to complete a brief demographic information sheet. Participation in this study is voluntary and hopefully you will find participation interesting.

Do I have to take part?

No, participation in this study is entirely voluntary. We will describe the study and go through this information sheet with you. If you agree to take part, we will then request you to sign a consent form.

What will taking part involve?

- Participation in this study will involve being interviewed about this topic by the study co-ordinator, organised at a time convenient for you. The interview is

likely to last between 40 and 90 minutes. During the interview, you will be asked a a series of questions relating to your conceptualisation of mental health.

- You will be asked to complete the attached demographic information sheet, which asks you some questions about your current job role.
- At the interview, we will be able to answer any further questions you have about the research; we will go through this information sheet and the consent form with you.

What are the potential benefits and costs of taking part in the study?

The research itself may not be of direct benefit to you. However, if the findings of this study are able to provide more information about the implications of conceptualisations of mental health on the therapeutic relationship, these may then be used to inform training of clinical psychologists in the future. Although the interview will be conducted at a time convenient to you, it will involve the cost of time to meet with the researcher. It is expected that the interviews will take place during working hours, therefore every effort will be made to conduct this at a time that causes least disruption to you and your colleagues; this will be considered when arranging the interview.

What will happen with the information I give during the study?

The interview will be recorded on a digital audio-recorder. This is so that the interview can be transcribed. The digital recordings will be stored in a locked filing cabinet until they can be transcribed, at which point the recording will be erased. The transcriptions will be anonymised using a coding system so that you will not be identifiable from the typed notes.

The personal information will be kept separate from the research data. Quotations from the interview may be used in the final version of the current research and may be submitted for publication in scientific journals and/or presentation at conferences. However, no one will be able to link the data you provide to you, and only the study co-ordinator will have access to the audio recordings and transcripts before they are anonymised.

Informed consent

Prior to participating in the interview, you will be requested to complete the attached consent form.

What will happen if I don't want to carry on with the study?

Your participation is entirely voluntary and you may decide to stop being a part of the research study at any time without explanation up to two weeks after the date of the interview. You have the right to ask that any data you have supplied to that point be withdrawn and destroyed. You have the right to refuse to respond to any question that is asked of you without penalty.

What if there is a problem?

Given the general nature of the questions, the study is unlikely to cause distress to participants. However, if you have a concern about any aspect of this study or if you experience distress as a result of participation, please contact the research supervisors for this project Dr Roshan das Nair or Dr Vanessa Dale-Hewitt on 0115- 846 8314.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham. Research ethics approval has been obtained from the Institute of Work, Health and Organisations at the University of Nottingham.

How do I get involved?

If you are interested in taking part in this study we would be delighted to hear from you. Please contact the study co-ordinator using the details provided below. We will be happy to answer any further questions you may have.

FOR FURTHER INFORMATION PLEASE CONTACT
AXEL LOFGREN
I-WHO, University of Nottingham
International House,
Jubilee Campus, Wollaton Road
Nottingham. NG8 1BB
E-mail: lwxal3@nottingham.ac.uk

APPENDIX B: CONSENT FORM

CONSENT FORM
(07/03/12 Version 3)

Title of Study: Clinical Psychologists' Conceptualisations of Mental Health and its Perceived Effect on their Work with Service-users

REC ref:
Researchers: Axel Lofgren, Dr Roshan das Nair and Dr Vanessa Dale-Hewitt

Name of Participant:
Participant ID:

1. I confirm that I have read and understand the information sheet (Version 3, 07/03/12) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw from the study two weeks from the date of interview without needing to justify my decision and without penalty.

3. I understand that authorised individuals may look at the data collected in the study where it is relevant to my taking part in this study. I give permission for these individuals to have access to and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential.

4. I understand that the interview will be audio-recorded and that anonymous direct quotes may be used in the study reports.

5. I have read and understood the above and I agree to take part in the study.

_____	_____	_____
Name of Participant	Date	Signature

_____	_____	_____
Name of Principal Investigator	Date	Signature

APPENDIX C: DEMOGRAPHIC INFORMATION FORM

The University of Nottingham

DEMOGRAPHIC INFORMATION FORM
(06/03/12 Version 3)

1. Please indicate your gender.

   _____

2. Please indicate your age (in years).

   ☐ 20-29 ☐ 30-39 ☐ 40-49 ☐ 50-59 ☐ above 60 years

3. Please indicate the number of years you have been qualified as a Clinical Psychologist.

   _____ years.

4. Please indicate the type of service that you work in?

   _____

5. Please indicate the approximate number of hours of your work-week spent in direct contact with service-users.

   _____ hours.

6. Are you providing supervision as part of your current job role?

   ☐ Yes ☐ No

7. If you answered yes to the previous question, please indicate how many hours a month you provide supervision.

   _____ hours.

APPENDIX D: INTERVIEW SCHEDULE

The University of Nottingham

INTERVIEW SCHEDULE
(06/03/12 - Version 3)

Introduction
- Cover confidentiality
- Go through what will happen during the interview.
- Any questions before we start?

Setting
1. What type of service do you work in?
Prompts
- Can you tell me a bit about the service you work in?
- How would you describe the people you work with in your clinical practice?
- What influenced your decision to work in (the service that you work in)?
- Is there anything in particular about the service that attracted you to it
- How do you think your colleagues in this service conceptualise mental health?

Clinical Practice
2. Can you tell me a bit about the work you do?
Prompts
- How would you describe your clinical practice?
- How would you describe yourself as a Clinical Psychologist?
- How do you identify yourself as a Clinical Psychologist?
- What informs the choices that you make in your clinical practice?
- How do you position yourself as a Clinical Psychologist?
- Do you align yourself with any particular school of thought?

Conceptualisations of Mental Health
3. What is your understanding of mental health?
Prompts
- How do you view the idea of mental health?
- How do you define mental health?
- How do you conceptualise mental health?
- How do you make sense of mental health?

Factors associated with Conceptualisations
4. What factors do you think influence your view of mental health?
Prompts
- Where does your idea of mental health stem from?
- What were your assumptions about mental health before training as a Clinical Psychologist?
- Have these assumptions changed?
- What assumptions have changed and how?

Link between Conceptualisations of Mental Health and Clinical Practice

5. How do you think your views about mental health influence your work with service-users?

Prompts

- In what way does your conceptualisation of mental health affect your clinical work?
- Are there certain aspects of the job that are more affected by your views of mental health than others?
- How do you think your conceptualisation of mental health fits with the service you work in?
- How do you think your conceptualisation of mental health fits with the rest of your colleagues?
- Do you think your service-users come away with an idea about your understanding of mental health?

APPENDIX E: ADAPTED JEFFERSONIAN TRANSCRIPTION NOTATION SYSTEM

Symbol	Example	Explanation
(0.8)	Are you (0.4) sure?	**Pause** is measured in tenths of a second.
(.)	so (.) what	**Micro-pause** is less than two-tenths of a second.
:::::	I:::: I am not sure	Colons denote **sound-stretching** of preceding sound (in tenths of seconds).
___	I <u>think</u> so	Underlining indicates **emphasis** by speaker.
{	I: **{**I was just CP: **{**Well if you	Left brackets indicate the point at which one speaker **overlaps** another's talk.
=	I was=well if	Equal sign indicates that there is **no hearable gap** between the words.
WORD	I'm not SURE	Capitals, except at beginnings, denote a **rise in volume**.
°	°or maybe not°	Words in degree signs denote **quieter** talk.
> <	>I'm not sure<	Carets pointing "inwards" mark faster pace.
< >	<I'm not sure>	Carets pointing "outwards" mark slower pace.
?	Right?	Question mark denotes **rising intonation.**
.	Of course.	Full stop indicates **falling intonation.**
Hhh	I can see .hhh that	A row of h's prefixed by a dot indicates an **inbreath**, without a dot, an outbreath (each h denotes duration in tenths of seconds).
( )	What is ( ) doing	Single bracket with no text for **unhearable** word.
(word)	What are you (doing)	Word in parentheses denotes the **best possible hearing.**
(( ))	I am not ((coughs))	Words in double parentheses contain **author's descriptions.**

(Adapted from Rapley, 2007).

APPENDIX F: ETHICAL APPROVAL DOCUMENTS

Institute of Work, Health & Organisations
http://www.nottingham.ac.uk/iwho

The University of Nottingham
UNITED KINGDOM • CHINA • MALAYSIA

Axel Lofgren

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18/11/2011

Dear Axel

I-WHO Ethics Committee Review

Thank you for submitting your proposal on "An Exploration of Clinical Psychologists' Conceptualism of Mental Health and its perceived Effect on their Work with Service-Users: A Qualitative Study". This proposal has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

The Committee require that you make the following amendments. The information sheet and consent form need to have the University header. Contact details on the information sheet need to include supervisor. Please submit the revised sheet to us.

If there are any significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

You should also take note of issues relating to safety. Some information can be found in the Safety Office pages of the University web site. Particularly relevant may be:

The *Safety Handbook*, which deal with working away from the University.
http://www.nottingham.ac.uk/safety/
Safety circulars: Fieldwork P5/99A on
http://www.nottingham.ac.uk/safety/publications/circulars/fieldwk.html
Overseas travel/work P4/97A on http://www.nottingham.ac.uk/safety/publications/circulars/overseas.html
Risk assessment on http://www.nottingham.ac.uk/safety/publications/circulars/risk-assessment.html

Responsibility for compliance with the University Data Protection Policy and Guidance lies with all researchers.

Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

We would remind all researchers of their responsibilities:

- to provide feedback to participants and participant organisations whenever appropriate, and
- to publish research for which ethical approval is given in appropriate academic and professional journals.

Yours sincerely

Professor Nadina Lincoln
Chair IWHO Ethics Committee

Institute of Work, Health & Organisations
http://www.nottingham.ac.uk/iwho

The University of Nottingham
UNITED KINGDOM · CHINA · MALAYSIA

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02/12/2011

Dear Axel

I-WHO Ethics Committee Review

Thank you for submitting your amendment to your study entitled "An Exploration of Clinical Psychologists' Conceptualism of Mental Health and its perceived Effect on their Work with Service-Users: A Qualitative Study". This amendment has now been reviewed by I-WHO's Ethics Committee to the extent that it is described in your submission.

I am happy to tell you the Committee found no problems with your amendments. If there are any further significant changes or developments in the methods, treatment of data or debriefing of participants, then you are obliged to seek further ethical approval for these changes.

We would remind all researchers of their ethical responsibilities to research participants. The Codes of Practice setting out these responsibilities have been published by the British Psychological Society. If you have any concerns whatsoever during the conduct of your research then you should consult those Codes of Practice and contact the Ethics Committee.

Responsibility for compliance with the University Data Protection Policy and Guidance lies with all researchers.

Ethics Committee approval does not alter, replace or remove those responsibilities, nor does it certify that they have been met.

Yours sincerely

Nadia Lin

Professor Nadina Lincoln
Chair IWHO Ethics Committee

APPENDIX F: FRAMEWORK FOR ANALYSIS

What are the patterns present in the text? (Potter & Wetherell, 1987)

What variations are there in the text? (Potter & Wetherell, 1987)

What kind of positions are set up and taken up? (Davies & Harré, 1990)

What kinds of identities are created? (Silverman, 2001)

What concepts are constructed as taken-for-granted, given or obvious? (Potter, 1996)

What are the dominant narratives in the accounts? (Parker, 1998)

What evidence of resistance to dominant narratives is present in the text? (Parker, 1998)

How are accounts of mental health designed to accomplish their factual status?

What rhetorical strategies and devices are used? (Edwards & Potter, 1992)

What problems might these rhetorical strategies function to manage? (Potter & Wetherell, 1987)

What are the metaphors used in the accounts? (Potter & Wetherell, 1987)

How do speakers attribute authority to their accounts?

What is not said that might have been? (Potter & Wetherell, 1987)

What oppositions are implied in the text? (Cameron, 2001)

What type of world is constructed in the text? (Rapley, 2007)

How is reality negotiated by speakers? (Potter, 1996)

What means of describing and defining mental health are present in the accounts?

What ideological effects might these have? (Willig, 2008)

What is achieved through these accounts?

Which of these effects occur frequently? (Willig, 2008)

What are the relationships between the different discourses of mental health?

APPENDIX G: STEPS TAKEN IN THE ANALYSIS

Step 1
Following each interview, interesting aspects were written down and considered in relation to other findings. Parts of the interviews that were deemed analytically interesting (e.g., relevant to the research questions, helpful in interpreting the data, good illustrations of themes and rhetorical devices) were also transcribed and brought to research supervision sessions for discussion.

Step 2
Following transcription, reading and re-reading of the data corpus facilitated the development of broad categories informed by the questions in the interview schedule. Features of the data that were considered interesting were also highlighted to generate additional headings using the same criteria as outlined in Step 1. Working as inclusively as possible, the transcripts were then re-read again and additional extracts were placed under the broad headings as were relevant notes and parts of extracts noted earlier in the process. Any parts of the transcripts deemed to belong to more than one category were copied to both or all. To allow the analysis to be visibly grounded in the data and to remain traceable, all extracts were referenced with the page number and pseudonym of participants' transcripts.

Step 3
At this stage of the analysis, I felt rather overwhelmed by the vast amount of categories and data, an experience described by previous discursive researchers (Potter & Wetherell, 1987). Research supervision sessions were invaluable in facilitating the process of selecting a narrower focus to provide a structure to the data. Through discussions with the research supervisors the following features were selected for further analysis: constructions of mental health and their effects, the negotiation of views with service-users, construction of views of mental health as needing to be controlled/regulated in interactions with service-users, construction of the issue of whether to disclose views of mental health to service-users. Within each of these wider categories there were a number of sub-categories (especially within the category of 'constructions of mental health' as reflected in the many aspects covered in the results section). As well as these broader categories, recurring features in the data and frequently employed discursive strategies were also included for further analysis. For instance, the CPs' tendency to respond with surprise and confusion to my question about their views of mental health was deemed analytically interesting and was therefore included.

Step 4
These extracts were then read keeping in mind the analytic questions outlined in Appendix G, picking out relevant trends and features in the data and thinking about these in relation to the research aims. This process resulted in the formation of novel categories, the merging of other categories and some of the original categories becoming redundant to the aims of the research and they were consequently omitted in line with the analytic framework (Potter & Wetherell, 1987). The links between the various categories were also considered and they were grouped accordingly to develop a framework for the analysis that would enable a coherent linear story to be told about each aspect of the research (e.g., realist and relativist constructions of mental health).

Step 5

Once an initial draft structure had been developed, extracts were chosen on the basis of their relevance to the aims of the study, their ability to illustrate prevalent features of the data in a way that did not require readers to refer to the rest of the excerpt, and the extent to which they were able to demonstrate richness, diversity and variation of an example. On this basis a first draft of the analysis section was prepared.

APPENDIX H: STATEMENT ON PERSONAL REFLEXIVITY

Following Yardley's (1997) recommendations regarding reflexivity, I will briefly summarise my position on conceptualisations of mental health. I am sceptical of biological conceptualisations of mental health as I think that there is a risk of taking a person's experience out of its social and historical context, thus dismissing significant aspects of their experience and converting it into an individual problem. Instead, I prefer to locate mental health within the wider contexts, such as families, institutions, and broader societal issues of inequality. The interviews were treated as conversations rather than as elicitations and both parties were considered responsible in the production of meaning, although from different positions. However, in the interviews I did not elaborate on my own views on mental health or any other topic. Throughout the process of this study I endeavoured to be attentive to my own perspectives and sought to address and discuss any preconceived ideas that were brought up and the impact of these on the research.