Accounting for health and illness: A social psychological investigation

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ACCOUNTING FOR HEALTH AND ILLNESS

A SOCIAL PSYCHOLOGICAL INVESTIGATION

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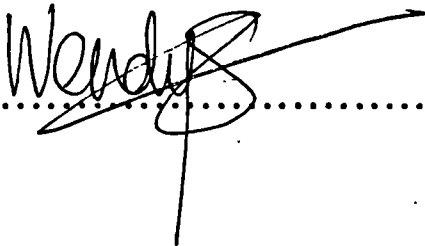
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SUMMARY

This thesis identifies and describes some of the main accounts for health and illness that are current in British culture, placing them within broader contexts of psychological, sociological, traditional, religious and moral discourses; within broader explanatory frameworks; and, by way of an analysis of these ecological aspects, seeks to illuminate our understanding of such accounting.

A combination of Q and ethnographic methods were used to elucidate a variety of alternative ways that people 'make sense' of health and illness. Three main studies were conducted. The first two investigated accounting for health and illness within a broad framework of accounts as 'explanations'; as moral judgements and prescriptions; and as defining meaning. The third study focussed on the external/internal explanatory framework, and demonstrated that accounting is far more complex than the Wallston and Wallston (1981) 'Health Locus of Control Construct' would suggest. Some accounts stressed 'internality', some 'externality', some a combination of both, and others viewed this construct as non-salient. These latter included accounts about personal autonomy, and, importantly, the 'medical model' account.

In the thesis overall, among the accounts identified were ones based upon notions of : 'the wonders of modern medicine'; 'stress'; 'the cultural critique'; 'a healthy lifestyle', 'tradition'; 'individual autonomy', 'Theism'; and 'Willpower'. These accounts are assumed to operate both within individual subjectivity and popular discourse, offering people a variety of complementary 'texts' with which to weave narratives, drawing upon different 'texts' according to situational and other demands. Thus accounting is portrayed as an active, thoughtful and sometimes contradictory 'storymaking' activity, and people as competent negotiators of reality.

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This thesis is dedicated with gratitude
and affection to Will Stephenson, who
has been the greatest inspiration.

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CHAPTER 1 : ACCOUNTING FOR HEALTH AND ILLNESS : THEORETICAL CONTEXT

1.00 INTRODUCTION

This thesis is about the way people in Britain account for health and illness - how they explain, to themselves and to others, what are the influences upon and reasons for good health, becoming ill and recovery. It is a specifically social psychological endeavour in that it seeks to articulate this accounting both within the domains of 'the psychological' and 'the social'.

Both its theorisation and empirical studies draw upon the work of Claudine Herzlich (1973) who has provided what is still the most influential analysis of the social psychology of accounting for health and illness. She worked within Moscovici's (1961) 'social representation' theory-base, which attempts to combine Durkheim's (1898) notions of individual and collective representation.

However, while Herzlich discovered a number of alternative metaphors and explanations for and representations of health and illness, her approach was basically nomothetic, stressing the communality of shared representations. The work presented here takes the alternative approach of exploring diversity, examining the many different kinds of explanations for and understandings of health and illness to be found operating both individually and collectively within contemporary British popular discourse. Unlike her exclusive use of ethnographic methodology, here ethnography has been combined with Q methodology (Stephenson, 1935, 1953), a methodological paradigm specifically intended to identify and describe alternative images, viewpoints or accounts.

The other major difference from Herzlich's work is that whereas she was primarily interested in just the content of the social representations she discovered, I have attempted to combine the tasks of identifying and describing different accounts for health and illness, and exploring how a focus on accounting may offer useful understandings about social cognition.

Thus as a starting point, I have assumed that people 'make sense' of a topic like health and illness, not by being driven by dispositional traits, psychological mechanisms or sociological forces, but by drawing upon a number of different accounts. The research to be presented here was designed to find out what kinds of accounts might be available to them, and how 'accounting' (cf Harré, 1979; Semin and Manstead, 1983) may offer a more plausible and workable portrayal of 'making sense' than such mechanistic modelling.

This Chapter is intended to 'set the scene' for the thesis, beginning with a brief overview of its theoretical starting-points, particularly that of the 'new paradigm' of interpretational social psychology. The next three Sections describe how the work of the thesis fits into broader anthropological, sociological and psychological theorisation. Finally the Chapter ends with an overview of the thesis as a whole, to provide clarification of how its various themes and components fit together.

1.1 THEORETICAL CONTEXT : NEW PARADIGMS FOR OLD

Just as the term ´nouvelle cuisine´ has been repeatedly used from at least the eighteenth century to describe whatever was the latest fashion in cookery, psychology, even in its much shorter history, has been continually faced with ´new paradigms´. Each one is presented as a dramatic refutal of a worn-out previous order, offering fresh insights and innovative solutions. It is almost as though theories, like washing machines, have built-in obsolescence, so that after a period of constant use, they cease to work efficiently and need to be replaced by a new model.

The most recent ´new paradigm´ of social psychology (cf Harré and Secord, 1972) is no exception, refuting the trap of essentialism, the austerity and artificiality of laboratory experimentation, and the image of people as "... idealized automata in bland, anomic environments" (Harré, 1979), proposing in its place a ´new psychology´ in which the purposive, rule-making and rule-following, constructive aspects of personhood and social interaction form the subject of study.

1.1.1 Tensions within current theorisation

This new social psychology was launched in the late sixties and early seventies at a time of major social upheaval in Western society; an upheaval comprised of paradoxical tensions between a renewed interest in sociological and cultural influences upon behaviour and experience, and commitment to ´social responsibility´; and an increasing interest in uniqueness of the individual, and commitment to self-expression.

On the one hand emergent feminist, Marxist, politically radical and civil rights groups were questioning what they saw as the "psychology of the ´good guys´" (Moscovici, 1971) dominating theorisation in a way that portrayed women, ethnic minorities and the poor as ´deviant´, and failed to recognise the effects of inequality and disadvantage. On the other hand, the humanistic and self-actualisation movements were questioning the mechanistic aspects of behaviourism that portrayed people as passive and mindless, denying individual creativity and spiritual values.

These tensions were reflected by pressures, from the former, to forge links with sociology (and less often with anthropology) in order to acknowledge the societal and cultural determinants defining and limiting action and constructing and constraining experience; and pressures from the latter to develop a new, emancipatory psychology which recognised the importance of self-determinancy and the individual´s capacity for self -definition.

Today these tensions between ´the social´ and ´the individual´ have emerged as the major theoretical problem that psychology has to face - how can we develop theories that do justice to the singularity of each individual´s unique experience, while at the same time recognising the importance of shared culture and common social experience ? The problem, drawing historically upon the I/me distinction proposed some fifty years ago by the sociologist G.H. Mead (1934), has been variously described as one of :

inner/outer dialectics (Riegel, 1978); person-constructs-reality /reality-constructs-person (Buss, 1979) person as subject/object (Henriques et al, 1984); psychological/sociological levels of analysis (Doise, 1986); material-like cultural/ mental domains (Pribram, 1986).

1.1.2 Democratic fusion versus sympatricity

The solutions adopted to this problem have been varied. Attempts to meld the two within a single theory have been articulated both within sociology and psychology. The sociologists Berger and Luckmann (1966), for instance, offered a social constructionist framework within which people are seen to construct their realities within a cyclical interplay of three 'moments' (internalization, objectification and externalization). Within psychology Riegel and Buss proposed different versions of a 'dialectical psychology' combining the two theoretical polarities of 'person' and 'society' within reflexivity, and Pribram has suggested that the duality can be elided over by simply assuming that they are alternative facets of a single entity.

However Henriques et al and Doise argue that such a 'democratic fusion' of theories is impracticable because they are "different universes of discourse" (Doise, op cit) and therefore cannot merely be combined or added together. Henriques et al argue the case strongly in their criticism of the questions raised by 'new paradigm' socialisation theories (such as those of Shotter, 1974 and Richards, 1974) :

"None of these questions can be addressed while psychology brackets off content into the domain of the social and defines it as outside of the boundaries of its theories, to fall within the domain of sociology, for example. In socialisation theory it is implicitly assumed that, if they are added together, the ideas of psychology and sociology will produce a full explanation. But this assumption is itself based upon the idea that the theoretcal objects of the two disciplines - individual and society - are commensurable. In fact in psychology they are two kinds of theoretical objects produced in different discourses through different disciplines, destined to bypass each other in the addition as they do in the interaction." (p20).

The basis of this assumption of incommensurability is the growing conviction (cf Devereux, 1972; Doise, 1978, 1986; Potter, 1984) that the articulation of new theories is not the product of Kuhnian (1962) ´paradigm shifts´ of sequential overthrow, each new paradigm replacing the last, but rather a situation where at any moment there will be competition between a number of mutually contradictory theories. Press (1980) has offered the term ´sympatricity´ for such a situation, drawing an analogy between theories, and species in a biological ecosystem.

Sympatric species are those that compete, within any ecosystem, for resources and ultimately for survival, but at any point in time will be seen to be co-existing and equally viable. The image is of sympatric theories that operate in parallel, at the one and the same time competing and co-existing. We thus arrive at a philosophy of science which argues that what researchers and theorists should be doing is not seeing theory testing and building as some evolutionary game of theoretical ´survival of the fittest´, but instead should be exploring theoretical ecology (cf Adam, 1987) within which each theory implicates (but at the same time excludes) the others.

1.1.3 Complementarity

These ecological notions are themselves not new. In the nineteenth century William James introduced a number of pertinent concepts that are now receiving renewed attention (e.g. Stephenson, 1986a, 1986b). Most central is that of theoretical ´complementarity´ (James, 1891), where phenomena require separate and different theory-bases to be understood. Stephenson (citing the physicist Bohr) offers the wave and particle theories of light in physics as an example.

Applied to present day psychology, the principle of complementarity proposes that no single theory will ever be able to ´make sense´ of social phenomena. Just as both wave and particle theories are necessary to ´make sense´ of the properties of light, so too must more than one theory be used to ´make sense´ of people´s thoughts and actions. They cannot be subsumed, because the nature of complementarity is that of alternative universes of meaning and explanation. What something ´means´ in one universe is different from what it ´means´ in another (what Barnes and Law, 1976 , call ´indexicality´).

1.1.4 Transitive and substantive thought

Stephenson (1986c), once more deriving his ideas from James, has suggested that this problem can be overcome by distinguishing between subjective thought that is ´transitive´, within which complementarity can be articulated; and explication or action, by its nature ´substantive´, where at any one moment only one state can exist. Theorisation, argues Stephenson, needs to be

transitive, whereby any theory is seen to implicate that which it does not explicate. Pribram argues a similar case, citing as an analogy the conceptual distinction made by the physicist Bohm (1971, 1973) between seeing ´reality´ through a lens or a hologram :

"Lenses focus, objectify and draw boundaries between parts. Holograms by contrast are distributive, unbounded, and holistic ... our lens-given ordinary perceptions (are) explicate, and those that are holographic (are) implicate." (Pribram, op cit, p 517).

As James (1878) explained it, when we hear thunder, we do not hear it ´pure´ as a loud crashing sound, but as thunder-breaking-upon-silence-and-contrasting-with-it. All of our thinking and experiencing (including the thinking we call theorisation) consists of implicating that which ´makes sense´ of what we are explicating. The message is that we should design theories that are holographic. Adam (1987) argues the case specifically, that we need :

"... an approach that is not fragmentary, static, linear and dichotomising, but one which seeks dynamic interrelations where that which is not studied remains, nevertheless implicated in that which is being explicated." (p 7)

1.1.5 A new theory of accounting

Perhaps the most exciting corollary of such an exhortation is that the principle of complementarity offers not just a conceptual framework for considering theorisation, but a basis for theorising itself, about, say, psychological phenomena like attitudes, opinions and beliefs. Such a theory of accounting is that the activity of accounting in everyday life is, as is academic theorising, a process of making explicit (and thereby

making substantive) one from a number of complementary accounts implicit within transitive thinking.

From this perspective, when an individual marks an item on an attitude scale, they are not simply operationalising 'their' opinion (i.e. making explicit a single implicit and enduring 'essence'), they are selecting one from a range of contradictory 'attitudes' - they are choosing which one to explicate according to such things as situational demands, 'mood', what is 'top of mind' and so on. But in a different state of mind, or different situation, or following a different set of prior events, they might well explicate a different 'attitude'. Like the physicist who selects which of the wave or particle theories to draw upon depending upon what is to be achieved, people select which of their accounts to draw upon according to the function to be served by its expression.

1.1.6 Holographic theorisation

This theory-base has been expressed within several current conceptual developments. One is discourse analysis (cf Potter and Wetherell, 1987) which stresses the constructive and variable nature of discourse, and seeks to study what people say in conversations in terms of the discursive functions of the variability to be found. The image is one of the person as a "capable negotiator of reality", able to perform a range of functions by their utterances, ranging, say, from self-presentation management to social 'grooming' when in interaction with others, and from say, rationalising to

problem-solving when engaged in private thought. Discourse analysis emerged from psycholinguistics (e.g. Chomsky, 1966; Searle et al, 1979), from ethnomethodology (particularly from the work of Garfinkel, 1967, 1974), from semiology (particularly the work of Saussure, 1974 and Barthes, 1985) and Mead's symbolic interactionism (1934).

Another example is 'situated identity' (cf Weinreich, 1969, 1980, 1983, 1986) which draws upon psychodynamic (e.g. Erikson, 1959, 1968), personal construct (cf Kelly, 1955) and, once more, symbolic interactionist (cf Mead, 1934; Goffman, 1959; Harré, 1979) theories, to articulate the interplay between personal and social identity, and the shifting expression of identity according to situational and other demand characteristics.

Paradoxically, what such formulations have in common is both a shift towards a holistic perception of experience and the person which seeks to integrate the many facets of accounting, discourse or identity; and a distributive perception of the contradictory features of the constituent elements. It is an approach which is fundamentally holographic, seeing the whole as implicated within each of the parts.

They are thus developments from the simpler ideas of 'constructive alternativism' (cf Kelly, 1966), 'social constructionism' (cf Berger and Luckmann, op cit) and 'invented realities' (cf Watzlawick, 1984) in that they posit not just the construction of reality, nor just that different people (as

individuals and groups) construct different realities, but that each individual and collective draws upon and lives within multiple realities.

But the image is not one of personal or collective ´schizophrenia´; of living and operating within a complete muddle of unmanageable confused and contradictory thoughts and selves (although it is a much more multifaceted image than most other perceptions). Rather, the image is one of people as "negotiators of reality" (Potter and Wetherell, op cit) whose supreme competence is that they <u>can</u> and <u>do</u> create order out of chaos, and make sense of their world amid the cacophony.

This portrayal of people as competent negotiators of reality, operating upon complementary and sympatric accounts to ´make sense´ of their social world and social being, was the basis of my selection of Q methodology as the main methodology to explore accounting. Stephenson, the originator of Q methodology, initially designed it and continues, fifty years on, to develop it as a means of identifying and describing the complementary elements that make up our "stream of consciousness" (James, 1909).

1.1.7 Accounts

The overarching theory-base for this thesis is thus founded upon the assumption that whenever people explain or describe or argue about a particular topic such as health and/or illness, they do so by drawing upon a number of complementary accounts. According to the moment-to -moment situation, they select from

these transitively sympatric accounts as a basis for substantive expression; thus at any moment, they explicate just one. But that they express just one at any point does not imply that they have just one, but that it is merely the basis of their current ´frame of mind´; and furthermore, in similar terms to what Potter and Wetherell (op cit) have argued, as their ´frame of mind´ shifts within the course of conversation or thinking, so too does the account from which they draw.

However, this theory-base is not just suggesting that accounts are synonymous with unconnected ´thoughts´. The assumption is that accounts are complex and highly articulated implicit theories within which are interwoven attributions about reasons and causes, predictions and understandings; within which particular meanings are accredited to propositions and words and images; within which are moral prescriptions and evaluations.

Accounts, as I have defined them for use in this thesis, share properties with Abelson´s (1976) ´scripts´, Bartlett´s (1932) concept of ´schema´, Moscovici´s (1961) ´social representations´, Kelly´s (1966) ´personal construct system´ and Potter and Litton´s (1985) ´linguistic reportoires´ in that they are the product of active striving to ´make sense´. Some will originate intrapersonally as a result of individual thinking and particular life-events, but others will have their roots in collective discourse, products of interpersonal debate, ideas and images proffered by the media, within socialisation, by folklore and popular wisdom, as the tenets of religious and ideological creeds, and so on. Accounts are both constructed by and

constructed for the individual, although they are often so overlearned by habitual use and hence so well established as taken-for-granteds, that they assume the status of 'truth', belying their hypothetical and constructed qualities.

1.2 ANTHROPOLOGICAL THEORIES OF ACCOUNTING FOR HEALTH AND ILLNESS

The majority of anthropological studies of accounting for health and illness have been (and continue to be) based upon fairly small-scale, very intensive investigations of the overall 'medical systems' of particular cultural groups, seldom distinguishing between health and illness related practices (which include, for example, what we would call public health measures) and the beliefs and explanations which underlie them.

As it is often impossible to extract just the aspects that refer to accounting, in this Section I will often refer to the broader 'medical system' of a culture or group.

1.2.1 The history of medical anthropological theorisation

Although the term 'medical anthropology' was not used until 1963 (by Scotch), anthropologists have explored the medical

systems of so-called 'primitive' cultures from at least the time of Rivers' (1924, 1926) descriptions of 'primitive' accounting for illness in terms of sorcery and agency of the spirit world; good health a matter of respecting taboos and religious rules of conduct; and curing as effected by ritual or magic. Somewhat later Clements (1932) classified 'primitive' medical systems in more detail, particularly the assumed mechanisms of illness causation - intrusion into the body by disease objects and spirits, and the capture of the soul. Ackerknecht (1942, 1971) subsequently argued that although all 'primitive' systems were essentially magico-religious, the accounting system for health and illness within each culture will reflect broader cultural features.

Ackerknecht, Rivers and Clements, like most early anthropologists, tended to be impressed by those aspects of other cultures that were strikingly different from their own - their literally outlandish rituals, taboos and practices. A number of contemporary medical anthropologists (e.g. Guess 1984; Kleinman, 1984) have noted that this resulted in early theorisation that assumed all 'primitive' accounting was magico-religious, ignoring the 'commonsense' practices (e.g. herbal remedies for everyday aches and pains) that were actually fairly common.

However, by the 1950s and 60s (e.g. Paul, 1955; Dunn, 1968) the 'primitive'/'civilised' distinction became increasingly untenable and systems theory was imported to provide a conceptual framework within which all medical systems could be compared, later yielding more ecological theories linking cultural elements into a more comprehensive system (e.g. Alland 1970;

Damon 1975; McCracken 1971; Wellin 1978). The advantage of the ecological models is that they introduced into medical anthropology the recognition that all accounting systems, including our own, need to be viewed within the ecology of the environment, prevailing ideologies, and society within which they operate. The new eclecticism also introduced time into the conceptual framework, opening up consideration of the evolution of medical systems, and the necessity of considering a culture's history if their current medical systems are to be better understood. The kinds of thoroughgoing analyses that emerged, such as Febrega's (1974), provided rich and detailed theory-bases which in their sheer range (as well as the elegant descriptions of empirical work carried out in a whole host of different cultures) made anthropology a discipline that became highly influential upon psychology and sociology.

1.2.2 Rejection of the dominance of biomedicine

However Young (1982) has argued that such overarching theories were not always productive. While the early phenomenological approach, specific to just explaining 'primitive' thought, at least paid lip-service to the notion that a people's accounting system needed to be understood in self-referential terms, attempts to impose generalised frameworks led to the imposition of the worldview of the theorists (particularly about the assumed superiority of biomedicine).

Thus more recently anthropologists have been particularly concerned to refute the idea that biomedicine is in any fundamental way different from or superior to other accounting

systems in other cultures; it is just one of many alternative ways of explaining illness and health, and directing medical treatment. The major conceptual paradigm within which this perspective has been promoted is that of social epistemology, drawing heavily on major theorists such as Foucault (1970), Habermas (e.g. 1970, 1983) Berger (e.g. 1965, 1979) and Douglas (e.g. 1978, 1982), all concerned with the representational forms and codification mechanisms by which knowledge is portrayed, shared, interpreted and constructed.

A number of contemporary medical anthropologists have thus devoted their energies to examining the way that the dominance of biomedicine reflects a relationship between the status of different forms of knowledge concerning health and illness in any society, and the distribution of power within that society. This interpretation argues that economic and professional dominance, and the threat posed by sickness, enable healers in all societies not only to gain status and material advantages, and control access to resources, but to promote their own accounting systems. Young (1980) noted that the dominant professional orthodoxy is believed by its proponents to be a matter of 'facts' rather than 'beliefs'. Taussig (1980) has argued that where biomedicine is concerned, such a process "... reproduce(s) a political ideology in the guise of a science of (apparently) 'real things'", and that as such poses a danger that "... the experts will avail themselves of that knowledge ... to make the science of human management all the more powerful and coercive". This has introduced into anthropology a perception of medicine as a mechanism of social control (e.g. Crawford, 1980, Zola 1972).

Aakster (1986) has suggested that biomedicine is also being questioned in Western popular discourse, with people becoming increasingly convinced that orthodox medicine fails to solve their health problems. Initially the response .was to pour more and more money and resources into the medical system. But as that failed to stem the tide of "... more cancer, more mental disease, more heart infarcations, ... suicides, addictions", they have increasingly turned to various forms of ´alternative medicine´ such as homeopathy, acupuncture and naturopathy.

Thus both within current anthropological theory and in the accounting systems operating within Western popular culture, we have arrived at a position in which biomedicine is ceasing to be seen as it has been in the past (in Western societies at least) as : "...the administration by doctors as a group of morally neutral, essentially benign and effective techniques for curing disease and reducing pain and suffering." (Ehrenreich 1978). This ´cultural crisis of modern medicine´ (the title of Ehrenreich´s book) is the dominant theme of medical sociology at present. What is surprising (and perhaps a little disturbing) is that it has also come to dominate, to a large extent, contemporary medical anthropology. There is a noticeable tendency for many of its most articulate and competent theorists (e.g. Crawford, Young and Taussig in America; Littlewood, Helman, Frankenburg, and Armstrong in Britain) to be concentrating upon the accounting systems of Western cultures, and particularly this issue of the role of biomedicine. To what extent this is a wise attempt to ´know thyself´ before attempting to understand others, and to what extent it is ethnocentrism in another guise remains to be

seen.

1.2.3 Intercultural differences

However, in its concern with the epistemological status of biomedicine, ecological modelling also developed the notion that accounting systems differ intraculturally as well as between cultures; that within any society or community there will operate a number of alternative systems, which co-exist and compete in dynamic interplay, varying in their culturally sanctioned legitimation. Kleinman (1978) for example has distinguished between 'folk', 'popular' and 'professional' medical systems. 'Professional' systems are the orthodoxy of whichever professional group has been culturally legitimated, 'folk' systems those that arise from indigenous ideas and folk wisdom, and 'popular' systems those current in everyday usage (which often combine 'professional' and 'folk'). More recently the concept of 'rival' systems has been introduced, based like 'professional' upon codified knowledge, but set up as alternatives to orthodoxy (e.g. homeopathy in our own culture).

Dunn (1977) has proposed the use of geographical divisions, identified according to their sphere of influence : cosmopolitan, regional and local. Local medical systems are defined as those restricted to small geographical areas, based upon the indigenous accounting systems of that area. Regional medical systems are also indigenous, with a single paradigm (often linked to religious and moral ideologies) extending its influence over a wider geographical area. As example would be Ayurveda medicine, arising from within classical Indian philosophy and religion, which extends its influence throughout the sub-continent of

India. A cosmopolitan medical system is one which has been exported world-wide, biomedicine being the most notable example, but including other systems with fundamentally different theory bases, such as Traditional Chinese Medicine. The concept of 'medical pluralism', and investigations of sympatricity within cultures (particularly competition between cosmopolitan biomedicine and local systems in areas like India and Mexico) is another major theme of contemporary medical anthropology.

Other classifications have focussed upon the kinds of belief systems themselves. The most comprehensive division is between attribitions of exogenous or endogenous causes of illness (cf Valebrega 1962; Stoetzel 1960). Herzlich (op cit) notes that Clements (op cit) 'primitive' ascribed causes can be accommodated within this framework: intrusions of disease objects or spirits being exogenous explanations; soul capture endogenous. However, many other classifications have been suggested. For example Foster distinguished between personalistic and naturalistic health belief systems (Foster 1976): between illness arising from the intended intervention of another person or being, and illness the product of naturally occurring processes. Others (e.g. Jones, 1977; Pellegreno, 1963) work from the assumption that accounting for health and illness reflects the overall worldview of the culture, and classify alternative systems accordingly. Jones, for instance, distinguishes between naturewissenshaft(N-tending) and geisteswissenshaft (G-tending) worldviews. Western scientific thought, including the accounting system of biomedicine, is firmly based within an N-tending worldview, whereas, for example, homeopathy and Traditional Chinese Medicine arise from within a G-tending

worldview.

Leslie (1987, personal communication) has recently suggested a framework which brings these various elements together into a simple but comprehensive classification that can be applied to all accounting systems. He argues that they all include (though in varying degrees of salience) three different kinds of explanation: mechanistic theories, which construe health as the correct functioning of a machine-like body, and illness as its breakdown; equilibrium theories that regard health as a matter of balance and harmony, and illness as their breakdown; and ethical theories linking health to 'right living' and seeing illness as a punishment for misdeeds or transgression of moral codes. There is considerable diversity within each of these, and the different ways they are incorporated together into the particular accounting system of a specific culture or group; a diversity that biomedicine (particularly in its training) undervalues and attempts to reduce and control.

1.2.4 Theories about the cognitive processes involved in accounting

A number of anthropologists (e.g. Blumhagen, 1980, 1981; Good 1977,1981; Kleinman 1978, 1980; Young, 1980, 1982, 1987) have developed quite complex theories about the cognitive processes by which people within a culture arrive at their accounts for health and illness. They all begin by distinguishing between three meanings of bodily, social or psychological discontinuity or deviance, to make explicit the difference between what it is that the person experiences, and what it is that biomedicine sees within its 'clinical gaze' (cf Foucault 1973). Overall, these are

called forms of 'sickness'. Disease is what doctors diagnose, is written in medical textbooks, and biomedicine treats. Illness is what people experience as bodily and psychological dis-ease.

Within this framework, Good (op cit) has specified a theory based upon <u>core symbolic elements</u>, where the polysemic characteristics of the dominant symbols in cultural thought allow for multiple application in different contexts, and in this way link different domains in cultural discourse and accounting. There are resonances here with the structural linguistics of Habermas (op cit), which itself draws from the work of Chomsky (op cit) and Searle (op cit) where communication is seen to transmit not just explicit and contextual messages, but also culturally sedimented aspects of social interaction, social relations and ideology. He proposes a cognitive system based upon a <u>semantic illness network</u> of linked ideas, definitions and relations.

Kleinman (op cit) proposes a similar model, concentrating upon what he calls <u>core clinical functions</u> which enable people to perform such cognitive activities as constructing illness as a psycho-social experience and managing illness episodes, devising strategies for seeking health care and healing, and responding to the outcomes of therapy. He regards these as fundamentally attempts (which are not always successful) to adapt to the worrisome circumstances of discontinuity that illness poses, within a social context in which only some forms of discontinuity are professionally sanctioned as 'disease' (i.e. <u>real</u> sickness). Thus he suggests that people internalise <u>explanatory models</u> (EMs) which contain knowledge about aetiology, what to

expect about the onset of symptoms, courses of sickness episodes, appropriate treatment and so on.

However, this formulation goes well beyond the assumption that individuals and groups adopt particular sets of explanations and systems of accounting for illness which do no more than provide recipes for understanding and action. He follows Geertz's (1966) ideas about religious beliefs, that cultures provide people with ways of thinking that are simulteneously models of and models for reality; EMs also create order and meaning, and produce the conditions required for their own perpetuation. EMs for becoming and being ill also define roles, norms of conduct, expectation of one's own actions and the actions of others when illness is seen to occur, not merely aids to understanding, but also powerful components in the act of constructing the events themselves.

Young (op cit) interprets semantic networks as the basis of EMs; they are abstract representations from which an EM can be generated to respond to a particular episode or set of events such as the occurence of bodily disturbance. By mapping events onto the network, the person extracts an explanatory model of what is going on, in order to be able to answer questions like "Am I ill, or just feeling under the weather ?", "Should I ignore this ache, or is it a symptom ?", "Is there a link between the way my stomach feels, and what I ate for lunch ?" and so on. But they also provide a basis for communicating with others in shared attempts to analyse and explain, including situations where a researcher is asking a person to give information about the way they account for illness.

Of particular interest is Young's suggestion that "... an informant's EMs may be changing during the period in which his(sic) statements are being made". Thus Young's formulations offer a direct model of the kind of intersubjective sympatricity of accounts suggested in the previous Section. Also, whereas Kleinman regarded EMs as essentially specific to the individual, Young sees them as culturally sedimented and shared, providing the component of a person's accounting which represent collective discourse. He argues that in addition people also resort to at least two other forms of knowledge which are more individual: prototypes (after Hallpike 1979) and chain complexes (after Vygotsky 1962). Prototypes consist of explanations couched in terms of strings of events and circumstances recalled from the past, sometimes connected by cause-and-effect assumptions, but often merely linked in terms of chronology, contiguity and resemblance. They are typically very personal, though they may be shared between a small number of people closely connected by friendship or family. Chain complexes are similar to prototypes, but are not explanatory, simply strings of recalled events, sensations and episodes that cohere and persist in the mind of the individual because of their salience, contiguity or chronology to the mental life of the person concerned.

Young has proposed this model because he sees people as offering highly complex and ambiguous descriptions of their accounting system. It is an attempt to provide a conceptual framework which does justice to the kinds of explanations people converse about in everyday life. He argues (personal communication) that people seldom - if ever - express abstract semantic explanations,

but rather weave their accounting within episodic and biographical reminiscences, comments about similarity and analogy, about social relations, norms of behavior, emotions and feelings.

1.2.5 Implications for the thesis

The earliest anthropological studies of accounting for health and illness, and Young's criticisms of the ethnocentricity of, particularly, the later systems theorists, remind us that in order to understand the accounting of others, we need to operate within their world-making, not through the distortions of our own.

Anthropology's broader interest in cultural influences upon social cognition and social being (cf Harré, 1979) stresses the reality-constructs-person aspect of accounting; the impact of shared, culturally sedimented ways of 'making sense' that construct the accounts upon which people in that culture draw.

Anthropology thus offers to psychology a frame of analysis which insists that individual subjectivity can never be divorced from the cultural milieu which constructs a great deal of their reality as taken-for-granted. In some ways it is only possible to recognise just how much, say, biomedical practitioners assume that their theories-of-disease are 'facts' by contrasting our situation with that of a person living in China, where Traditional Chinese Medicine would be the dominant explanatory system, and it would be biomedical ideas that were 'strange' or

'counter intuitive'.

What are perhaps more surprising to the psychologist are the attempts by anthropologists to devise cognitive theories. The models of Good, Kleinmann and Young are in many ways very similar to cognitive psychology's theories of long-term memory (e.g. Tulving's 1972 distinction between 'episodic' and 'semantic' memories).

Young's formulations are of particular interest to the work of this thesis, because they talk directly about ideas akin to account sympatricity, and attempt to model both the idiographic and nomothetic features of accounting. More recent theorisation by Boyer (1987) is even closer in flavour to the approach taken here. Writing about the difference between systems of 'traditional knowledge' as culturally sedimented, and their explication as individually articulated, he suggests :

"Some anthropologists consider the system ... as a 'text' people can use, cite and manipulate. What is on people's minds at any moment is only a certain idiosyncratic version. " (p 59).

He argues that the task of the anthropologist is to find ways of identifying and describing the "... underlying edito princeps" of each system, as implicated by the utterances of people in that culture, and goes on to discuss the problems that ethnographic method faces in acomplishing this task. My use of Q methodology is intended to contribute to this endeavour.

1.3 SOCIOLOGICAL THEORIES OF ACCOUNTING FOR HEALTH AND ILLNESS

Sociological theorisation in this area tends to concentrate upon the effects upon accounting of social forces, particularly those arising out of the power relationships between different social groups, such as the State, the professional interests of the medical and scientific communities, industry and commerce and lay pressure groups. Much of the conceptualisation is presented within broader sociological frameworks, in particular the major competing theories of societal action: structural functionalism versus dominance theories; and competing theories of epistemology : as constructed for/ constructed by people (resonant with the dichotomies described in Section 1.1.1).

1.3.1   Medicine within structural functionalist and dominance theories

It was Parsons (1951) who introduced the term ´sick role´ and brought the ´deviance´ of illness into sociological theorisation. Before Parsons, because illness was regarded as unmotivated, it tended to be excluded from sociological analyses of deviance (e.g. of criminality). Parsons theorised that as illness interferes with the performance of normal social roles, albeit without deliberate intent, society has to set up mechanisms for channelling and controlling it so that it does not strain social order and the smooth functioning of the social system. He argued that whereas, say, criminal deviance is controlled by

institutionalised law, the deviance of illness is controlled by assigning approved roles to the ill person and service providers to the ill.

Society, from this perspective, has developed a complex of functional, 'self-evident' principles upon which our responses to illness are predicated. Firstly, there are sedimented beliefs about ill people being exempted from some responsibilities, but acquiring others; their lack of culpability for their illness, but a consequent incapability to overcome it for themselves. Second, there are sedimented beliefs about the relations between society and ill people; the responsibility to 'care for' and offer them sources of expert and effective help. From the dialectic between these two arises the third set of sedimented beliefs about the role of the medical profession and service provision for illness, including assuming that medicine offers efficacious treatment, and consequently that medical practitioners must be given the social status to enable them to enforce compliance.

The question asked is whether these responses are merely 'functional', or do they operate as a system of social control ? In functionalist terms, they ensure that society meets the needs of its more dependent members. In dominance theory terms, they enable the powerful groups in society to promote their interests by exploiting or marginalising others. The most influential account of this viewpoint is Zola's (1972) essay in which he argues that medicine has become:

"... a major institution of social control, nudging aside, if not incorporating, the more traditional institutions of religion and

law. It is becoming the new repository for truth, the place where absolute and often final judgements are made by supposedly morally neutral and objective experts. And these judgements are made, not in the name of virtue or legitimacy, but in the name of health." (p 487)

Zola argues that the functionalist analysis allows people to persuade themselves that modern medicine is a benign and humanitarian force which replaces 'punishment' (e.g. of alcoholics) by 'treatment' and absolves the individual from responsibility for their own misfortunes. This supposedly liberal discourse, argues Zola, is not benign at all; condemnation is not avoided but merely displaced. The result of such processes is that they "... bring man (sic), not bacteria to the centre of the stage and lead thereby to a re-examination of the individual's role in his own demise, disability and even recovery.".

Zola suggests that there are four main ways in which our lives have become 'medicalised' by the way in which the medical profession have increasingly taken into their jurisdiction more and more aspects of our lives : Firstly, the expansion of what in life is deemed subsumable within the good practice of medicine. For example, now that aspects of life-style and habits are regarded as important factors in illness, the medical profession is increasingly telling people what to eat, how much exercise to take, etc. Secondly, the retention of absolute control over technical procedures. Since doctors alone may prescribe many drugs and perform surgery, they are able to determine not just disease treatment, but a wide range of other aspects of people's lives, from cosmetic surgery to kidney transplants; 'test tube babies' to euthanasia; contraception to tranquillisation. Next, medicine retains near absolute access to certain 'taboo' areas,

such as drug 'addiction' and alcoholism. Finally, the expansion of what, in medicine, is deemed relevant to good practice. The 'interests of good health' may be used to influence increasingly large areas of life (e.g controls on advertising of tobacco and alcohol).

"From sex to food, aspirins to clothes, from driving your car to riding the surf, it seems that under certain conditions, or in combination with certain other substances or activities, or if done too much or too little, virtually anything can lead to certain medical problems ... every aspect of our daily life has in it elements of risk to health." (p 498)

There are a variety of critics of the version of social reality so transmitted and promoted, including Marxist (e.g. Navarro 1977; Waitzkin 1979); Feminist (e.g. Ehrenreich and English 1973; Barrett and Roberts 1978); Humanist (e.g. Illich 1976) and more broad politico-economic (e.g. Ehrenreich 1978, Doyal 1981). Each one offers alternative values, providing compelling accounts of the way that capitalism, professional and corporate self-interest, the patriarchy, Third World exploitation, industrial pollution, economic and social inequalities etc. are the true culprits for ill health. Their argument is that by and large ordinary people have been duped into a 'false consciousness' which prevents them from challenging the construction provided for them by medicine.

1.3.2 Social control epistemological theories

Both the functionalist and dominance versions of social control theory assume that popular accounting systems arise passively out of the imposition of social processes acting upon them. As such, both portray the commonsense accounting systems of ordinary

people as being constructed <u>for</u> them to serve the purposes of others - an image that Digwall (1976) describes as viewing ordinary people as the 'puppets' of dominant groups (whom Becker, 1963 refers to as 'moral entrepreneurs'). The theorist who has articulated this perspective most comprehensively is Friedson (1970), focussing on the interaction between and within professional and popular accounting systems, particularly in terms of the notion of 'deviance' and the way that medicine has gained the authority to legitimate illness.

Friedson has tried to explain the considerable divisions in our society between the esoteric body of knowledge which constitutes the professional acounting system, and the ignorance, misconceptions and irrationality of the popular system, particularly that held by the 'lowest social classes'. According to Friedson, by their ignorance and seemingly total lack of understanding of medicine (in professional terms) they acquire deviant status and hence medical practitioners tend to give up any attempt to communicate with them. They respond by distrust, suspicion and not unsurprising dislike of the way they are treated, and hence their ignorance is at best untouched, at worst increased. Their accounting system thus becomes not just 'different' but less valid; the working class do not construct or own their accounting system, but rather have it foisted upon them by social forces. According to Friedson, doctors have become the 'architects of medical knowledge', knowledge that fails to serve any functional role for the working class, but rather becomes incorporated into their exploited and marginalised social role at the bottom of the class heirarchy.

There is a danger of responding to such theories simply in terms of their elitist terminology, and missing the point they are making about the enormous pressures that are placed upon particular social groups by the dominance of the more powerful 'architects' of knowledge, such as the medical profession. As Young (op cit) has made clear, professional orthodoxy does not just assume its knowledge is better, it regards other accounting systems as "not really medicine", and thus creates a setting in which lay people find it very difficult to be taken seriously, or indeed, to take themselves seriously. The power relations within medical encounters are major influences not just in the way professionals construct the knowledge of their patients within that immediate setting, but operate at second-hand within popular discourse.

1.3.3 Social constructive theories of accounting

Just as psychology has shifted into a 'new paradigm' in which people are construed as actively constructing their own realities, sociology has similarly shifted towards a social constructionist analysis which stresses the capability of people to construct their own knowledge. Its starting point in terms of accounts for health and illness is that illness is a socially defined state : " the invasion of a human organism by cholera germs carries with it no more the stamp of 'illness' than does the souring of milk by other forms of bacteria." (Sedwick, 1982). Dingwall (op cit) is the best known theorist to promote the social constructionist viewpoint, asserting that popular accounting systems should recognised as functional within their own domain, and accorded equal epistemological status with other systems.

In this Dingwall was not arguing that all accounting systems are functionally equal, nor denying that they are in part constructed for people by other groups, but seeking to redress a balance, by stressing that people from all social groups engage in active construction and interpretation for themselves. He focused his theory of accounting upon the concept of 'ordinariness', conveying the importance of general social norms in accounting for health and illness. To be ordinary is to do usual, expected, normal things at usual times in usual places. However, despite its everyday taken-for-grantedness, being ordinary actually involves a great deal of fluency with 'commonsense knowledge' (e.g. Cicourel 1973). Dingwall places accounting for health and illness (both popular and professional) within the context of a much broader accounting system in which people theorise, to themselves and others, in terms of estimates of ordinariness and its various antitheses - deviance, unusualness, discontinuity, and so on.

A great deal of accounting for health and illness within this framework is concerned with managing the body in ordinary ways that are consistent with the social norms of the reference group (e.g. according to age or gender), creating an assumed definition of health that is somewhat tautological - healthy people are normal, and normal people are healthy. The concept of social norms, however enables the notion of normality to be context specific; it will differ, say, between the young and old, between men and women (particularly in terms of gender specific states such as pregnancy and menopause).

Dingwall adopted the term 'discontinuity' as the most useful way of describing the kinds of states, events and phenomena which demand consideration of 'ordinariness' and 'abnormality' in order to decide between ascriptions of 'health' or 'illness'. The social desirability of 'ordinariness' in the face of discontinuity provides a compelling motivational frame within which people account for illness, leading to another central notion within his work, 'theoreticity', adapted from the work of Puccetti (1968), Blum and McHugh (1971) and particularly Voysey (1975). Voysey defined theoreticity as involving two elements, 'intelligence' (having access to and being able to invoke some symbolic conceptual scheme) and 'morality' (the incorporation of moral symbols). Blum and McHugh describe it more simply as '... the state of being aware of what you are doing'. A person who is operating within a theoretic mode is somebody who is aware of the social norms and rules (both explanatory and morally prescriptive) involved, and intends their action in the light of this knowledge. In this framework, deviance is not just a state constructed for a person by society, or powerful groups within society, but also involves deliberate and thoughtful decisions on the part of the person to act in 'deviant' ways. Hence Dingwall interpreted popular accounting for health and illness as not simply interpretations or understandings of discontinuities, but powerfully focussed on question of responsibility, blame and moral culpability.

However, Dingwall argued that in the West, as a result of the widening of the gap between work and home (cf Lasch 1975), the consequent assumption by the State of tasks previously carried out by families, and the increasing importance of large

corporations and the impact of social planning, the distinction between private and public morality has become increasingly blurred, reducing the freedom of individuals to define discontinuity for themselves, or have it defined for them by their immediate social groups as anything other than illness. "Other possibilities - witchcraft, spiritual intervention, sin, bad taste, poor manners and the like - are less and less frequently available" (Dingwall, op cit).

Thus in the West illness has come to represent the overriding attribution that can be proffered to exonerate a person from the stigma of culpable deviance. So long as they can establish that they did not behave in ways that brought it upon themselves, illness is a way that a generally ordinary, theoretic person can legitimately, and socially acceptibly, account for behaving in unusual ways or demonstrate unusual bodily manifestations. However, the tension between ordinariness and deviance means that illness cannot be regarded as an accepted part of everyday life. It must be divorced from it by its seclusion as 'private trouble' within the family, or, if it is more serious, contained within institutions like hospitals to insulate public awareness from the deviance in its midst.

1.3.4 The institutionalisation and stigmatisation of disability and illness

Theorists like Goffman (1968) have argued that such institutionalisation tends to exaggerate the deviance of illness, both as a result of institutional regimes themselves, and the separation from the everyday world that institutionalisation creates. Outside institutions, 'illness' is a very restricted

escape route from 'deviance', only available for sickness of short duration. Permanant disability tends to be stigmatised :
"... people expect ... the cripple to be crippled; to be disabled and helpless; to be inferior to themselves, and they will become suspicious and insecure if the cripple falls short of these expectations. ... the cripple has to play the part of the cripple..." (Goffman 1963).

Life-threatening illnesses, especially those that have acquired strong social metaphorical status (cf Sontag 1977) as 'scourges', particularly stigmatise the sufferer. According to Herzlich and Pierret (1985) a 'scourge' is not merely perceived as a state of an individual body; it represents a very threatening form of collective 'misfortune', since it affects the equilibrium of the community. Up until recently in the West, cancer has tended to be the dominantly stigmatised illness (Lebrun 1984; Pinell 1986). Now AIDS is rapidly acquiring the status of a powerfully stigmatised disease (Birchall and Birchall, 1987) even in cases where moral culpability is not assumed (e.g. hoemophilia). AIDS has all of the qualities that override any ability of illness to avoid the attribution of stigmatism - it has gained strong moral antagonistic symbolism because of its associations with other forms of deviance (i.e. drug addiction, homosexuality and sexual promiscuity); it arouses terror because of its lengthy incubation period; its mechanisms of infection are poorly understood, and so it engenders fears about contagion; it leads to disfigurement and a slow, painful and at present inevitable death (Kingham, 1987).

In their desire to redress an assumed dominance of the

taken-for-grantedness of naturalistic accounts for illness, all of the social constructionist analyses of illness have tended to underestimate the biological threat of illnesses that are contagious and consequently menacing. It is here that perhaps the ethnocentricity of sociological theorisation is most apparent. In Third World Countries the biological reality of sickness, famine and high infant mortality has always been highly salient. AIDS is re-introducing into the West the need to develop socially functional responses to sickness that, so far, biomedicine cannot tackle. Its means of infection demand reconsideration of the 'social control' thesis; for, within our current understanding, only changes in lifestyle and behaviour can alter its exponential spread (Birchall and Birchall, op cit).

1.3.5 Implications for the thesis

Sociological theorisation in general offers three main conceptual constructive frameworks pertinent to the work of the thesis. Firstly, its emphasis upon sociological forces (like anthropology's concern with culture) provides a rich source of ideas about the ways that people's realities are constructed for them, including the social functions of the 'sick role' in the maintenance of social order, the ways in which powerful hegemonies act as the 'architects of knowledge' and the potential impact of medicine as a system of social control.

However, the development of the concept of 'theoreticity' demonstrates that sociological theorisation also has insights to offer our understanding of the person-constructs-reality aspects of accounting, in particular in its focus on its moral aspects, and concerns about blame and responsibility.

Thirdly, sociological analyses of the concepts of 'deviance' and its contrast 'ordinariness' have clear links to the growing interest within psychological theorisation about accounting as a means of explaining or justifying disruptions of social interaction, norm infractions (cf Harré, 1979; Semin and Manstead, 1983) and coping with situations like threatened identities (cf Weinreich, 1979, 1983). Such theories have tended to focus upon the social and psychological fracturing of the taken-for-granted flow of social being, but Dingwall's analysis of the way that illness is construed in relation to 'ordinariness' brings biological discontinuity into the accounting arena. Henriques et al (1984) insist that our theories must accomodate our biological as well as our social realities, and therefore our theorisation about accounting needs to be informed by the detailed analysis that sociology has made of the 'deviant' qualities of illness.

And finally, it is important to note that a sociological analysis of the influence of economic and political factors upon health and ill health, and the role of power and control in both creating the disadvantages that lead to ill health, and in constructing knowledge, is itself an account for health and illness, a cultural critique of medicine that challenges the biomedical account.

1.4 PSYCHOLOGICAL MODELS OF ACCOUNTING

Buss (op cit) argued that psychological paradigms reflect one of two underlying perceptions : a) Person-constructs-reality, and b) Reality-constructs-person. Paradigm revolutions, according to Buss, are either shifts from a) to b) or from b) to a). For example, psychoanalysis represented a shift from person -constructs-reality to reality-constructs-person. Prior to Freud, rationality and consciousness were emphasised, with an individual seen as acting in ways that a 'reasonable person' would.

Freud and his biological theories of motivation undermined and transformed this view, with the subject becoming the object of irrational and unconscious forces. Humanistic approaches shifted once more to person as subject, as a reaction both to psychodynamics and behaviourism, emphasising self-development, the individual in control of her/his destiny, and actively striving towards fulfillment and self-actualisation.

In a somewhat parallel manner, we can observe that the operationalisations assumed to be salient within psychological theories of accounting (e.g. beliefs, opinions, values and implicit theories) have at various times been treated as either dependent variables, products of, say, particular events, psychological processes, or psychological mechanisms; or as independent variables, reasons for, say, action.

These two dichotomies can be used to provide a conceptual framework within which to examine different psychological

theories and models of accounting :

	Reality-constructs -person	Person-constructs -reality
accounts as dependent variables	A	B
accounts as independent variables	C	D

This schematisation over-simplifies, in that many theories seek to explain more than one cell in the matrix, but broadly this does distinguish between theories that :

A : construe accounting as the result of events, processes or mechanisms acting upon the person as ´object´;

B : construe accounting as the result of the person, as ´subject´, constructing it for themself;

C : see the person as ´object´ whose accounting results in particular perceptions, behaviours, symptoms etc.;

D : see the person as ´subject´, whose accounting enables them to construe the world in a particular way, act,etc..

Rather than attempt to review all psychological theories of accounting, I will illustrate these alternative kinds of model in terms of a selection of the best-known.

1.4.1 Person as object, accounting as dependent variable

As Buss identified, psychodynamic theories are within the mode of reality- constructs-person, the ´reality´ in this case being seen as the interface between events (mostly in childhood), biological, developmental processes and the conflicting forces of psychological components of the ´self´. A person´s psychological ´reality´ is the result of their experiences, as interpreted in terms of the inner conflicts between unconscious forces and as a consequence of how they, as an individual, have (or have not) resolved them at different stages in their life-cycle.

Psychodynamic theory has thus provided a rich source of ideas about accounting as a dependent variable, beginning with the idea of ego defence established by Freud himself (cf 1926) and developed by his daughter, Anna Freud (1936) and Alexander (1934) in particular. Within this framework, the way a person explains their world is a product of competing psychic forces such as conscience, impulses of the id, and reality formation.

Probably the best known legacy of this approach is Adorno, Frenkel-Brunswick, Levinson and Sanford's (1950) description of the ´authoritarian personality´, a ´view of the world´ which renders people submissive to authority figures, hostile to the violation of social norms and antagonistic to ´deviance´

(i.e. particularly vulnerable to the kinds of social determinants of accounting described in Sections 1.3.1, 1.3.2 and 1.3.4). In less extreme formulations, the psychodynamic model of acounting stresses the salience of 'psycho-logic'; mechanisms like defensiveness, self-justification and self-protection.

Festinger's (1957) cognitive dissonance theory is another reality-constructs-person formulation. Festinger actually gave an accounting for health example, of a person who simultaneously smokes and believes that smoking causes cancer. Dissonance reduction may take the form of refusing to accept the evidence of the link between cancer and smoking; or focus on counter examples from their own experience; changing to filter-tips and persuading themself that this reduces the risk; assert the advantages of smoking; stress its pleasurability; or promote an anti-authority view of their actions. Thus dissonance theory sees accounting not as rational, but rationalising; a person's account enabling them to justify actions which for one reason or another they are highly motivated to pursue.

Another form of rationalisation is when people respond self-defensively (Walster 1966; Shaver 1970) to calamities. A tragic event produces a need for observers to believe that the event could have been averted, and thus could not happen to them. Thus the victim is blamed for their misfortune, and the worse the tragedy, the more uncomfortable it is to acknowledge that this kind of thing could happen to 'me', and so the greater the tendency to see the victim as culpable. Similarly attribution theories (e.g. Kelley, 1967) assume that accounting is often a product of a need to feel in control of the environment.

Within the behaviourist reality-constructs-person perspective, one of the best known accounting theories, which focussed directly upon this notion of control, is Rotter's (1966) 'Locus of control' construct, which has lead to a great deal of theorisation, research and debate (see Lefcourt, 1981, 1982, 1983, 1984 for reviews). Of particular interest here is a development of the concept which is directed specifically towards health and illness, the 'Health Locus of Control' construct (cf Wallston and Wallston 1978). In its most recent form, it sees people as acquiring one of three alternative accounting systems for health and illness : 'internal control' where the individual sees themselves as able to gain and maintain good health, and avoid illness by their own actions; 'external control' where the individual assumes that good health is a matter of good luck, and illness a matter of bad luck, themselves unable to do anything to alter their chances of being well or ill; and 'powerful others' where the individual regards their health as controlled by people like doctors, and their illness (particularly recovery from illness) as depending upon what other people do, not on what they themselves do.

This particular accounting theory is clearly of great interest, in particular in relation to the sociological and anthropological models described in Sections 1.2 and 1.3. These notions of internal/external/powerful others were therefore selected for empirical study, described in Chapter 7. More detailed analysis of Locus of Control in general, and Health Locus of Control in particular, is provided in Chapter 6.

Seligman's (1975) 'Learned Helplessness' Theory, also based within social learning theory, and drawing upon notions of external/internal control, has in its later version (e.g. Abramson, Seligman, and Teasdale 1978) sought to explain two kinds of 'hopelessness'. Where experiences of lack of control over outcome are attributed as arising externally, then learned helplessness leads to a fatalistic accounting system - tragic and distressing events (such as illness and disability) are assumed to occur by chance, or by the agency of powerful others. But when the individual blames themself, then the accounting system becomes one of recrimination - events are assumed to occur because of one's own failings.

1.4.2 Person as object, accounting as an independent variable

Psychodynamic theory suggests that people may unconsciously 'want' or 'need' to be ill, because this enables them to resolve inner conflicts; however dysfunctional or irrational a particular act there is always a reason - though the reason may be based upon unconscious motivations. Illness is a defence mechanism or a mechanism for justifying what would otherwise be considered aggressive behaviour. Psychodynamic theory also suggests that physical symptoms may be the products of psychic energy seeping out somatically, whether as the hysteria of the nineteenth century or the migraines of the twentieth. Unacceptable or threatening emotions may be rechannelled into somatic illness, or they may result from pressures to submerge (rather than act out) anger or frustration. That such accounting has entered into popular discourse is evidenced by Sontag's (op cit) description of a woman who blamed her cancer on 'inner negative feelings', and Crawford's (1984) description of a man who blamed his on the

inability to control his anger.

However, the best known version of this theory is the popular conception that illness is the result of 'stress' or 'hypertension' (Blumhagen 1980), also evident in the theory base of the links assumed between 'Type A' personality and illness, particularly coronary risk (Glass 1977; Helman 1987). (Although it is worth noting that the notion of Type A personality has also been used within person-constructs-reality formulations, cf Smith and Anderson (1986)). This, originally academic theory for illness, has also by now become pervasive within both professional and popular discourse (Herzlich op cit; Young, 1980).

However, by far the most unbiquitous set of accounting theories within this class is the broad sweep of attitude theories that have proposed attitudes as independent variables that can be measured and then used to predict action. As McGuire (1986) has remarked, the repeated failure to do so "...has remained a scandal of social psychology ever since." A proper review of these theories could take up a Chapter in itself, and so (as the reader will no doubt be relieved to know) I will concentrate on just two. The first is the Fishbein and Ajzen model of reasoned action, which has been increasingly applied in health related contexts in attempts to predict such things as cigarette smoking (Chassin et al, 1981) drug use (Budd et al 1983) and contraception (Fishbein et al 1980). The second is the Health Beliefs Model (cf Rosenstock, 1974) used to attempt to link accounting to uptake of preventive medicine (Becker et al 1977, Maiman et al 1977), chronic illness behaviour (Kasl, 1974)

preventive dental behaviour (e.g. Weisenberg et al, 1980; Chen and Land, 1986), attending exercise classes (Heinzmann and Bagley, 1970) and many others.

The theory of reasoned action (Ajzen and Fishbein, 1969, 1972; Fishbein 1980) was derived from Dulany's (1961, 1964, 1968) theory of propositional control, firmly based within a behaviouristic framework. The main concern of the theory is to predict behavioural intentions which are assumed to mediate overt behaviour. According to the model, an individual's intention to perform a given act is a mathematical function of their attitude towards performing the act, their estimate of what others expect them to do in that situation (normative beliefs) and individual's motivation to comply with the norms. A number of workers have attempted to improve on this model's predictability by introducing other factors into the equation such as 'ideal behavioural intentions' (Budd and Spencer, 1985), and by making the mathematical relationships between the various components of the equation more complex (e.g. Grube, Morgan and McGree, 1986 used a computer model that incorporated interactive effects, and multidimensional estimates of normative beliefs from parents and peers, which they claimed provided a better fit to the data they obtained).

The Health Beliefs model was originally designed to predict health preventive behaviours (e.g. having innoculations, attending screening sessions). It assumes that people consider action rationally according to their beliefs about four main aspects : the extent to which they see themselves as susceptible to the disease in question; their perception of the barriers

which must be overcome to act; their view of how serious the disease would be; and their general ideas about health prevention. In addition, these are seen to be mediated by a general psychological readiness for action, the degree to which they regard prevention as feasible, and, importantly, whether there has been a stimulus (e.g. an inviting letter, TV programme or contact with a friend who has participated). Thus although accounting is regarded as an important independent variable, it is seen as mediated by a number of other factors.

1.4.3 Person as subject, accounting as a dependent variable

It is existential psychology which probably provides the best overarching description for the new person-constructs-reality psychology in the 1960s and 1970s that focussed on accounting as a dependent variable. Within this perception, accounting is seen as the product of individual freedom and choice :

"The individual is therefore responsible for constructing his(sic) own experience and reality. Every person is in the position of having to realise that they are the creator of their own world; that all life's experiences are there because they have drawn them thus, and that they can do with them as they choose; that one is one's choices. " (Graham, 1986, p 68)

Graham suggests that the European tradition of existential psychology (based upon the works of Sartre, Camus and Kierkegaard) generated an image of the person as on the one hand fundamentally free and self-directive, but, in acceptance of death as a necessary force in constructing an authentic and purposeful reality, on the other hand able to recognise their fundamental isolation. In this respect existential psychology differs from the predominantly North American humanistic psychologies of, for example, Maslow and Rogers. Holland (1977)

has suggested that the characteristic sentimentality of humanistic psychology, in contrast to the much harsher existentialism in Europe, arose because humanistic psychology developed within the 'me' culture of the North American middle-classes, whereas the Europeans like Laing (1959, 1983) and Frankl (1955, 1969, 1973) devised their theories in the context of poverty, institutionalisation and inhumanity (for Laing, the mental hospitals of the East End of London; for Frankl, as an innmate himself in Auschwitz). Not surprisingly, then, existentialism is an 'angry' rejection of the prior order. Frankl wrote :

"I am absolutely convinced that the gas chambers of Auschwitz, Treblinka, and Maidanek were ultimately prepared not in some Ministry or other in Berlin, but rather at the desks and the lecture halls of nihilistic scientists and philosophers" (1955, 1973 edn, pxxi)

Frankl's existential psychology therefore combined the person -constructs-reality principle with a strong moral element; his model of accounting is one in which human existence is characterised by three things : a person's spirituality, their freedom, and their responsibility. Consequently, he strongly denied what he saw as the psychodynamic position, in which 'sickness' is equated with a distorted world-view :

" a distorted world-view cannot be set straight by psychotherapy ... Not only is it inadequate, but not competent ... psychotherapy has insufficient resources to deal with the totality of psychic reality. On top of this insufficiency there is its incompetence to deal with spiritual reality in its own right. Not only is it exceeding its authority in dealing with the individual's world-view as a 'neurotic' phenomenon; it is going too far altogether when it constructs theories of the pathological origin of all world-views." (as above, p14)

Thus this is an accounting system which claims that the 'self' can and should transcend its biological and social limitations;

what matters is not what happens, but how one choses to interpret it. He gives numerous examples of people who are facing death, coping with bereavement and with many other tragedies who made a choice - to allow themselves to give up to dispair, or to embrace the experience and make it meaningful. Within this context, illness may be a biological reality, but this is not the reality that matters - what is important is the meaning with which the individual imbues the experience. He developed 'logotherapy' (therapy of making spiritually meaningful), the basis for which is the positive power of an individual's spirit and sense of purpose.

Frankl does not deny the reality of physical and mental illness; rather, he says that these are only a part of a person's totality, and that they apply to only some forms of troubledness that people bring to doctors (a position reminiscent of Dingwall's). A proportion of these are noogenic 'soul sicknesses' arising out of a sense of drowning in the ubiquity of mass culture, and the kind of fatalistic innability to avoid disaster that comes from living in the age of atomic weapons, linked with a fanatical clinging to one's own worldview and rejection of all others. These are moral, not psychosomatic conflicts, matters of conscience that require spiritual healing. The epidemics of such moral malaises are, Frankl argues, within society itself.

1.4.4 Person as subject, accounting as an independent variable

Kelly's (1966) Personal Construct Theory is the best known and most thoroughly articulated person-constructs-reality functional model, within which accounting is a regarded as a dynamic, self-modifying system in which the constructed reality is continually tested against observed events and recouched in

terms of what happens. The taken-for-granted reality that forms the basis for everyday life is a functional 'objectivity' that enables individuals to cope with the complex demands of living in society, making decisions, planning action and understanding one's own actions and the actions of others. In emphasising person-as-scientist, Kelly stressed that this is just one aspect of many forms of constructive alternativism that occur within accounting. Swift, Watts and Pope (1983) have argued that the notion of 'scientist' has often been wrongly interpreted as an entirely reductionist, rationalising, dehumanising image, whereas for Kelly the term was chosen for its liberating properties - its ability to reject reductionism and overcome the dehumanising 'person-as-passive-organism' image of behaviourism.

Kelly's basic postulate that a person's processes are psychologically channelized by the ways in which they anticipate events, made clear that he saw the system as directively dynamic. The focus on anticipating events enables active 'understanding' and 'insight' by organising the uniqueness of events into some kind of framework by which they can be classified, understood and responded to. However, a point frequently forgotten about Kelly's model is that he was not implying a single, coherent, logically intact system; his fragmentation corollary specifically states that there are many more or less independent sub-systems which are inferentially incompatible with one another. In other words, 'account sympatricity' and complementarity fit well into a Kellyan framework.

Personal construct theory is not, however, just about individual construction. Kelly's communality corollary makes explicit

that people can and do experience the world in similar ways, to the extent to which their construct systems are similar. Communality of construction is crucial to operate effectively within a social world, success as a social being depending upon how accurate those constructs are, and how appropriately they are applied. However, Kelly placed the communality and sociality corollaries subservient to the range and modulation corollaries, arguing that while people can and do have similar construct systems, ultimately constructs that are central to one person are irrelevant to another. Kelly's is a <u>personal</u> construct theory, stressing the uniqueness of each individual construct system, in contrast to theories such as Moscovici's (1981, 1984) 'social representation' theory and 'linguistic repertoire' theories of Potter and Litton (1985) which focus upon the sharing of common understanding.

1.4.5 Dialectical models and their appropriate methodology

The 'social representation' and other similar approaches are, in principle if not always in practice, dialectical theories that stress the interface between reality as construced by and constructed for the individual, operating, for example, at the individual level of self-concept and at the same time at the social level of group membership (See, for example, Doise, op cit; and Moscovici and Hewstone, 1983). An increasing number of studies in this field are to be found in the social psychological literature, examples being Litton and Potter's (1985) investigation of 'lay explanations' of the St. Paul's 'riot'; Furnham and Henderson's (1983) study of 'lay theories' of delinquency, and Amanico and Soczka's (1986) investigation of the 'understandings' current in Portugese culture about

discrimination against women at work.

All of these share two things in common. First, they are account, not person, taxonomic, seeking to identify and describe a variety of accounts as sympatric alternatives. Instead of trying to classify people, they seek to elucidate the different theories, explanations or understandings that people express. Secondly, they are all ecological, interpreting account sympatricity within broad social, cultural and historical frameworks. Potter and Litton's work, for example, made use of data from mass media (and people's responses to them) in order to understand better the interface between individual constructions of events, and events as constructed by say, television news reporting; and analyses of the impact of minority cultural worldviews (i.e. of 'blacks' living in a predominantly 'white' society) within a social setting like St.Pauls.

However, despite their sophisticated theory-bases which emphasise the importance of 'everyday' and 'commonsense' accounting within the 'new paradigm' (i.e. within realistic settings, and in self-referential domains), their methodologies are less advanced. Harré (1979), still one of the foremost proponents of the 'new paradigm', argues that psychologists need to find new ways of investigating such phenomena as accounts that offer at least some hope of getting to grips with the reality-as-understood -by-the-subject-of-study. He is equally denigrating about interview and questionnaire methods :

"The interview itself is a social event, heavy with ambiguity, and shot through with efforts at self-presentation by both the interviewer and the interviewee, so that it is doubtful whether, in many cases, the interviewer understands the answers of the

interviewee or the interviewee understands the questions of the interviewer. Each, apparently, reconstrues the speech of the other in accordance with their own conceptual framework. ... (T)he use of questionnaires with a limited range of questions ... which effectively preclude elaborations and reinterpretations ... means that the concepts deployed ... are predetermined. The effect of this is to produce not a representation of the social world being studied, but the representation of the shadow cast upon the social world by the prior conceptual apparatus deployed by the person who constructed the questionnaire." (p 115).

Harré argues that what is needed are techniques that make people their own ethnographers; that give them opportunities to express their own 'meanings' and not have them interpreted for them by interviewers, or foisted upon them by questionnaire designers. The studies in this thesis have used Q-methodology, developed over fifty years ago by William Stephenson, in conjunction with ethnographic (interview and written open-ended responses) in an attempt to provide such opportunities. As will be described in Chapter 3, Stephenson devised this technique and developed its theory base as a means for studying what he has called 'operant subjectivity' - as a technique for enabling people to make explicit their own 'attitude of mind' (Stephenson, 1953). This technique has much in common with repertory grids, but was selected rather than that approach because it also directly enables, via its by-person factor analysis of response configurations, the identification of shared patterns of operancy. Unlike the usual item-by-item factor analysis, which dismembers individuals' response patterns, homogenising all of the responses of a group, and then reconstitutes patterns of response, Q factor analysis correlates and clusters holistically. It identifies those overall response patterns which are common to groups of people. It therefore seemed to offer the best method available today to investigate accounts as the expression of 'understandings', 'explanations' and so on, as articulated by

individuals but also as shared between them.

1.5 OVERVIEW OF THE THESIS

It is within this kind of dialectical framework that this thesis has been carried out; like the studies described above, to approach the topic of accounting for health and illness as taxonomic and ecological investigations. Three main objectives were set :

1. To identify and describe some of the main accounts for health and illness that are current in British culture, in terms of their broad ecological setting within the extant medical (orthodox and rival), religious, sociological, psychological and moral discourses in which they operate.

2. To identify and describe accounts for health and illness within different explanatory frameworks, particularly in relation to alternative understandings of 'internal' and 'external' influences and controls, and to set these too within their broader societal/psychological/moral ecologies.

3. To explore what these account taxonomies and ecologies have to offer to illuminate our understanding of accounting itself.

The next two Chapters describe the empirical and methodological bases upon which these objectives have been investigated. Chapter 2 reviews the recent empirical work carried out elsewhere to investigate accounting for health and illness: studies of 'folk' and 'indigenous' accounting; studies of social

determinants of accounting; and studies which have demonstrated
account sympatricity (including Q-methodological studies about
health and illness).   Chapter 3 is devoted to Q methodology,
providing details of its operation, history, theory-base and
current status.

There follow two Chapters describing empirical work. Chapter 4
presents Study 1, an initial investigation into account taxonomy,
both a Q study in its own right, and conducted to provide the
basis for Study 2. Chapter   5   describes   Study 2, in which an
80-item Q sort completed by seventy participants identified nine
alternative accounts for health and illness which included some
accounts which were primarily explanatory, some primarily about
'meaning' and some primarily about moral issues; and couched
within alternative socio-political explanations about health and
illness viewed within the relationship between the individual and
society, through explanations articulated around the links
between biology and medicine, to accounts that were concerned
with notions of blame and responsibility, and the rights of the
individual. The division between internal/external influences
emerged here as particularly salient to explanation.

Chapter 6 offers a brief review of the literature on 'locus of
control' generally, and studies of 'health locus of control' in
particular. Chapter 7 describes Study 3, in which three
instruments were used to explore the internal/external control
construct in relation to account sympatricity: the standard
'Multivariate Health Locus of Control Scale' (MHLC) (analysed
conventionally and using by-person factor analysis); an
'Influences on Health and Illness Questionnaire' (IHIQ), and a
Q-sort.   In this study eighty three participants completed all

three instruments, and their responses were used to tease out the similarities and differences between the accounts identified. While the MHLC scale data offered support for the established external/internal construct for some participants, even this data provided evidence for a number of alternative accounts; and the IHIQ and Q-sort data de-constructed the 'health locus of control' construct further. Chapter 8 concludes the thesis with a review of the empirical results and theoretical insights gained, making suggestions about theoretical and practical applications, and potential developments.

CHAPTER 2 : STUDIES OF ACCOUNTING FOR HEALTH AND ILLNESS

2.00 INTRODUCTION

This Chapter provides a review of the empirical studies that have been conducted to investigate ´lay´ accounting for health and illness within contemporary British and North American cultures; that is, different aspects of the way ordinary people (as opposed to medical professionals) explain, understand and portray health and illness, becoming ill and recovering from illness.

The earliest empirical studies of such ´lay´ accounts (usually termed ´lay health beliefs´) were carried out in North America. They demonstrated that although biomedicine tended to dominate ´lay´ as well as ´professional´ accounting, and that the physician was popularly seen as the primary source of medical consultation and treatment, respondents also cited a whole range of other sources (e.g. Chiropractors, Christian Science Readers, the ´corner druggist´) and reported using a wide variety of over-the-counter treatments (e.g. trusses and sun lamps) (Saunders and Hewes, 1953). Consultations with physicians tended to be restricted to occasions when the symptoms of illness were seen to be ambiguous and to interfere with work or social obligations (Apple, 1960). This was particularly the case with poorer people, who were more likely than the better-off to treat themselves, or seek alternative advice. These differences between rich and poor were partly attributed to the cost of treatment, and partly to the ethos of robust ´keeping going´ in adversity and lower expectations of working class culture (Koos, 1954). Finally, early research on the concept of ´health´ found it was articulated as a complex of three main constructs : feeling good, absence of symptoms and the ability to perform normal functions

(Baumann, 1961), with the working class people tending to favour the latter two categories.

More recent studies have tended to adopt one of three approaches : the 'folk' approach, arising primarily from anthropology; the social determination approach arising primarily from sociology, and the 'account plurality' approach, originating from various disciplines but focussing upon the diversity of alternative accounts to which people have access.

2.1 THE 'FOLK' APPROACH

The studies of accounting arising from an anthropological base have concentrated upon examining how the 'lay' beliefs of ordinary people in British and North American culture differed from the professional accounting system of biomedicine, and in particular upon their links to the indigenous folklore of the cultural group within which they were expressed. I have selected as examples of this approach a study by Snow which explored the 'folk' beliefs of poor people living in Tucson, Arizona, and a study by Helman, a British GP working in Stanmore, of the 'folk' beliefs of his patients.

2.1.1 Snow's study of American folk beliefs

The 'folk beliefs' studied by Snow (1974) derived from a mixture of European folklore, African cultural roots (particularly concerning genetic illnesses specific to blacks), the form of Voodoo religion that arose from the West Indies (particularly notions of sympathetic magic), and hot-cold theories arising

from Spain, via Mexico; these overlaid by the trimmings of scientific medicine and the messages of the American media (where, for example, far more patent medicines - for instance, for haemorrhoids and diarrhoea - are advertised on television than are seen as acceptable to ´good taste´ in Britain).

Snow interviewed 47 poor, predominantly female and black inhabitants of Tucson, Arizona, and also attended community and religious meetings to put the interview data into context. All but one of her respondents had been born in the ´Deep South´ and, aged between 35-85, most had experienced considerable racial discrimination. Her investigation was very detailed, including at least two lengthy interviews with each person, covering life-history and aspects of work, religious practices and family organisation (70% were single-parent heads of households) in addition to specific questions about beliefs concerning health and illness.

These respondents perceived the world within which they lived as hostile and dangerous, beset by natural agents of disease (e.g. the chill wind and damp, polluted air), supernatural influences (e,g. a punishing God, devils and spirits) and the malevolence of other people (e.g. via hexing, spells and mal ojo (evil eye)). Within this worldview, the individual was thought of as powerless, dependent upon the aid of talismans, spiritual healers and religious intervention to cope with illness.

Notions of balance were very pervasive, both in terms of the body (to retain its natural equilibrium) and in social life (to avoid

God's punishment for being 'uppity', or the envy of others). To stay healthy in this hostile, precarious world it was seen as crucial to eat, drink and live in a temperate, respectable manner. This was seen as particularly important at times of increased vulnerability; for example, during menstruation and pregnancy, at particular times (e.g. the waning of the moon) and stages in the life-cycle (e.g. infancy and old age).

Within the notion of balance an important concept was that of hot-cold, which has been traced back from humoral pathology via Spanish folklore and then via Mexican and Puerto-Rican folklore, into American cultural ideas (cf Clark, 1970; Currier, 1966; Harwood, 1971). Illnesses were thus regarded as either caused by 'too much heat' or 'too much cold', arising, for example, from imbalances in diet, the effects of climate, or exposure to water or wind. By reference to the hot-cold system, complex explanations were built up to account for illness and suggest remedies. For example, eating insufficient blood-building, 'hot' food was seen to lead to 'low blood' illnesses like anaemia or tuberculosis. Healing was seen as a personal gift (usually from God) rather than the product of training.

Typically spiritual, religious or indigenous healers were regarded with much more respect and authority than physicians, seen as greedy and often hostile to the black community and poor whites alike. This reaction is not at all surprising, given the enormous gulf that existed between poorer North American 'ethnic minorities' and the predominantly white, male, Jewish and Protestant medical establishment. Their worldviews operated upon

entirely different assumptions, and often came into conflict (for instance, when a doctor diagnosed both high bloodpressure [high blood] and anaemia [low blood]).

2.1.2 Helman's study of the folk beliefs of his patients

In the context of Snow's work, Helman's (1978) study of the folk beliefs of his patients, people living in Stanmore and Edgeware in Britain, suggests at first sight that within a system of welfare provision of medicine (i.e. the British National Health Service) there are fewer divisions between popular and professional accounting. However, it is important to note that Helman's data were derived mainly from interactions between a physician (himself) and patients, and upon second-hand reports by other health professionals (e.g. via interviews with nurses, other GPs and receptionists). Thus they represent the accounts a) of people who had taken their medical problems to doctors' surgeries and b) that people were prepared to express in that context.

Helman entitled his paper 'Feed a cold and starve a fever', and focussed on the ubiquity of a colds/fevers classificatory system current in British culture which was used particularly by older patients. Most minor illnesses, according to Helman, tended to be classified by patients and by doctors in their consultations according to the way they made a person feel (i.e. 'hot' or 'cold') and the kind of symptoms ('wet' or 'dry'), leading to an assumed division between 'colds and chills' and 'fevers and infections', the two accorded different aetiology and assumed to need different kinds of treatment.

Colds and chills were predominantly assumed to be caused by the influence of exposure to some unfavourable aspect of the environment, in particular damp, rain, cold winds and draughts - i.e. anything which lowered the body temperature. Exposed skin, particularly on the top of the head, neck and feet (but not face and hands) was seen as particularly vulnerable, if not 'properly wrapped up'. For example, men often assumed they were likely to get a 'head cold' after a haircut unless they wore a hat. Other forms of vulnerability reported were transitions between hot and cold - sitting in a draught or going out into the cold after a hot bath; seasonal changes in the weather (November and February were both considered dangerous months because of their transitional nature) and shifts from one climate to another (e.g. 'summer colds' attributed to returning from hot countries to colder Britain).

These assumed links imbued colds with a quality of moral responsibility and culpability; the idea was that they could be prevented by avoiding exposure - waiting a sensible time after a bath before going outside; wrapping up warm in winter; changing out of damp clothes. Alternatively, they were a 'price to be paid' for new fangled ideas like holidays in Spain, or skimpy fashionable clothes. However, strength to fight the cold was seen as built from within, by tonics like Virol, Cod Liver Oil, Haliborange and Sanatogen, by eating warming food and drinking warming drinks (ideas taken up by advertisements for example, for porridge : 'central heating for kids', hot Ribena and drinking chocolate, all of which have used strong images of 'inner' warmth). Treatments similarly stressed the need to warm the body,

with hot lemon and honey drinks, hot water bottles, vapour rubs (e.g. Vick) and ample warming food ("feed a cold").

By contrast, fevers were assumed to be characterised by a feeling of 'hotness' , to be more severe, longer-lasting, and potentially more dangerous than 'colds' and to be due to infection from 'bugs', 'germs' or 'viruses', terms borrowed from biomedicine, but rooted more strongly within folklore than in modern microbiology. Germs were seen as living, invisible, very small malevolent entities that you catch, mostly from other people's sneezes, dirty hands, unsavoury toilet habits or through ill-prepared food, entering through the body's orifices. Once inside the body they were assumed to move around and be able to infect almost any part. There were thought to be no good 'germs' only bad, harmful ones. Viruses and bacteria were seen as equivalent. There was far less moral culpability attached to fevers. Although always 'caught' from somebody else, that was part of the risk of normal, everyday social interaction. Moral imperatives were placed upon sufferers (e.g. not to spread their germs by going into work with 'flu, or sending a child to school with chicken pox), but there was much more of a sense that if there is '... a bug going around' then there is little anybody can do to avoid catching it.

Methods of dealing with germ illnesses fell into three categories. The germs could be ejected - 'washed out' or 'flushed out' by taking fluids, coughed up by taking expectorants, or sweated out (encouraged by hot drinks, warm rooms and extra bedclothes); starved (particularly stomach

´bugs´) and killed, usually by antibiotics. Helman commented upon the pressure frequently put upon GPs to supply antibiotics for almost any form of infectious illness, irrespective of their side-effects and inability to treat viral infections.

Helman pointed out that the accounting system used by GPs in their interactions with patients mirrors that of the popular system. GPs, he claimed, frequently tell people things like ´You´ve picked up a germ that´s going round´ or ´You seem to have a urinary infection´, which, despite their vagueness, satisfy patients and reassure them that no further diagnosis is necessary. Seldom is any attempt made to identify the infectious organism, promoting the view that all ´bugs´ attacking a similar site can be dealt with in a similar manner - and indeed, doing little to question the efficacy of antibiotics as ´magic bullets´ for any kind of infection. Helman suggested that as a result (due largely to the self-limiting nature of the illnesses, and the constraints on the GPs time and resources) most GPs reassure patients by confirming their expectations about treatment (´Go to bed, take plenty of fluids, and keep warm´) and offering prescriptions for unneeded, expensive and often positively harmful medications. For instance, at the time of writing the paper, Helman estimated that six million gallons of cough mixtures were prescribed each year on the NHS, despite the considerable doubts that have been expressed about whether they serve any therapeutic functions other than reassurance.

2.1.3 Common themes within studies of 'folk beliefs'

While there may seem to have been greater communality between Helman's patients' accounting systems and that of biomedicine, than between biomedicine and the accounting of poor black people in Tucson, this may well be somewhat illusory. Helman showed that GPs tend to concentrate on providing reassurance and acknowledgement of the individual's symptoms as disease, rather than treatment or accurate diagnosis - not, in practice, all that different from spirit healers promising to remove a 'hex'. Similarly, Snow's identification of three main themes in the accounting of the people she studied suggests that the basis of accounting for health and illness was not nearly as different in the two cultural settings as her descriptions of mal ojo, voodoo and a punative God implied. Her themes were :

"First, that the world is a hostile and dangerous place; second, that the individual is liable to attack from external sources; third, that the individual is helpless and has no internal resources to combat such attack but must depend on outside aid." [p83]

Helman's patients also saw the world as a hostile place, a source of attack upon the individual - environmentally (in terms of wet, damp and winds) and microbiologically (in terms of 'germs' that can invade the body). They too saw themselves as helpless, assuming that whenever they were ill they needed treatments like cough mixtures and antibiotics rather than accepting that most minor illnesses are self-limiting. That ideas of supernatural causes of illness or personal malevolence did not enter Helman's analysis may well merely reflect the 'official' settings in which his data were collected. Other

workers (e.g. Csordas, 1986; Leslie, 1976; Williams, 1986) suggest that religion pervades most accounting for health and illness, even for people who are not affiliated to any particular church. Williams, for example, talks of the ´invisible religion´ :

"... of a worldview which, often selective in doctrine and uncommitted to the church, nevertheless (draws) upon universal statements of faith or ethics to make sense of experience ... in the medical sphere, both secular pragmatism and ´invisible´ religion are currently important in shaping answers to the moral questions posed by bodily decline." (Williams, 1986, conference paper abstract).

Snow´s and Helman´s studies demonstrate that in Western settings no less than in the Third World communities that form the bulk of anthropological data sources, the accounting systems adopted by ordinary people to explain health and illness, and tackle the problems that illness generates, can only be understood within the much broader context of indigenous culture and ´folk´ wisdom. Folklore is not something restricted to historical times or so-called ´primitive´ cultures, but is alive and active within America and Britain today. It has historical, indigenous roots, transmitted for instance as aphorisms and as powerful cultural archetypes, reinforced by socialisation, media images and ´professional´ endorsement. ´Folk wisdom´ is the very fabric within which popular discourse is woven.

2.2 INVESTIGATIONS OF SOCIAL DETERMINANTS OF ACCOUNTING

An increasing amount of research has been conducted, particularly in Britain, to investigate the links between accounting systems

and health inequalities. The Black Report (Cf Townsend and Davidson 1982) established a strong positive relationship between socio-economic status and health - the lower a person's socio-economic status, the more likely they are to die young or suffer chronic illness, a finding recently confirmed by the (now defunct) Health Education Council's publication 'The Health Divide' (1987).

Many researchers have sought to investigate the reasons why there are large inequalities between the health of poor and rich people in Britain. While structural factors (e.g. poor housing, limited income and unhealthy working conditions, see for example, Doyal ,1979; Mitchell, 1984) have been blamed, differences in behaviour and lifestyle (e.g. diet and smoking habits) have also been implicated, resulting, it has been suggested, from educational limitations, alienation between the medical profession and working class people and structurally and socially induced 'learned helplessness' (cf Seligman 1975).

In consequence a number of studies have recently been conducted to investigate the health beliefs of working class people, both with a specific focus on particular communities, and in comparison with middle class accounting systems. The purposes of research were to discover to what extent health inequality was a product of differences in the way better-off and poor people account for health and illness, and, in consequence, differences in their propensity to adopt 'healthy' or 'unhealthy' habits and lifestyles.

2.2.1 Studies of lay aetiology within working class culture

The best known British research into lay aetiology is Blaxter and Paterson's (1982) detailed ethnographic study of the beliefs about the causes of disease held by working class mothers and their mothers (i.e. women who were grandmothers) living in Aberdeen, based upon content analysis of a series of in-depth structured interviews with each respondent. I will begin here with the responses of the 46 grandmothers (Blaxter 1984). Blaxter stressed that these women had sophisticated models of disease causation, mentioning a wide variety of causative factors, including : infections, heredity and familial tendencies, agents in the environment (e.g. pollution), the effects of drugs (e.g. the contraceptive pill), secondary consequences of other illnesses, stress, strain and worry, effects of childbirth/menopause etc., of injury, or surgery, neglect, the constraints of poverty, individual susceptibility, behaviour, ageing, and natural degeneration.

Infection was the most commonly cited cause of illness, though this reflected in part the commonplace nature of many infectious childhood diseases. The older women distinguished between these mild and untroublesome infections, and past memories of serious, life-threatening illnesses like diptheria. While some reported active steps to eradicate ´germs´ (e.g. boiling dishes), far more frequently infection was seen as outside of their control - prey to the weather, brought on by damp housing, ´something in the water´.

The next most commonly cited cause was heredity and family susceptibility including notions of both genetic cause and mere family similarity. Comments were also made about individuals having ´particular weaknesses´. This category of attribution was one which shifted blame away from the individual. Reactions to the ´natural´ ageing process (including the menopause), and the effects of childbearing similarly denied culpability - one should expect to suffer consequences from pregnancy and giving birth, from the menopause and getting old, they are an inevitable aspect of these processes. Stress, strain and worry, together with reactions of anger, resentment, frustration and despair was another major category.

Blaxter included in her ´agents in the environment´ category a wide range of rather different causal factors considered capable of increasing the chances of falling prey to infection, from ´poisons´ through to working conditions and climate. While Blaxter accepted that indeed these women did face predominantly hostile environmental conditions in terms of climate, poor tenement style housing and unpleasant working conditions, she noted "To find a cause in the environment was more acceptable than to locate the responsibility in one´s own body...". When it came to attributions specifically linking behaviour to illness (e.g. a fondness for sugar leading to diabetes), Blaxter commented that once more "... self-responsibility was explicitly denied. Yes, it was this behaviour that caused the disease, but in the circumstances, no one could behave differently."

Although the content classification used in the study gave the impression that many attributions were single, Blaxter emphasised that they were generally placed within the interviews within a much more complex, biographic context. A minor illness (e.g. ´flu) would be spoken of as leading to bronchitis, which might ´weaken the heart´. While a doctor may see illness incidents as discrete events, to the individual experiencing the sequence of illnesses, they are often interpreted as causally interlinked, and indeed not just linked to each other, but to all manner of life events, circumstances and individual responses.

The overall picture of the older women´s accounting was of low expectations, their portrayal of ´good health´ being predominantly one of the capacity to continue to function ´normally´. Health was construed within a stern moral context of ´not complaining´, with ´giving in´ to illness seen as a weakness of character. Within this construal, the women sought to absolve the individual from any personal blame if they did become ill – their behaviour may be the reason for illness, but was not its cause. That lay not in themselves, but in the conditions in which they lived their lives.

When Blaxter and Paterson (1982) compared the accounts of the two generations, while the concept of health was similar for the older women and their daughters of a younger generation, their attitudes to doctors and use of medical services were different. The majority of the older generation expressed trusting, grateful and deferential attitudes towards doctors, stressing what ´good patients´ they were, and derogating the way others abused the NHS

by seeking help for trivial reasons. The attitudes of the daughters were much more varied, and often more critical. Their use of-Health Services (both community and hospital emergency services) was far greater, as were their expectations. Many told stories of clashes with doctors who would not give them sufficient information, or who refused to provide the level of service to which they considered themselves entitled. Attitudes to health visitors depended a great deal upon their circumstances and self-confidence. Those who were coping well with predominantly healthy children usually spoke favourably of the support the health visitors provided; however those who were coping less well and had children in poorer health often resented what they saw as being 'judged' and 'told what to do', and tended to make least use of preventive services like inoculations and dental checks.

Blaxter and Paterson initiated their research to explore the hypothesis that had been publicised by Keith Joseph that deprivation is cyclical - disadvantaged parents transmit the roots of deprivation to their offspring. In particular they wanted to investigate the extent to which the older women had influenced their daughters' accounting, such that when they became mothers themselves, they adopted dysfunctional attitudes. No evidence for this thesis was discovered, and Blaxter and Paterson argued that whereas there were similarities between the accounts of the two generations, it was much more likely that they had a common source (i.e. social disadvantage itself) than that the similarity was a product of socialisation. The new generation of mothers saw themselves - and were seen by their

mothers - as living in a very different world, in which friends and people like health visitors were a much better source of advice about health matters than their mothers.

2.2.2 Lay attributions of ´external´ and ´internal´ control

Pill and Stott (1981; 1982; 1985a; 1985b; 1987) carried out a series of studies within a research programme in which the beliefs about health and illness of Welsh ´lower working class´ mothers were explored with specific focus upon the distinctions construed between internal causality (i.e. individual responsibility) and external attributions (fate and the influence of powerful others). They used a combination of in-depth interview techniques (from which they derived indices of health related behaviours and lifestyle), and psychometric instruments, including tests of ´knowledge´ and the Multivariate Health Locus of Control Scale (MHLC) (Wallston and Wallston, 1978).This construct and research with the scale, including further analysis of Pill and Stott´s work, are described in more detail in Chapter 6).

In their 1981 study Pill and Stott developed a ´Salience of Lifestyle´ (SLI) index which was used to distinguish between ´lifestylists´ and ´fatalists´. ´Lifestylists´ were the women who defined health in terms of a dynamic relationship between the individual and their environment; who saw health as under a level of individual control, although they also saw resistance, life events, interpersonal relationships and emotions

as influences on health. They had positive concepts about mental and physical wellbeing, and gained higher scores on tests for knowledge (i.e. of current orthodox wisdom about the causes of heart attacks and cancer) than the ´fatalists´, and they spontaneously reported taking active health-promoting steps such as exercise and stress reduction, and said they would evaluate the medical advice offered to them, rather than follow it unquestioningly. These 'lifestylists' were contrasted with the ´fatalists´ in terms of their scores on the HLC scale. Although there was a trend for the ´lifestylists´ to score higher on the ´internal control´ sub-scale, and score lower on the ´external control´ sub-scales (chance and powerful others) than ´fatalists´, this trend did not reach statistical significance.

In their later study (1985), using a much larger respondent sample, Pill and Stott elucidated the relationship betweeen SLI scores and attributions. Moving away from the simple lifestylist/fatalist dichotomy, they identified three clusters of causal attribution :

Score on SLI scale	Attribution of illness and role of behaviour
LOW	Tended to reject the idea of blame and personal responsibility completely, or attributed illness to dysfunctional mental attitudes.
MEDIUM	Tended to emphasise the role of short-term risks involving stupid or careless behaviour as causes of illness.
HIGH	Tended to stress the role of life-style, and the need to take long-term health maintenance measures to avoid illness.

Pill and Stott stressed that within their sample "...most of our respondents were probably neither out-and-out fatalists nor did they believe that leading a healthy life would guarantee complete immunity", indeed "(M)ost people appear to be quite capable of holding a number of apparently contradictory general theories of causation at the same time ... The overlapping nature of the characteristics reveals ... how those with some degree of belief in the importance of lifestyle decisions develop more complex views which can embrace both fatalistic and lifestyle orientations without cognitive strain."

Pill and Stott attempted to elucidate accounting further by looking for links between MHLC and SLI scores and other factors such as home ownership, marital and employment status, education and participation in outside organisations (e.g. religious affiliation). While they did establish significant positive correlations between SLI and both educational level and amount of religious commitment, with the other variables significant effects only emerged via more complex interactions. For example, house ownership alone did not link significantly to a rejection of 'chance' in illness causation and high SLI scores, but ownership plus more education did.

Overall, Pill and Stott refuted the traditional stereotyping of working class fecklessness and laissez-faire attitudes, contrasted with an assumption of middle class concern for health and a greater commitment to healthy lifestyles. Instead they argued that those who were poorest off were being realistic in

their attribution of illness to living conditions and the struggle for family survival in an urban environment. For example, in answer to a question about the main reasons for falling ill, one respondent replied :

"Overwork, pace of living - people just not getting the proteins they need and there is just not the money about to give your children what they need ... I think it boils down to money every time as far as I'm concerned because people like, you know, my husband has to work so many hours to make it worthwhile for your family and your everyday life to go all right - if you know what I mean - as far as food and that goes. There's a lot of worry attached to it - I think it is this that makes people ill, mainly nerves and, you know, the rush ! My husband has to get up at 4.00 am in the morning for the morning shift. I don't think it's right for any man to work like that - if you work the normal hours you haven't got enough."

As did the women in Blaxter's sample, many of Pill and Stott's respondents acknowledged a link between behaviour and lifestyle, and health and illness. But the issue was <u>not</u> seen as one of personal responsibility. Living in conditions which give you few choices about your actions, how can (or should) you accept blame ? Pill and Stott suggested that "(W)hat, from one point of view, may be seen as 'fatalism' may from another perspective, be interpreted as a realistic appraisal of the complex variables involved in the aetiology of illness...". In their most recent paper (Pill and Stott, 1987) they have offered a complex 'cascade' model which links together sociodemographic factors, accounting and various barriers to action which they see as interweaving in a complex manner to influence lifestyle and behaviour. This model is illustrated in Figure 2.1.

Figure 2.1 Pill and Stott's cascade model of antecedents to health behaviours (from Pill and Stott, 1987).

Sociodemographic Factors	Beliefs & attitudes	Barriers[1]	Behaviours

Education

Childhood socialisation

Religious commitment

Marital status

Income

Concepts of causation, prevention & responsibility in illness

Beliefs about the nature of health and factors which promote or hinder health maintenance

* PREVENTIVE HEALTH PROCEDURES

* PERSONAL HEALTH PRACTICES

Support - overall

    - relatives

    - friends

Work - self

    - husband

Family structure

Conjugal relationship

Beliefs about personal control in life and role of chance in illness or health

* SELF-DEFINED HEALTH CHOICES

[1] All antecedents in the cascade may have the potential to act as barriers under certain circumstances.

2.2.3 Comparing 'middle class' and 'working class' accounts

Unlike the previous two research programmes, which focussed entirely on the accounting of working class women, Calnan and Johnson (1985) specifically attempted to compare the accounts of working class women with those of middle class women. Their sample consisted of 30 women from each group who lived in London, all interviewed by a single interviewer. They did find some differences, particularly in the way the two groups defined health. While the middle class women offered many more definitions, there was a tendency to offer proportionally more positive descriptions than the working class women. This showed up most clearly in the middle class women's emphasis on health as a feeling of fitness and strength, being active and energetic compared with the working class emphasis on 'getting through the day' and 'never being ill'.

There was far less difference in reported feelings of vulnerability, although Calnan and Johnson did observe, as had Blaxter, a tendency for working class women to see worrying about illness as unhealthy in its own right, as weakness or hypochondria. For both groups, but particularly for the middle class women, perceived vulnerability to illness tended to arise out of experience of symptoms (e.g. suspecting a breast lump) rather than a person's own actions (e.g. smoking). Calnan and Johnson suggested that health beliefs of the 'abstract' kind they examined may be more a matter of making sense of health actions than acting as precursors to action.

However, this study is difficult to interpret, Calnan and Johnson

themselves noting sampling problems and that some of the effects may have been due to differential responding to the middle class interviewer. It is also hard to tell to what extent, say, the greater stress laid by working class women upon not worrying about illness reflected structural differences (e.g. in the resources to allow for 'being ill', or to seek medical advice and treatment) rather than differences in accounting.

2.2.4   Overall themes in studies of social determination of accounting

The ethos of working class accounting as noted much earlier in North America by Koos (op cit) appears to be one of denying individual responsibility and culpability, of low expectations, and of robust stoicism in the face of adversity. All three of the studies offered consistent support for this description. However, while these studies do provide evidence to refute the stereotyping of working class people as causing their poor health through their own feckless behaviour, none of them really get to grips with the main question of whether working class values and discourses per se play a role in promoting inequality. All three sets of authors note that the structural disadvantages experienced by the working class women were so pervasive and so influential within their daily lives, that it was impossible to discern whether their accounts (e.g. denial of blame) were simply the products of disadvantage, or contributed to it. Part of the problem arises from the way ethnographic methods iron out variability in accounting. Reading the studies, very little impression is given of the diversity of accounts within working

class culture - how people who share similar levels of structural disadvantage might adopt different strategies to cope with it, based on different accounts.

Even with Pill and Stott's programme of research, where attempts were specifically made to tease out alternative perceptions, the high/medium/low SLI index confounded accounting and socio-economic status. Their data indicated more about the process of upward social mobility than they did about the cycle of deprivation : that the more upward social mobility a working class person achieves, the more they are likely both to have acquired the resources to adopt the behavioural and practical trappings of a good 'lifestylist' and the more likely they are to have internalised middle class individualist values.

What, of course, the MHLC data analysis leaves out is consideration of structural features, excluding attributions of external influences such as poverty or poor housing and working conditions which showed up so strongly in the interview data. As I will describe in Chapter 6, detailed analyses of the original Locus of Control Scale (cf Lefcourt, 1980) indicate that it has a political dimension; that 'internality' is also a measure of political conservatism (i.e. as epitomised by the 'New Right'). Radical and politically active socialists and Marxists tend to score as 'externals' (although attributing control to big business and dominant hegemonies rather than fate). Since this aspect of externality/internality is excluded from the MHLC scale it is perhaps not all that surprising that Pill and Stott found the MHLC data so disappointing, only yielding significant

effects when linked to measures of socio-economic status (like home-ownership and education levels).

Thus Pill and Stott's work, as much as the other two studies, leaves the reader hanging. Did the 'lifestylists' acquire their more positive self-perceptions and expectations as a consequence of overcoming or avoiding adversity - or did they overcome or avoid adversity because of the attitudes to life they adopted ? Were the 'fatalists' fatalistic because life had given them a raw deal, or did they get a raw deal because their fatalism led them to make no effort to help themselves ? There is polemic in plenty about this issue, but so far no research of sufficient sophistication to go much beyond polemic. Rather, these two alternatives are themselves 'accounts for health and illness', as the studies described later in this thesis show.

2.3 STUDIES OF ACCOUNT SYMPATRICITY

The studies described in this Section are ones which have specifically explored <u>alternative</u> accounts for health and illness. That is, they were all based upon the theoretical assumption that individuals have access to more than one kind of account, accounts varying either in their content, or form, or both. Within anthropological theorisation this parallelism is usually referred to as 'medical pluralism' (cf. for instance Kleinman's (1978) division into 'folk', 'popular' and 'professional' systems). Within sociology it is generally couched within a framework of competing belief systems arising out of sociological divisions (cf. for instance, Friedson's (1970)

analysis of the divisions between 'medical' and 'lay' accounting). Within psychology, account sympatricity has been treated theoretically by way of such constructs as 'social representation' (cf Moscovici, 1961, 1984) 'constructive alternativism' (cf Kelly, 1966) and 'complementarity' (cf Stephenson, 1986a)

In all these disciplines the notion of 'alternativism' is based upon a social epistemological interpretation in which accounts are construed as the products of variable forces within collective discourse. Directed towards the topic of health and illness, they all posit that since reality is socially constructed, accounts for health and illness vary according to the particular forces (cultural, sociological, inter- and intrapersonal) impinging on the individual as part of a social group. The empirical studies have thus sought to identify and elucidate these different accounts for health and illness, and to gain a better understanding of their sources.

2.3.1 Social representations of health and illness

Herzlich (1973) carried out extensive interviews with predominantly middle class Parisians (and a few country dwellers). From their accounts, she developed sophisticated descriptions of the social representations for health and illness that she saw as operating both subjectively and intersubjectively - as accounts that individual have internally represented within their thinking and as discourses within the public domain. From her interviews, Herzlich concluded that different accounts

for health/illness are not polar opposites to each other, but quite discrete conceptions.

She interpreted her data as evidence that individuals have access to multiple conceptions of ´healths´; co-existing formulations of different aspects : health-in-a-vacuum; reserve of health; and equilibrium. ´Health-in-a-vacuum´ was the term Herzlich used for the notion of health as the absence of illness, of a lack of awareness of the body, and/or simply not being bothered by it, essentially a state of "bodily silence". ´Reserve of health´ represents health as an asset or investment rather than a state. It has two main aspects : physical robustness or strength; and resistance to attacks, fatigue and illness. Health is something you ´have´ that enables you to perform your job, etc., defend yourself against disease, recover from illness. ´Equilibrium´ was described by Herzlich´s respondents as "real health" or health in its highest sense; it carried the notion of positive wellbeing or "high level wellness" (cf Ardell 1977) as well as some of the sense of balance and harmony and even some of the attributes that psychologists such as Maslow (.1968) have proposed for optimal human functioning, such as self-actualisation. Herzlich commented that although her respondents used the term ´equilibrium´ with frequency, they found it hard to pin down, and overall it seemed to carry a two level meaning: a substrate of essential harmony and balance in bodily, psychological and spiritual life - from which a functional sense of self-confidence, alertness, freedom, energy and indefatiguability stem. Thus it had both a psychological reality concerned with self perception, and a somatic reality to do with physical

capability and readiness to take on all comers.

Herzlich's respondents distinguished between four different
classes of illness : serious illnesses which may be fatal;
chronic conditions; everyday, trivial illnesses like colds and
'flu; and childhood ailments. They also: referred frequently to
intermediary states between 'real' illness and 'real' health :

"There are the little troubles, the little situations of
discomfort which you have more or less all the year round,
headaches, the after-effects of alcohol, digestive difficulties,
fatigue..." [p 54]

These intermediate states were typified by links to mood
(particularly depression and inertia); to their undesirable
impact on relationships with others; and their tendency to be
long-lasting.

However, beyond this, in contrast to the well articulated
classification of aspects of health, accounts of illness were
vague, unsystematic and heterogenous. There were attempts to
distinguish illness from other states (e.g. accidents and
physical disability) and a variety of dimensions were
introduced : (e.g. severity, painfulness, curability). Despite
this lack of clarity, however, Herzlich did identify three
'metaphors' for illness which distinguished between different
social representations : illness as destroyer; illness as
liberator and illness as occupation.

'Illness as destroyer' was an image which tended to be held by
people who were or had been particularly active or engaged in

society, and for whom any interference with their professional or family role was a serious problem. The focus was upon the impact of illness to limit fulfillment of role responsibilities, and concomitant loss of social position and subsequent social isolation. Bound together in this social representation were fundamental assumptions about responsibilities to others, and the ability for dependency to negate the individual as ´less of a person´. People who saw illness as ´destroyer´ stressed the positive aspects of health; they responded to illness, paradoxically, both by trying to assume control (by denying it, or keeping going as if they were not ill) and by feeling impotent (by ´giving up´ when struck). These were the people who avoided doctors at all costs, and would do almost anything rather than accept the label ´ill´.

´Illness as liberator´ in contrast, stressed the capacity of illness to liberate the individual from their responsibilities, or the pressures that life places upon them :

"When I´m very tired, I often wish I were ill ... illness is a kind of rest, when you can be free from your everyday burdens ... For me, illness is breaking off from social life, from life outside and social obligations, it´s being set free." [p 114]

The benefits of illness were seen as making possible greater intellectual activity that the pressures of everyday life exclude; the solitude of illness could be enjoyable; there were privileges to be gained, sympathy and care from others. Herzlich argued that within this perception are provided the seeds of the ´invalid´ personality, bound up in ideas of the capacity of invalidity to promote self-examination, that experiencing illness can enrich understanding and force upon the sufferer a better and

more valid set of values; a belief that experiencing illness is a route through which an individual can attain full self-knowledge.

´Illness as occupation´ was the notion that when you are ill, you should see illness as a challenge - as something that you must fight with all the powers you have. It stressed the energy needed to . focus all your energies to get better and not to worry about your other responsibilities. It carried two main imperatives - to accept your illness as real, and a moral responsibility to take an active role in your own recovery. There was also a strong sense of ´mind over matter´.

Although these three descriptions tend to read as though people could be classified according to one or other perception, Herzlich stressed that only some individuals adopted a single construction; most people drew upon two or all three, offering complex understandings and explanations. Herzlich argued that these social representations, singly or in concert, acted as strong determinants, not just of the way illness was perceived and responded to, but also of the way people saw themselves when they were ill, when they were well, and particularly when they were in intermediate states between ill and well.

The disjunction between the representations of health and of illness meant that representations of what influences health were construed differently from attributions for becoming ill. Health, predominantly, was seen as a matter of individual strength and resistance, of a capacity to adjust and find harmony between the self and the environment, in part a kind of ´natural heritage´ of

bodily strength, in part a product of self-fulfillment; health was represented as something <u>inside</u> the individual. Illness, conversely, was construed as the result of assaults upon health from the <u>outside</u> such as pollution, the wear and tear of modern life, the pressures of confinement. It also included the effects of behaviour (e.g. staying up late, not eating sensibly), but these were usually seen as themselves a product of 'way of life' - dysfunctional responses to the root cause of ill health, the stress, fatigue and pressure of urban living (and less frequently, of country living) :

"You could say that now, with the life we lead, certain diseases are increasing because our body no longer reacts because it no longer has enough resistance ... Modern life induces a kind of fatigue which makes us ill ... everything to do with modern work and its conditions makes us more vulnerable to most diseases."
[p 21]

Resistance, within this analysis, was attributable to three main factors : a) inherited bodily predisposition - people are born physically strong or weakly, with high or low or intermediate reserves to fight off onslaughts from way of life; b) temperament - the ability to fight is in part a product of the kind of person you are; and c) specific weaknesses and vulnerabilities - individuals are seen to vary in the kinds of assault (specific germs) to which they are vulnerable and/or particular parts of the body that are prey to attack, for example 'a weak nervous system'.

Illness was thus represented as a product of interaction between a person's individual characteristics, and their 'way of life'. But it is noticeable that 'way of life', as described by these

middle class Parisians, was not equivalent to 'lifestyle' (as Pill and Stott would define it) but rather an interpretation in which people are construed as passive objects upon which a particular 'way of life' was imposed. While its illness-provoking qualities were construed as products of the modern 'rat race', the tendency to blame agents in the outside world for illness (directly and vicariously) was very similar indeed to the refutal of personal culpability discovered within the working class samples studied by Blaxter and Paterson, Pill and Stott, and Calnan and Johnson. In the 1960s, when Herzlich carried out the interviews, middle class people appeared to deny personal culpability as much as working class people.

2.3.2 Studies of the accounting of older people

Williams' (1981a, 1981b, 1983, 1986a, 1986b) researched specifically into the accounts for health, illness and in particular about ageing of 'older people' (i.e. 65+). Williams used similar ethnographic methods to other researchers in this area, but where his work differed from that of others in this field was in his use of formal logic to analyse his data, exploring the categories Herzlich discovered, particularly those of 'health as destroyer' and 'health as occupation', seeking to elucidate what he calls the 'lay logic' and 'structure of ideologies' that underlie such concepts.

Williams' early studies (1981a and b) were primarily concerned with the 'lay logic' behind older people's notions of health and illness in relation to their own experiences of ageing. His

data showed that that although it is sometimes naively assumed
that 'old people' can be treated as a single group and assumed to
see the world in similar ways, in his sample different people
interpreted the physical manifestations of growing old in
radically different ways. Those people who adopted a 'health as
destroyer' metaphor tended to see themselves as being 'finished'
or 'fading away' when they experience the gradual physical
decline of older age. However, those who adopted a 'health as
occupation' metaphor were much more likely to see themselves as
basically healthy as they got older, albeit maybe suffering from
some form of specific weakness. Such a person was more likely to
see themself as 'keeping going' and 'fighting on' despite the
inevitable degeneration that old age brought. This helped to
explain the apparent paradox which emerged from his interviews
and Herzlich's, that people often considered themselves
'healthy' even though they reported symptoms of illness. Among
Williams' (1983) sample of older people, over fifty percent of
those experiencing chronic conditions (e.g. arthritis) rated
their health as good or excellent.

However, Williams argued that all of his respondents shared a
common account of 'health as strength', a corollary of
Herzlich's 'reserve of health'. Within this account, health was
seen as a property that can either be 'taken care of', built up
or maintained - or alternatively, spent or squandered. Williams'
respondents talked about how this strength could be compromised
in one of at least four ways : a) by being temporarily depleted,
but with full or partial recovery expected; b) by the effects of
localised chronic disease, suggesting a particular weakness of

some part; c) by the development of general weakness which has the effect of overall attenuation; and d) by the exhaustion of the power of recovery.

Williams´ interviews were conducted with a carefully balanced sample, but his identified alternative accounting for ageing appeared to arise from factors which were quite different from those ´controlled for´ by sampling techniques. Neither age, social class or gender could predict whether people saw growing old as a time of decline and inevitable decay and restriction - or as a liberation from responsibility, to be savoured and fought for against any irritating symptoms of old age. Recent work by Cornwell (1986) has suggested that which of these is adopted in later life is largely a reflection of biography and the self-concepts and strategies each individual has developed in their earlier life. She commented, for example, upon the "... immense variation between the older respondents with regard to what they consider to be ´normal´ ageing" [pll]. This diversity reflected some aspects of biography that were common to all members of the same age cohort (e.g. World War II, the introduction of the National Health Service), some that were shared by particular groups or collectivities (e.g. the poverty and mass unemployment of the Depression in the 1930s that affected working class people differently from middle class people), and some that are more specific to the individual (e.g. a good or bad marriage).

While Cornwell has tended to emphasise individual biography as the framework upon which accounting is built in the ´now´,

Williams' more recent work (1986b) has stressed the role of collective discourse as a basis within which a number of logical premises can be ´made sense of´. For example, some people were able to reconcile the premise that early old age (.e.g. just after retirement) is a setback with the premise that it is a repairing of defences, thus arriving at the conclusion that ageing is a resistable process. In carrying out an analysis of this kind, they constantly referred not just to their own ideas but to their estimates about ´what other people would think´ and to moral and ethical standards set both by the individual for themself, and by the community at large. Williams described three main "schemes of ageing" :   as a resurgence; as a siege and as a delayed capitulation :

"... each internally coherent, which at once supply and limit the stock of ideas on which Aberdonians draw. It is between these possibilities that those searching for coherence have to chose..." [pp 15-16]

Thus while Cornwell´s analysis of accounting about health and illness in old age was predominantly idiographic, Williams was much more concerned with the intersubjective discourses available to the individual to draw upon in order to make sense of what they frequently recognised as paradoxical and conflicting patterns of ideas of their own. He saw these discourses - he calls them ´schemes´ or ´schemas´ - as reference sources which an individual can use to impose structure upon their understanding. These are not just specific to the topic in question, but embody commonly shared values :

"... this generation had the basis for a unified consciousness of certain distinctive values - respect for neighbourliness, for

authority, for perseverence and thrift." [p19].

Thus Williams saw accounting as a product of a personal dialectic, with the individual account arising ˙ both by way of reality-constructs-person and person-constructs-reality processes.

2.3.3 Studies of ´public´ and ´private´ accounting

Cornwell´s earlier research (1984) investigated the accounts for health and illness of 24 people who lived in London´s East End (Bethnal Green). She also obtained data about her respondents´ housing, work, life-histories and social networks so that she could place their accounts into the context of their daily lives, family relationships and personal histories, as well as within the broader geographical and historical context of the area. She obtained two distinctly different kinds of account - the public and the private.

Public accounts, usually offered in early interviews in response to general questions about, say, the causes of illness, she saw as lay interpretation of expert opinion. They were often prefaced by such phrases as "Well, they think that....", reproducing what was seen as legitimised knowledge. These, she argued, were the kinds of account a researcher must generally expect to be offered in the setting of a formal interview, when the interviewee sees themself as somewhat ´putting on a performance´. Such performance variables are well known to psychologists (Cf Rosenwald, 1986; Semin and Rogers, 1973) and are one of the ways that the research process itself tends to

reify culturally sedimented discourses as ´what people think´ or ´what people believe´ when, in fact, they may well have more the qualities of a contract in which the interviewee offers the interviewer what they (the interviewee) assume the researcher expects to hear.

Private accounts, by contrast, Cornwell argued, arose out of personal experiences, and from the feelings and thoughts that accompanied them. They were usually offered in later interviews when Cornwell had become more accepted and trusted, and had managed to reduce the social distance between herself and her interviewees. But they also arose in response to requests for stories about the respondent´s own experiences, or those of their family and friends.

Public accounts tended to be complex (in fact very similar in content to Blaxter´s lay aetiologies), and what Cornwell (personal communication) has called ´static´ : "By static I mean ´one thing acts upon the other´ and that is it. No movement backwards or forwards." In other words, public accounts were linear chains of assumed causality, and somewhat abstracted from the context of biography - rather like Young´s (1982) ´explanatory models´. Cornwell abstracted from her public account data a three-part classification of illness causation :

* internal/external
* avoidable/unavoidable
* blame/no-blame

However, although logically there were more possible

combinations,only the following four were used :

1. internal/avoidable/blame
2. external/avoidable/blame
3. internal/unavoidable/no-blame
4. external/unavoidable/no-blame

Within these different explanations the avoidable/blame categories were far less frequently mentioned than the unavoidable/no-blame, and in the former, blame was usually attributed to others (e.g. other parents for sending their children to school with infections). Personal blame for illness was denied, and in particular, the idea that individuals can alter their life-styles to promote good health and avoid illness. Blame was only accepted to the extent that other people were seen to adopt defeatist attitudes or engage in stupid or careless behaviour. Of Cornwell's twenty four respondents, only two accepted as valid the messages of the "Look after yourself" health education campaign current at the time (i.e. to reduce drinking, stop smoking, eat properly and take exercise).

Cornwell suggested there were many forces militating against such messages, including the moral imperative that morbid thinking about illness is contrary to the cultural ideology of cheerful acceptance; resentment about 'being told what to do' by meddling outsiders; the perceived difficulty of overcoming the influences of individual constitution or cheating fate; conflicting personal experiences (e.g knowing smokers who had lived to a ripe old age) and a perception of the benefits to be gained from 'unhealthy' habits - e.g. the relaxation to be obtained from smoking. Cornwell argued against seeing such accounts as

'fatalistic' because to do so overlooks " the premium ... attach(ed) to taking the initiative in relation to health problems ... making individuals responsible for their diseases ... conflicts with their most fundamental attitudes and moral beliefs." Such beliefs about illness causation were, she argued, embedded within a broader worldview.

She suggested that the more general worldview was primarily a product of the 'hard earned lives' of the working class within "...an unequal, heirarchical, and largely immutable 'natural order of things'...". Workers can respond to such a system in one of two ways. They can construe themselves as passive victims, prey to the whims of "The Bosses". Or they can, with dignity, see themselves as cheerful, right-minded, robust individuals who put a 'good face' on adversity. Within this latter construal, for an individual to accept responsibility for illness would be to to deny the powerful economic and political constraints upon them, and would undermine their perception of themselves as able to 'win out' against the odds stacked against them. Thus denial of culpability is a logical corollary of maintaining a role as 'victor' rather than 'victim'.

The private accounts were far less frequent and scattered through the interviews and other conversations, often emerging when other topics were the ostensive focus for discussion. An example which illustrates the very different flavour of this kind of account was Mary Webb's descriptions of her brother, Arthur's, illnesses and subsequent death. Mary saw the sequence beginning with Arthur catching jaundice in the Second World War,

introducing a specific "weakness" in his liver - a condition subsequently exacerbated by his drinking, a result of his 'sociable nature' and its consequences. This led to cancer, but according to Mary it was the surgical intervention for cancer, not cancer itself, that killed him - by 'opening up' his body, and thus allowing the disease to 'get a grip'. Thus in Mary's private account could be discerned a complex network of reasons, linkages and assumed causes and effects used to make sense of Arthur's biography and ultimate death.

Cornwell described the reasoning of her respondents within private accounts as not so much a matter of attempting to ascribe 'blame' but one of "What if ?". What if Arthur had not been called up ? What if his nature had not been sociable ? Illness was frequently construed as potentially 'avoidable'(i.e. not inevitable) but its complex aetiology, arising - as it was seen to do - from a web of interconnecting elements, meant that it could not be 'blamed' on anybody. Arthur could not be blamed for being called up into the Navy, nor for having a sociable nature. Private accounts were thus not just more personal in content than public accounts, they were also different in form, incorporating elements which were linked together dynamically and interactively.

Cornwell's analysis suggests that the accounts for health and illness may differ in form as well as content; underlying public accounts of an explanatory nature or co-existing with them are more private accounts with rather different characteristics. However, it is not necessary to engage in intimate conversations

to discover aspects of private accounting. For example, recent work by Morgan and Spanish (1985) using highly public group interview techniques, found that in response to requests for 'stories' and 'personal experience' respondents gave individualised, concrete accounts whereas in later phases, in response to requests for 'theories', respondents demonstrated categorical, and later abstract, systems of knowledge.

Morgan and Spanish suggested that people formulate and use 'health belief schemata' to organise knowledge and thus inform beliefs, a schema being based upon three levels of accounting : Abstact understanding, categorical analysis and episodic knowledge. Young (op cit) has offered a similar framework, though the terms he used were different - explanatory models, 'prototypes' and chain complexes, each representing knowledge in a different form, with different characteristics. More recently (1986b) Cornwell herself has argued that the public/private dimension is less important than recognising the variety of alternative sources of knowledge upon which people base their accounting in different settings and circumstances, and the need to explore these more fully :

"Social and personal experience are important sources of ideas and theories about the causes of illness, but there are others. There are 'common stocks' of information and ideas in different social mileux; there are information and ideas specific to particular families and informal social networks, and there are 'external' and 'official' sources of information about health matters - medicine and media. The range of elements - symbols and images, factual knowledge and heresay, folk wisdom and medical certainties - in the common stock of different social mileux remains to be fully documented."

2.3.4 Studies of the emerging 'healthist' image in popular culture

In contrast to Cornwell's East Enders' rejection of 'Health Education' messages, Crawford (1980) studied the way that 'healthism' (particularly in the USA) has become a dominant cultural image :

"A new popular health consciousness pervades our culture. The concern with personal health has become a national preoccupation. Ever increasing personal effort, political attention, and consumer dollars are being expended in the name of health. The past few years have witnessed an exercise and running explosion, the emergence of vocal and often aggressive anti-smoking ethic, the proliferation of popular health magazines, and the appearance with amazing frequency of health themes in newspapers, magazines and advertisements for even the most remotely related products ... On numerous social occasions, and in spite of much professed rejection of concern or derisive amusement, personal health has become a favourite topic of conversation" [p 365]

He has suggested that people in the West have become increasingly health conscious because they are not just bombarded with advice from their doctors about diet, exercise etc. but also by similar messages from health educators, with popular magazines and television shows jumping on the bandwaggon, and the emergence of a whole new industry providing designer jogging suits and Jane Fonda exercise tapes. The hash-brownies of the seventies have been replaced by the wholemeal-added-fibre-low-fat brownies of the eighties. Today, he argues, health is not just being individualised (i.e. promoted as a personal responsibility) but commodified.

Crawford subsequently (1984) conducted an interview study which provided evidence that the 'healthist' account was indeed articulated by (mostly middle-class) North Americans. However, his research also discovered a second, competing account which

represented health is as a ´release´ from pressure - that being healthy is to do with a <u>rejection</u> of self-control, involving a determination <u>not</u> to passively respond to ´kill-joy´ invectives to follow a ´healthy lifestyle´. Within this account, health is to do with personal fulfillment, gained by enjoying ´the good things in life´.

Arguing against theorists like Reiff (1966) and Lasch (1978), he suggested that this ´release´ account was not merely a denial of the dominant cultural theme of ´responsibility´ in the form of individualistic hedonism or an anti-authority ethic, but is a competing cultural theme itself, arising out of social pressures within a consumer society to see oneself as entitled to life´s pleasures - the ´good life´ that is marketed by the tobacco, confectionary and alcohol producers, among others :

"Consumption itself must be understood as a moral demand system, with its own controls, internalizations, and modal personalities. Our notions of self, fulfillment, and even health are substantized through the ´gorgeous variety of satisfactions´ that the new system both offers and demands." [Crawford 1984, p 91]

He thus interpreted contemporary Americans as the objects and subjects of two opposing mandates, one to adopt self-discipline (both in the search for health, and as necessary as labour producers) and the other to indulge in gratification (as consumers). This is epitomised, he suggested, in paradoxical messages (e.g to slim and to eat) which create their own disorders (e.g. bulima); in the competing messages of tobacco as a form of unwinding release from the tensions of life, and a damage to health; the elixir of pleasure and pain offered by

health clubs : 'We'll work you out and then pamper you' as advertised by a Chicago health studio.

Crawford, like Herzlich and Williams, noted that although some people tended to focus on one or other of the cultural mandates, most people he interviewed referred to both. Within 'middle America's' highly commodified culture, he argues that health has taken on a variety of representations constructed by the mass media which equally stress personal worth and fulfillment, but offer contrasting routes by which it is to be gained. Within such an analysis, people do not so much have access to a single account of health as several accounts; their accounting for health and illness is a process of shifting between these alternatives.

2.3.5   Q Studies of accounts for health and illness

In the 1960s Stephenson, the originator of Q methodology, carried out a series of studies to investigate alternative 'images' of health that were current in the culture of the North American Midwest at the time   (1962, 1963). The first of these explored accounts that were primarily concerned with the organisation and funding of the medical systems. Using a combination of intensive open-ended interviews and Q methodology (which will be described in full in the next Chapter) he identified   three alternative accounts.

The first was an account which was predominantly expressed by poorer people. It construed existing medical care and treatment

at the time as effective and benign, but the practice of medicine as based too much upon profit, as too specialised and as over-professionalised. It favoured a shift to an insuranced based system for paying for medical treatment, which was seen as able to maintain people's independence, choice and self-sufficiency while avoiding the crippling costs of the current fee-for-service system. The second account, expressed more by the well-off (including many people who were themselves medical professionals), was satisfied both with the current practice of medicine, and with its ability to cure illness and maintain health. This account endorsed the existing fee-for-service means of payment, wary of any move to an insurance based scheme which would detract from the independence of medical practitioners. The third account, expressed by a liberal and wealthy Democrat, focussed on wellbeing rather than mere health, and while broadly favourable towards current medical care, saw health as just one among many important human values. This account favoured a socialised system of funding, that would determine provision of health care in response to need (e.g. in old age) rather than ability to pay.

These accounts were identified by factor analysis of a Q sort (based upon the writings of a contemporary opinion leader) and elaborated by data from detailed interviews. For the second study (Stephenson 1963) a new Q sample of 56 statements was constructed containing a few of the items from the previous sample, but mostly new ones derived from statements people had made in the interviews. For example :

10. Welfare takes away individual responsibility - you have somebody else to look after you.

14. I think everybody should have medical care who really needs it, and should pay for it in proportion to his(sic) income.

41. The statement of a goal in life is paramount for people looking for direction for themselves - we all need a sense of 'living'.

56. The unknown should be left alone; much of what the scientists are discovering can only lead to harm.

This study is of particular interest because the accounts were gained from people who were physically challenged or chronically ill, and their carers. The subject sample consisted of twenty four chronically ill or 'disabled' persons, and eleven of the people who cared for them. The disabled/ill people ranged from a ninety four year old widow who, Stephenson described, was "...suffering from nothing more than hurt pride and old age" (p58) to a twenty three year old college sophomore, paralysed from polio in both arms and legs, who manipulated pages of books (and, when he came to do it, the Q sort) with a stick held in his mouth. The group included six people with polio, two people confined to wheelchairs following accidents, three people suffering from coronary disease, a quadruple paraplegic, somebody with congenital syphilis, several with cancer and seven older people (aged seventy to ninety four) who were experiencing multiple physical symptoms of ageing.

All participants in the study were intensively interviewed first, using pictures to get conversation going, then more specific questioning about health and finally a focus on chronic illness. After the interview the respondents carried out a Q sort using the new sample that had been derived from the interview protocols

of the respondents in the previous study.

Three factors were identified. The first (Factor I) Stephenson labelled the independent viewpoint; the second, Factor II) the interdependent and the third (Factor III), the dependent. These can be briefly summarised as follows :

Factor I : Independent

The main theme of this account was very strong approval of medical professionals, seeing doctors and nurses as high-level professionals who know their job, valuing personal qualities as well as technical skill, and seeing existing medical treatment as highly effective against both physical and mental illness and in preventing illness and promoting healthy old age. The account was highly antagonistic to any form of socialised medicine, denying any need to offer free services to those who could not afford them or to put more public money into medical aid. The interviews with the people whose Q sorts loaded strongly onto this factor all emphasised a strong commitment to independence; focussing on the need to struggle to achieve, to manage on one's own and pay one's own way, expressed with a certain harshness and emphatic moral undertones that it is wrong to be dependent, and sinful to be weak - and also morally wrong to disrespect rightful authorities such as doctors, or find any fault with so dedicated and selfless a profession as medicine. Most of the people who expressed this account, despite their disabilities, were managing to hold down jobs. Those that were not lived in families sufficiently well off to care for them without need for welfare or external support.

Factor II : Interdependent

This account saw people as having the right to medical care as a product of need, not ability to pay, and stressed the humanitarian obligation of society to help the chronically ill; also it endorsed broader social values (e.g. provision of foreign aid). The interviews of those who expressed this account clearly impressed Stephenson - he wrote of "... the liveliness of mind, alertness, charm and wonderful adjustment" of all the individuals whose Q sorts identified this factor and that "...they accept no easy solutions, no hard-and-fast stereotypes ... they are flexible and autonomous... they are realistic and essentially libertarian ... they idealise no one, and yet can be grateful." Some of these people commented that they had accepted financial support (e.g. from the Polio Foundation) and it had saved them from financial ruin. They saw society as needing to operate in a way in which people could retain their dignity and self-esteem, and yet be interdependent - giving and accepting help from each other.

Factor III : Dependent

The main theme running through this account was that those who are chronically sick or disabled need the support of others, and medical care should be available to all who need it, irrespective of ability to pay for it (and indeed, that this should have priority, say, over foreign aid, which would be better spent on federal medical programs for poor Americans). Perhaps not surprisingly the people whose Q sorts identified this factor were the poorest in the sample, usually lacking in education and most of them living in the poorest slums in the area. Their interviews described an overall picture of gross deprivation - of chronic illness and disability meaning that they could not work, of the welfare payments they received being inadequate for well people, let alone to provide for the needs of the sick, and of their disabilities being exacerbated by the physical constraints of their poor living conditions, inadequate diets, and inability to afford the medical treatment they needed - and the psychological impact of ´existing´ rather than living.

Stephenson noted that there were no obvious demographic differences between those who expressed either the accounts linked with Factor I or Factor II, and gave the impression that their very different viewpoints and responses to their own disability were products of person-constructs-reality aspects of their worldviews. Both sets of people were relatively well off and able to cope with their disabilities, but had constructed different images of themselves and of how society should operate. Factor I account gave the impression of Herzlich´s ´illness as occupation´, whereas the Factor II account suggested an image of ´illness as release´. However, the people who expressed Factor I were also those for whom personal independence was as a deeply held value, whereas those who expressed Factor II placed more value on equality. Rokeach (1968) has suggested that of all his ´terminal values´, ´freedom´ and ´equality´ are the most distinctively political. For example, participants in and sympathisers with civil rights demonstrations are much more

likely to stress 'equality' as their most important value, whereas those who are positively unsympathetic are more likely to place 'freedom' as most important.

With the Factor III account, the impression given was of an account which was derived more from reality-constructs-person forces. The people who expressed this account were so structurally constrained by their material disadvantages, socially low status and lack of power in addition to their physical handicaps or chronic illnesses, that they seem to have had little opportunity to construe their illness as either an 'occupation' or as a 'release'; it was just another factor in their overall state of dependency and powerlessness.

The results of this study suggest that different accounts are likely to have different aetiologies. Rather than seeking any general model which attempts to show how various forces operate in the construction process, it should be recognised that what might be important for one account may be unimportant for another. For some social or structural or cultural forces may dominate; for others personal values may be the major determinant; for yet others, different factors entirely (e.g. membership of particular social groups) may be the key to understanding. The balance between person-constructs-reality and reality-constructs-person is likely to differ, perhaps as much as the accounts themselves differ from one another.

More recently Levin and Coreil (1986) have used Q analysis to identify alternative accounts within what they termed 'new age

healing´ in the culture of North America. These accounts were not derived via Q methodological study of people´s operant subjectivity, but from Q analysis of the authors´ interpretations of variables relating to aetiology, origins of founder, orientation of teachings, source of healing, means of treatment and styles of treatment, based upon written descriptions of 81 examples of ´new age healing´. Five factors were identified, with 49 of the examples loading >0.6 on one or other. From further interpretation of these data, they arrived at a typology of three main alternative accounts. These are illustrated in Figure 2.2.

Within the first account, the major emphasis was upon ways of attaining somatic or psychosomatic health or wellbeing, usually by new means, not by rediscovered ancient teachings. It is an account which is secular, Western and not supernaturally orientated, concerned with mental or physical self-betterment. Examples were Biogenics, Eidetics and a variety of ideologies upon which had been built theraputic communities such as the ´Cornucopia Living Love Center´, Kerista Village and ´Wellness Associates´. While the groups concerned varied widely in their conceptualisations of health and healing, all shared a wholistic approach in which body, mind and soul are seen as equally important, and stressed the role of individual action and ´doing´.

The second account emphasised esoteric teachings as the route to health, drawing upon some ancient corpus of ´truth´. The groups adopting this account profess belief in supernatural healing and sources of illness, and many define themselves as explicit

Figure 2.2   Levin and Coreil's typology of new age healing
(From Levin and Coreil, 1986

Mode of healing	Primary emphasis	Common characteristics
FIRST ACCOUNT		
Mental or physical self-betterment	Body	Secular, Western, not supernaturally oriented
SECOND ACCOUNT		
Esoteric teachings	Mind	Mostly Western, supernaturally oriented, not ritualistic
THIRD ACCOUNT		
Contemplative practice	Soul	Religious, Eastern, mostly ritualistic, mostly super-naturally oriented

churches or religious sects, including the Theosophical Society in America, the Universal Church of Scientific Truth, and the Ojai Foundation. These groups perceive the oneness of all humans as critical, placing strong emphasis upon learning from ´teachings´ and intellectual engagement as means of enlightenment, and thus health, stressing the role of ´knowledge´.

The third account was characterised by those predominantly Eastern imported ideas that encourage spiritual practice as the basic means of attaining good health, particularly forms of contemplation and meditation. Examples include Swami Rama´s Himalayan International Institute of Yoga Science and Philosophy, Chowado Henjo Kyo, the Inner Light Foundation and the Inter Cosmic Spiritual Association. While the other two accounts often included meditation or contemplation within their practices and treatments, within this account such practices are central, stressing the role of ´inner experiencing´.

These three accounts remind us that new and radical ideologies (e.g. existentialist and humanistic accounts, as described in Chapter 1) and the worldviews of other cultures, particularly from the East, are having an increasing impact upon popular accounting, observable in the emerging public and ´professional´ acceptability of and more frequent resource to ´alternative´ medicine (cf Aakster, 1986; Keulartz, Kwa and Radder, 1985). In Britain ´alternative medicine´ has gained the added endorsement of the royalty, rendering homeopathy in particular less ´cranky´ in popular discourse than in, say, North

America. The 'new age healing' accounts also suggest that in contemporary Western culture as well as in the East, religion may not only provide a background framework of values (as Williams has argued for the Calvanistic tradition in Scotland) but in some accounts be much more directly linked into explanations for health and illness (e.g. as in Christian Science and Spiritualism as well as religions such as Buddhism and Hinduism).

2.3.6 Overall themes in studies of account sympratricity

These studies portray accounting for illness as much more complex than either the 'folk' or 'social determinants' approaches, demonstrating that people seldom, if ever, express a single account, but rather draw upon many. This is true in at least three senses. First, as particularly illustrated by the work of Herzlich and Williams, people frequently account for health in different ways from those they adopt to account for illness, and indeed, often there are further sub-divisions, including alternative accounting for processes like recovery from illness and ageing, and for capacities like 'resistance'. Second, as evident from the work of Cornwell, Morgan and Spanish, and Young, the kinds of 'knowledge' from which accounts are constructed vary (see also Blumhagen,1980; Good, 1981 and Kleinman 1978). In some cases it is abstract and semantic, in the form of an explanatory model; in others more personal or episodic. Finally, and most crucially for the concerns of this thesis, accounts are sympatric, co-existing and competing both within cultural discourse as alternative 'ways of making sense of the world' that

filter and construct individual understanding, and internalised within individual thinking itself, as contradictory representations available to be drawn upon at different times and in different circumstances. This sympatricity was expressly referred to by Herzlich, Crawford and Williams (and in earlier Sections by Pill and Stott) and was indeed the basis for the Q analyses carried out by Stephenson and by Levin and Coreil.

2.4 OVERALL CONCLUSIONS

In this Chapter I have briefly reviewed the contemporary literature which describes empirical studies of ´lay´ accounting for health and illness in British and North American culture. A number of themes emerge, but two are particularly strong and consistent. The first of these is that although biomedicine is the orthodox ´professional´ account in these cultures, ´lay´ accounting is not the mere watered-down version of biomedicine that many physicians assume (cf, for example, Stoekle and Barsky, 1980). Whereas the scientific basis of biomedicine expressly decouples its accounting for health and illness from other epistemological realms, ´lay´ accounting for health and illness is deeply and intimately bound within a broader framework of accounting in which ´folk wisdom´, the ideologies and values of particular cultures and social groups, personal experiences, religion and ethics all play a part.

Ordinary people do not ´make sense´ of such questions as "Why me ?" and "Why now ?" by reference to some specific,

self-contained account for illness, but within a much broader set of 'plausibility structures' (cf Berger and Luckmann 1966). They interpret their own role, particularly in terms of links between their actions and their state of health, not within some narrow aetiological theory, but as a product of their construals of the social, circumstantial and environmental forces upon them, and as a reflection of the accounts they have constructed to describe and make sense of who they are, and where they are 'in the order of things'. Consequently, the perceived extent of an individual's personal control over, and responsibility for health and illness cannot be decided by reference to an explanatory model restricted to health and illness alone.

It is this which provides the second major theme of studies of 'lay' accounting, the concern about perceived control and culpability. The accounts divided between those which asserted that health is very much a matter of individual striving and personal control (notably the 'healthist' image described by Crawford, and the 'new age healing' systems described by Levin and Coreil) and those that denied personal responsibility, notably the accounts described by Blaxter and Patterson, Pill and Stott, Herzlich and Cornwell. These latter accounts did not refute that certain actions ran the risk of causing or increasing the likelihood of illness, or that certain 'ways of life' were bad for health, but these were not seen as implying that individuals have much control over whether they stay healthy or become ill.

These two themes provided the impetus for the empirical work

conducted for this thesis. The first two studies, described in Chapters 4 and 5, sought to find out more about accounting for health and illness within a broader epistemological context - to see how accounts may link to such other accounting domains as politics and ideology, experiences of chronic illness and 'disability' and terminal values such as equality and individual freedom. The third study, described in Chapter 6, sought to identify and elucidate different accounts in terms of perceived control, culpability and influence, and included opportunities to explore perceptions of the role of God and supernatural power as well as looking at more traditional concerns within the external/internal dimension, including self, chance, powerful others and social and environmental factors.

As has already been described in Chapter 1, Q methodology was included as one of the techniques by which accounts were to be identified and described, and account sympatricity examined. At the time at which these studies were planned and carried out I was unaware of either Stephenson's or Levin and Coreil's studies (neither had been published) and chose Q method independently, as a promising route by which a wide variety of accounts could be observed. The next Chapter provides a description of Q method and its theory base, and explains why I chose it as a technique capable of offering original and interesting data within this area.

CHAPTER 3 :   Q METHODOLOGY AND ITS THEORY BASE

3.0 INTRODUCTION

Excellent reviews of Q method and theory exist elsewhere (notably Brown, 1980; Kitzinger, 1984) and it is not intended to replicate them unnecessarily. However, since Q theory and methodology are central to the thesis, this Chapter is included to place both its theorisation and empirical work in context. The Chapter is divided into four main sections, the first describing Q method, showing how it differs from other psychological methods, and describing how Q theory fits into the broader framework of interpretational social psychology; the second tracing the history of Q method and Q theory; and the third dealing with criticisms, distinguishing between those that are inappropriate (because they have arisen from misunderstandings of Q) and those that do need to be taken into account and dealt with by researchers who adopt Q within their methodological repertoire. Finally, in the light of these three, the fourth section explains why Q method was chosen to study accounts for health and illness from a social epistemological perspective.

3.1 Q METHOD, Q DATA AND Q THEORY

3.1.1 Q method

Q method is based upon the activity of Q-sorting, which consists of providing people with a number (somewhere between 30-100) of items which they are asked to evaluate. Posters (Wattier, 1986), paintings (Sherlock, 1980), photographs (Goldman, 1984; Lesser and Hughes, 1986; Savage, 1985) and cartoons have all been used as items, but statements are more

commonly used, and all the Q studies carried out in this thesis used statements. An example set of items employed is provided in Appendix 3. As can be seen, all of the statements are 'matters of opinion', not 'matters of fact', which the Q sorter evaluates self-referently - e.g. from 'most disagree with' to 'most agree with'.

The sorter is provided with each of the statements on separate cards or pieces of paper (a Q-pack, or Q-deck) and instructed to first sort the statements into three piles : one for 'disagrees'; one for 'agrees'; and a middle pile for 'uncertains', and statements about which the sorter feels ambivalent, or neutral. Then the sorter refers to a response matrix provided, as shown in Figure 3.1. In this case there would be 54 statements, and the sorter's task would be to allocate the statements according to the grid (See Appendix 3 for an example of instructions given to sorters). Markers (i.e. cards marked with -5 to +5 and the number of statements to be allocated) are usually provided to facilitate sorting and act as reminders. Figures 3.2 - 3.6 illustrate a Q-sort being carried out. The administration of Q sorts is described more fully in Brown (op cit, pp 194-197).

3.1.2   Q data

When the statements have been sorted in this way, their numbers are transferred to the response matrix (Figure 3.1). For analysis they are converted to scores, with, for example, -5 in this grid being coded as 1, -4 as 2, up to +5 as 11. These data are subjected to a by-person factor analysis i.e. where the full data

Figure 3.1 Example Response Matrix as used in a Q study

STRONGLY   STRONGLY
DISAGREE   AGREE

-5   -4   -3   -2   -1   0   +1   +2   +3   +4   +5

Figure 3.2 Participant cutting up Q items from sheets supplied
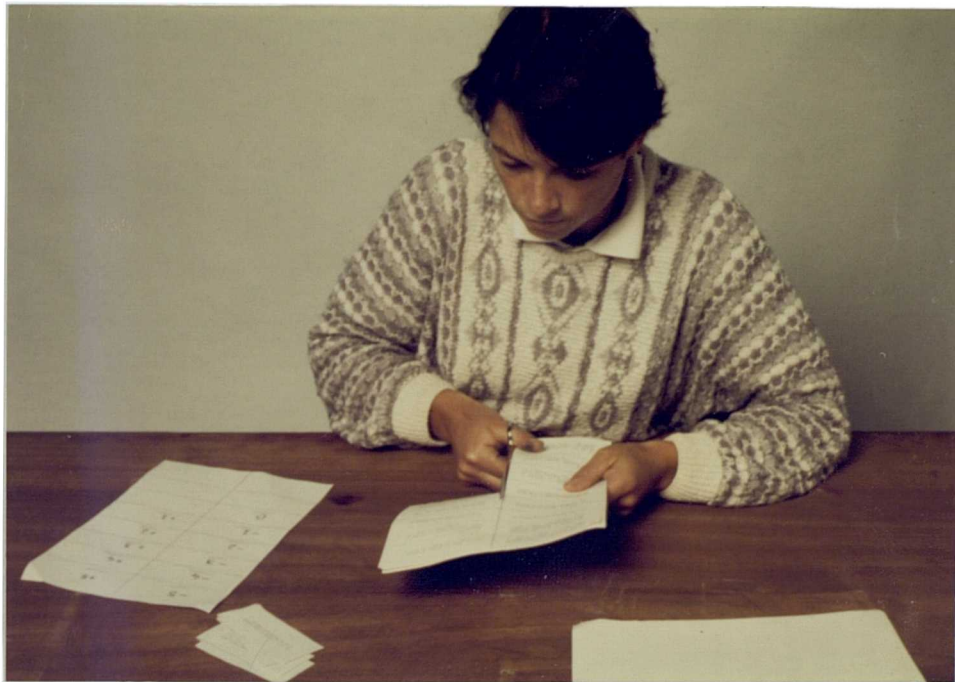
Figure 3.3 Participant starts by arranging markers, and sorting the items into three piles

Figure 3.4   Participant starts sorting at extremes

Figure 3.5   Participant completing the sort

Figure 3.6 Participant writing responses onto response Matrix

set from each sort is compared with the data sets from all other sorts. The statistical manipulations are identical to conventional orthogonal factor analysis, but the data is correlated. person-by-person rather than the item-by-item correlation of traditional factor analysis. Full details are provided in Brown (op cit pp 208-224). This by-person factor analysis thus identifies factors which indicate alternative, statistically different and independent sorting configurations. Brown describes the process thus :

"... factor analysis is a method for determining how persons have classified themselves ... If two persons are like-minded on a topic, their Q sorts will be similar and they will both end up on the same factor." (Brown, op cit)

A number of methods of rotation can be used to obtain the most useful or pertinent factor discrimination (Brown, op cit, pp 224-239 provides full details). In this thesis varimax rotation was used. The factor analysis provides a factor loading for each factor attributable to each Q sort. Factor interpretation is carried out by identifying as exemplificatory Q sorts for each factor those that load strongly onto just that one factor and have non-substantive loadings on the others. In each study criteria are selected (e.g. all loadings >0.60, where no other loading is >0.35) to identify examplars. A procedure of weighting and averaging the individual factor scores is then used to integrate the individual exemplar Q sorts, providing an idealised Q sort pattern that provides a 'best approximation' of that factor's response pattern. (This procedure is described in Brown, op cit, pp 239-243). The account described by the factor can then be interpreted by reference to the statement placements, examining the configuration of statements in relation to each

other (once more described by Brown, op cit, pp 247-258).

Q data thus differ specifically from the measurements usually gained from, say, Likert scales. Q data, obtained by asking people to consider items in relation to each other, and interpreted via an analysis of their configurational properties, incorporate evaluations of the contextual and relational properties of statements as they 'make sense', subjectively, to the individuals who sort them. Q data therefore contain two sources of information. The metrics attached to each item (the factor scores) give clues about the evaluative dimension (e.g. more or less 'agreed with'). But in addition, the data reflect configurations of item placements which give clues about sorters' interpretation of the meaning and significance of items in respect to each other. The by-person factor analysis identifies alternative patterns of response, thus treating each person's data set wholistically. As used in this thesis, Q data provide the opportunity to identify alternative, independent, response patterns which, when interpreted by referring back to the item placements, enable the identification and description of alternative accounts.

3.1.3 Q theory

The theory base of Q methodology relates to the purposes for which Q method and data are used - to gain insight into alternative construals of an issue, topic or image. Q sorting has been used in this thesis to gain access to alternative accounts, both to identify what they are and distinguish between

them, and to provide clearly articulated descriptions of them. It is thus specifically antagonistic to hypothetico-deductive theory, proposing that knowledge about another's subjectivity must be gained via their expression of that subjectivity, made operant within their Q sorting, and cannot be defined, tested or classified according to a researcher's prior objective definitions, prior hypotheses or prior assumptions. For any topic there is assumed to be a concourse (See Stephenson, 1986d and 1986e) of salient propositions available both within individuals' subjectivity and within cultural discourse e.g. within 'attitude' or 'belief' systems and within interaction and communication as expressed within everyday conversations, via mass media etc.. This concourse is the universe from which the Q statements for a Q sort are sampled; thus the statements are the sample of the study, needing to be comprehensive and representative of the concourse.

Propositions that make up accounts are assumed to be linked into articulated discourses - they are not experienced or thought about in isolation, but are formed into arguments, explanations or theories by way of what is often referred to as 'insight', intuition and 'making sense of the world'. Crucially, people - as individuals and as members of social and cultural groups - are assumed to differ in the accounts they utilise and construct within a dialectical framework. In this Q theory is neither nomothetic nor idiographic; it neither assumes that all accounts are essentially similar for all people, nor that each individual adopts an unique set of accounts.

Thus Q theory, as adopted within this thesis, has a lot of similarities with Kelly's constructive alternativism, with Moscovici's social representation theory, and with Berger and Luckmann's social construction of reality formulation, in that it stresses variability, constructivism and an interface between the individual's role as a <u>constructor</u> of discourses, and their role as a <u>recipient</u> of discourses constructed for them by social and cultural forces. People are assumed to have access to a variety of alternative accounts, which are sympatric both within individual accounting (e.g. to serve different discursive functions, as suggested by Potter and Wetherell, 1987) and within collective discourse (e.g. to serve different social functions, as posited by Moscovici, 1961,· 1981,1984).

Q theory thus provides the rationale for Q method, and an explanation of what it is intended to achieve. The end result of a Q study is a set of descriptions of different accounts, where the interpretational links between elements within each account are derived from the different ways people actually linked statements together in their sorting. It needs to be stressed that these descriptions are <u>not</u> intended to be classifications of people, but clarifications of <u>the accounts themselves</u>. Q theory and its methodology, as used in this thesis, are means by which the social epistemology of accounts within a dialectical framework can be abducted from the operant subjectivity of the people taking part in the study.

3.1.4 The difference between Q and R factor analysis

A compelling illustration of the fundamental difference between

Q and more conventional factor analytic approaches has been provided by Brown (1972), in a study designed specifically to make explicit the difference between : R (i.e. conventional) and Q data; R (traditional) and Q factor analysis; and between the study of objectivity and the study of subjectivity. Brown used data about the human body to demonstrate three approaches. First he carried out a standard R analysis of R data. He took objective measurements of 25 parts of the body from 20 persons. These were subjected to conventional (i.e. item by item) factor analysis, and eight factors emerged, clustering together, for instance (Factor 1) measurements of height, arms and legs. This showed quite clearly what the usual R analysis approach achieves. It compounds together in an homogenising way all the data from a sample of people, and then dismembers it into parts - identifying 'traits' which indicated here that the human body is made up of limbs, of ears, the trunk and so on. The outcome of the analysis is illustrated in Figure 3.7.

Brown next inverted the analysis of the R data. The same measurements as before were put into an inverted matrix and subjected to factor analysis by person. A single factor emerged, which accounted for 99.42% of the variance, with all the persons loading 0.99 or more onto it. This had the effect of treating the data wholistically, indicating that the bodies of the twenty people all conformed to the same overall plan. The outcome of this analysis is illustrated in Figure 3.8, which was drawn from normalised factor scores.

What these different factor analyses showed was that the

Figure 3.7 Artists impressions of the factors identified by R (traditional) factor analysis of R (body measurements) data

Factor 1
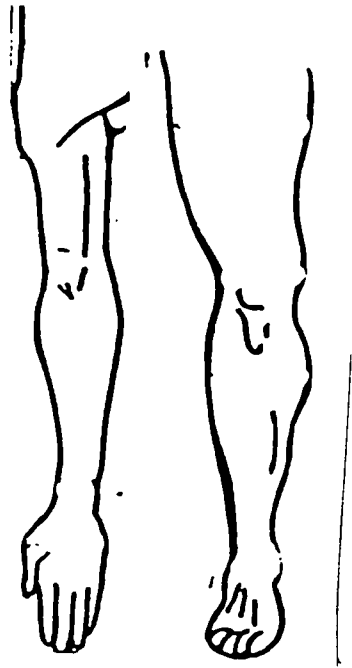
Factor 2
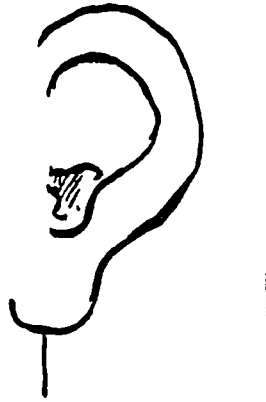
Factor 4
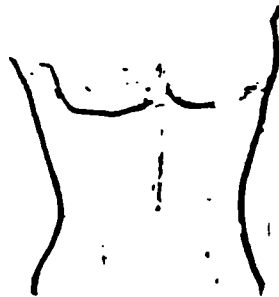
N.B. Factor 3 proved non-interpretable

Figure 3.8   Artists   impressions   of the factor identified
by Q (by-person) factor analysis of R (body measurements)
data
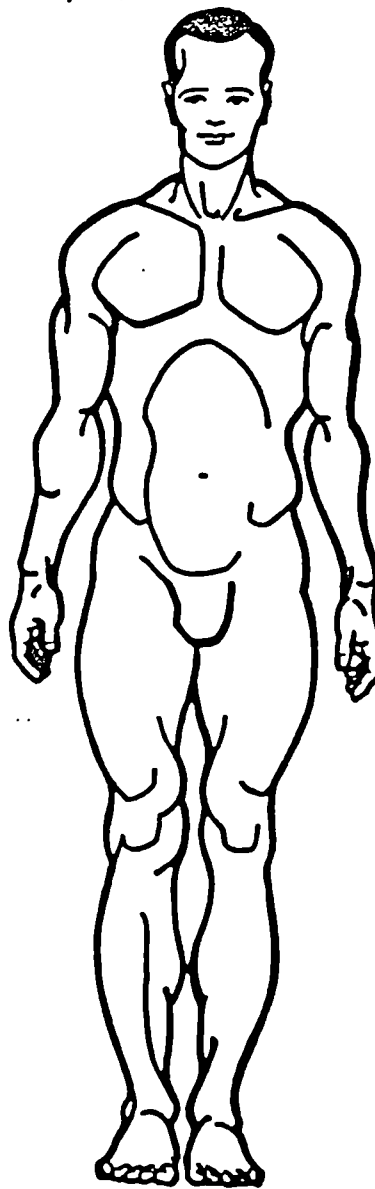
results of conventional and inverted analysis of the same data are <u>interpretationally</u> quite distinct; conventional factor analysis dismembers and dissects, (in this case the body into separate body parts) whereas the by-person factor analysis brings out the wholistic configuration - that while people may differ in specifics, the human body basically conforms to a tight overall plan. Brown (1980) makes this clear by suggesting that one imagine never having seen a human body before in its totality, only pictures of its parts (as in Figure 3.7). It would be impossible to reconstruct an accurate body picture. Because of course we do know what bodies look like, we could reconstitute one from Figure 3.7. But it is our <u>prior knowledge</u> that provides the capability to do so, not the data itself.

However the crucial difference between R and Q analysis becomes much more explicit when Brown introduced the proper subject matter of Q analysis - subjectivity. The same twenty people were given a list of body parts corresponding closely to the measurements taken, and each of them were asked to rank them from 'most significant to me' to 'most insignificant to me' (i.e. seeking measures of self-referential psychological significance). These ranked data were factor analysed by person (i.e. Q factor analysis), and four factors were identified. That is, within the twenty people ranking the body parts for importance, four different patterns of response were to be found, identifying four alternative perceptions of 'what matters'. Factor 1, which was described only by women, emphasised the importance of the eyes, head, mouth, neck and chest. Factor 4, which was described only by men who were tall and slim, emphasised the hand. The

Figure 3.9   Artists impression of one of the factors
identified by Q (by-person) factor analysis of Q (subjective
estimates of importance of body parts) data
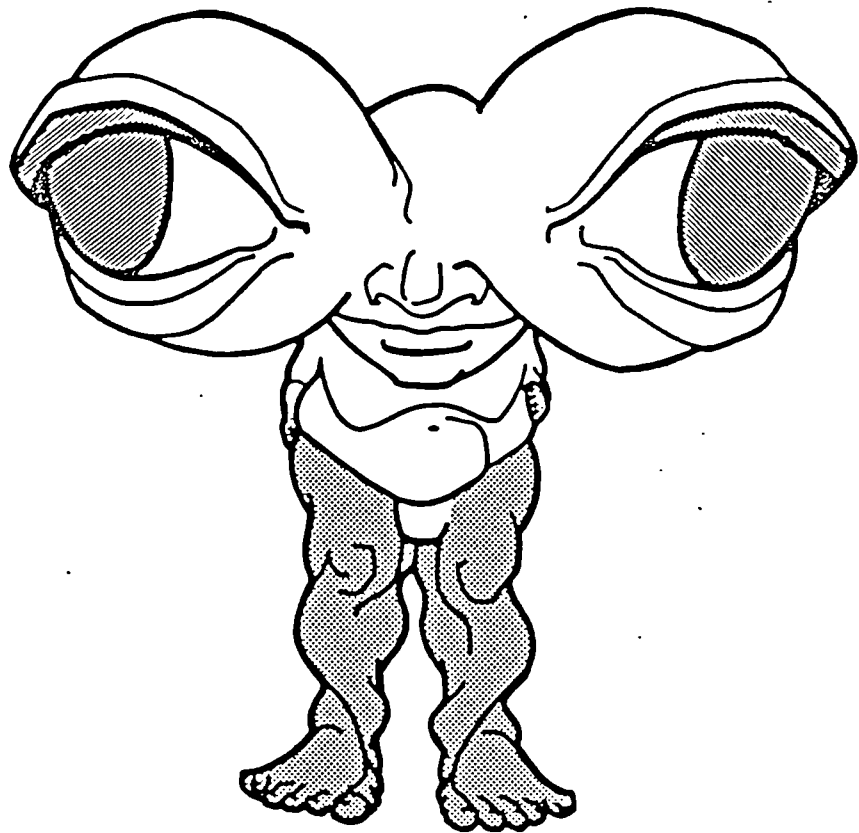
The artist was told which were the largest and smallest
factor scores, and then all the others estimates were
expressed as proportions   of   these. The illustration was
drawn from these proportions, the most and least important
parts drawn larger than those sorted in the middle of the
grid.   Those sorted into the 'least important' categories
are drawn shaded.   Thus the largest, unshaded parts of the
body were those to which this Factor accorded most
importance, and the largest, shaded parts of the body were
those to which least importance had been accorded.

Factor scores for Factor 1 were treated as before and an illustration drawn, reconstructing an image of 'psychologically significance' from the values, as shown in Figure 3.9.

The difference between this and Figure 3.8 is a striking portrayal of the difference between studying objectivity and subjectivity. The Q analysis of psychological significance yielded an image of the body which looks very strange indeed, but conveys a sense of subjective 'reality' which tells us a lot about how these women see themselves in relation to their bodies. It is a pity that Brown did not have the other Factors drawn up, as this would undoubtedly have shown - in a way any analysis of measurements never could - the huge divergence between the four different images. Q analysis of Q data is wholistic, in that it retains people's responses as overall, related patterns. But it is not homogenising - where true alternatives exist, they are made explicit.

3.1.5 Q as an abductive methodology

Q methodology and theory are not, however, just different means of handling data : "...methodologies are at issue, and not merely a few statistical theorems" (Stephenson, 1953). Q theory occupies a place within the emergent anti-positivism of much contemporary social theory to be found, for instance, in sociology (e.g. Giddens 1977), political science (e.g. Miller, 1972) and social psychology (See, for example, Gauld and Shotter, 1977; Gergen, 1982; Harré and Secord, 1972; Rosenwald, 1986 and Semin and Manstead, 1983). However, Q theory, developed by Stephenson in the 1930s, 40s and 50s, evolved in parallel to

and independently from the better-known interpretational

approaches based, for example, on hermeneutics and social

constructionism. Stephenson's formulations in the 1950s were very

much ahead of his time, as exemplified by these statements in

his Study of Behaviour (1953) :

"The situation in psychology ... calls for an attitude of
curiosity as well as hypothetico-deductive logic. A somewhat
detached, but inquiring attitude is called for, in which one
seeks to learn more about the intrinsic empirical possibilities
rather than the purely logical or deductive, or carefully
reasoned ones. We should be making discoveries rather than
testing our reasoning." [p 151, emphasis in the original].

"An experiment, therefore, is much more than the fulfillment of
predictions, or of the empirical testing of previously asserted
propositions. It is an opportunity for making discoveries. They
may be incidental or accidental, trivial or important. Flemming
discovered penicillin rather accidentally, but the result was
profound. In psychological research there should be room for
matters of this kind, as an intrinsic feature of the
methodology."[p 329, emphasis in the original]

Thus Q method was devised to utilise the potentialities of factor

analysis to investigate such things as accounts in a manner which

is genuinely exploratory. Brown (op cit) describes this well :

"... Q samples provide the launch pad for an investigation, an
entré into a phenomenon, the scientists best initial guess as to
how a particular ... social consciousness, or whatever operates.
The data gathered with the Q sample may lead in quite different
directions, however, since theoretical rotation may produce a
factor structure about which the original statement design has
little to say. There is never a guarantee, in other words, that
splashdown will occur in the same area as the point of
departure." [p 39].

Q method is primarily, therefore concerned with what Peirce

(1934) termed 'abduction', described by Stephenson (1961) as "...

inference, like induction, but concerned with explanation,

whereas induction (is) descriptive." (See also the writings of

the philosopher Rozeboom, 1961, 1972). To abduct an hypothesis is

to build it up _from_ data - "The concern primarily is with discovery ... The logic is that if certain facts occur, they will have such-and-such explanation." (Stephenson, 1953). The task of the Q researcher is to provide, via a Q sample, (derived from an appropriate concourse) opportunities for others, in effect, to ´create facts´ - that is, to make operant by their Q-sorting limited numbers of configurations of response from the enormously large number of configurations possible. These data are the basis upon which the researcher must abduce hypotheses; provide descriptions that are consistent with the operantly expressed configurations.

Q method, in common with other interpretational approaches, thus differs from those methods based upon hypothetico-deductivism in two fundamental ways . It is anti-positivistic in that it stresses the importance of ´meaning´ as constructed; and it is abductive, seeking to discover rather than merely test hypotheses.

3.1.6 Differences from ethnography

Q is not, of course, the only anti-positivistic methodology used by psychologists, ethnographic methods are similarly abductive. However, there are two fundamental differences between Q and ethnography. Herzlich´s (1973) study of social representations of health and illness, (described in the last Chapter, Section 2.3.1), provides a good illustration of the distinctions. For instance, Herzlich described accounting for illness thus :

"Subjects almost unanimously describe, often vehemently, how city life produces a world of fatigue and nervous tension. Way of life

and fatigue and disturbance of nervous equillibrium are, in the last resort, synonymous for the individual. ´Paris is fatigue and nervous tension, with this exhausting and rather unhealthy life.´ ´The constant commotion isn´t made to make people ordinary, they are difficult, nervous, tired; that´s the truth about modern life.´... ´Modern life induces a kind of fatigue which makes us ill ... everything to do with modern work and its conditions makes us more vulnerable to disease.´." [pp 20-21]

It is her "almost unanimously" that indicates the first difference between ethnographic analysis and that of Q method. Potter and Litton (1985), and Potter and Wetherall (op cit) among others criticise such reporting as glossing over the many, and potentially highly salient, inconsistencies that arise in interviews :

"The broad categories often used in content analysis ... can easily obscure theoretically interesting differences in the discourse ... analysts working with open-ended discourse find it relatively easy to construct one coherent story of events, processes or beliefs out of the material at their disposal. Versions that are in line with their preferred story can be reified and others, which are in conflict with it, can be ironized." (Potter and Wetherell, 1987 : 41-42) [´Ironization´ is the term they use to indicate the opposite of reification]).

This homogenising of accounts, stressing similarity, is a feature of ethnographic studies which adopt a nomothetic approach. While they provide rich and compelling descriptions of the way people ´in general´ are interpreted as understanding and making sense of a particular topic, they inevitably iron out discrepancies and portray popular discourse as highly consensual. In contrast, the purpose of a Q study is to seek for diversity. Herzlich and indeed several of the other researchers described in the previous Chapter (notably Pill and Stott, Crawford and Williams) both derived alternative accounts and commented upon people´s facility to draw upon more than one "without cognitive strain" (as Pill and Stott, 1985, put it). But whereas their

extraction of alternative accounts was a <u>post hoc</u> analytic response required to ´make sense´ of data that could not be moulded into a single account, Q method assumes alternativism <u>a priori</u>.

The contrast is that in an ethnographic study, the abduction of alternative accounts is in part a product of the conversational skills of the subjects. There will always be a tendency for those participants who are most vocal and most articulate to dominate the process of interpretation ‐ for their accounts to stand out and demand attention, gaining more credence than the less vocal and articulate. In a Q study it is the factor rotation which performs the process of abduction, and in this way the alternative accounts abducted are a product of <u>all</u> the response patterns of <u>all</u> the participants in the study.

The second difference between Q and ethnographic method is that in ethnography the abduction of accounts depends upon the skill of the researcher in inferring them from the densely interwoven discourse of the subjects´ interviews. Q researchers argue that this, no less than hypothetico‐deductive methodology, is a process of studying the researchers´, not the subjects´ hypotheses. Ethnographers are generally highly skilled interpreters, and devote enormous effort to immersing themselves in their data in their quest for understanding. But ultimately it is their thinking which forms the basis for whatever classification they arrive at. In Q methodology it is the response configurations provided by subjects´ making operant their subjectivity upon which account classification is built.

Interpretational skills are still required in the task of reconstituting an account from each arrangement of item placements. And in many Q studies additional open-ended data is used (as Stephenson, 1962, 1963 did with his study of ´public health images´) to augment the interpretation of the Q data. But these are post hoc interpretational processes of refinement and elucidation. The abduction of the accounts themselves is based upon - and only upon - subjects´ operancy, and performed by factor rotation not by interpretation.

3.1.7 Idiographic uses of Q method

Q method as used in this thesis differs from idiographic methods (e.g. the use of repertory grids to identify personal constructs) in that it seeks to identify alternative accounts as shared within collectivities; the Q Factors discriminate the different accounts about a particular topic as they are expressed within the Q sorts of those people participating in the study. However, just as repertory grids can be used nomothetically, Q method can be used idiographically as a case study of an individual. Instead of the Q sorts being administered to many people, and factoring used to identify alternative accounts within collective discourse, Q sorting is carried out by an individual a number of times according to different conditions of instruction. In this case the factoring identifies alternative conceptions within an individual´s discourse. Stephenson himself has carried out a large number of such single case studies (see Stephenson 1974). Other examples are Maudlin´s (1985) exploration of the self concept of a young woman he called Evyln, and Ricks´ (1972)

investigation of the person perception and self-concept of a black janitor.

Typically the items used for sorting are derived from the individual's own statements (e.g. from interviews), the aim being to to explore the individual accounting, teasing out the alternative construals to which that one person has access. Since the work in this thesis has been sited within an explicitly dialectical framework, single case Q method has not been used here, though its potential for examining accounts in fine detail and as constructed by individuals would undoubtedly have much to offer in the area of health and illness.

3.2 THE HISTORY OF Q METHOD AND THEORY

3.2.1 Origins

As has been already noted, Q as an abductive methodology, and Q as an interpretational theory were developed independently from (and largely prior to) the development in mainstream psychology of hermeneutic and social constructionist approaches. Stephenson devised Q theory and method as means to use factor analysis (upon which he was working at that time with Spearman) to study subjective experience. From the 1930s and throughout the heyday of reality-constructs-person behaviourism in the 40s, 50s and 60s, Stephenson swam against the tide, unfashionably denying that psychology can be studied positivistically.

He proposed that what matters in human thought is psychological significance. In this he was (as he freely admitted)

merely restating an already well established alternative viewpoint to positivism, based upon ideas going at least as far back as the work of Giambattista Vico (see Berlin,1969, 1976 and Shotter, 1981) who in 1725 proposed a <u>Scienza Nuova</u>, a ´new science´ of history. Vico argued that we can know <u>more</u> about our own and other people´s experiences (in which we act as participants and indeed as instigators) than about the physical world, which we can only ever observe from the outside, and moreover, that such self-knowledge can only be obtained <u>per causas</u>, ´through causes´. We can only fully know something if, and only if, we know why it is as it is, or how it came to be, not merely that it is as it is. This idea Vico embodied within a principle of <u>verum ipsum factum</u>, that we can only guarantee the truth which we ourselves make.

Closer in time and place to Stephenson, Bartlett was saying similar things about about the psychological study of memory. Refuting Ebbinghaus´ (1885) attempts to study human memory by way of recall of nonsense syllables, he argued that it is "... impossible to rid stimuli of meaning so long as they remain capable of arousing any human response", that attempting to do so creates an artificial situation and thus prevents the study of what is most <u>human</u> about memory and "... ignores dangerously those equally important conditions of response which belong to the subjective attitude." (Bartlett,1932). He also stressed the interpretative and constructive processes involved in memory, both at an individual and social level.

Stephenson´s innovation cannot be claimed, therefore, to be one

of expressing the importance of psychological salience, nor of linking individual and group constructivity. What he did that was innovatory was to suggest how this aspect could be empirically studied using Q method. Its components were already well established in the group within which Stephenson was working. Burt (1915) had already tried out by-person factor analysis, and ratings of, say, picture-postcards of paintings were one of the techniques being used to explore aesthetic preferences. What Stephenson did was bring these together, suggesting they provided a means by which a researcher could explore subjectivity in a systematic manner. He wrote in June, 1935a, in _Nature_ that inversion of the traditional forms of factor analysis "...has interesting practical applications... and reaches into spheres of work hitherto untouched or not amenable to factorisation. It is especially valuable in experimental aesthetics and in educational psychology, no less than in pure psychology." (This letter is provided in full in pp9-10 in Brown, 1980).

There followed a number of papers (e.g. Stephenson, 1935b, 1936, 1949, 1950a, 1950b, 1952) but it was not until 1953, in his book "The Study of Behaviour : Q Technique and its Methodology that he provided a comprehensive account of his theory and method. Probably the best description of Q method in Stephenson's own words is from a later book, The Play Theory of Mass Communication (1967) :

"Fundamentally it is a method by which an individual can model for himself(sic) what his attitude of mind is about complicated topics, issues or situations. Its primary concern therefore is with a person's subjectivity as he describes it, not as we

(as psychologists or onlookers) infer it. All measurements in Q are central to the person - the scales, so to speak, are in the person's own mind. The method begins with ... what one person models about himself and compares this with models provided by others." [p5] (emphases in the original).

This description says some quite simple things, which can be easily overlooked, but it is these that distinguish Stephenson's work from that of the many others who have sought to study subjectivity. First, he makes it clear that the method is primarily intended to enable a person to gain insight about and express their own 'attitude of mind' - before all else the method is a form of <u>self-expression</u>, like the kinds of humanistic approaches which see their fundamental purpose as facilitating the individual's ability to gain a better understanding of themselves. But it differs from humanistic approaches in that it also seeks to discover systematic similarities and differences between alternative ways of making sense of the topic in question.

Thus Q sorting was devised to perform two crucial functions, and it is the combination of these that are its strength and demonstrate what it is that Stephenson has offered as his innovation. By making the expression of a 'way of seeing things' an explicit task for the individual, Q method makes the subject of the study the true 'subject' (in contrast to their usual position as 'object', cf Riegel, 1978). Q sorting is a means by which a person is helped to explicate their own understanding, not just have it interpreted for them by a researcher. But by doing so in a manner that allows one person's explication to be compared with another's, the factor analysis carried out on

Q sorts   enables   the researcher to discover a range of collectively shared understandings.

3.2.2   Early misconceptions

It was unfortunate that the first report of Q method (1935) referred to 'inverted' factor analysis, focussing on the statistical manipulation involved. It led to considerable misunderstanding which became entrenched in the minds of his contemporaries including Cattell, Burt and Thompson, who argued that conventional factor analysis and Q analysis were merely variants of each other. Burt (1972), for example, maintained that Stephenson's Q analysis was no different from his own use of by-person factor analysis in an earlier study to investigate 'character-qualities' of children (Burt, 1915), set up to discover whether children's emotional manifestations co-varied in a similar fashion to their intellectual performance.

Teachers were asked to rate children in terms of the frequency with which they were observed to show particular kinds of 'emotional behaviour', and these ratings were factor analysed in the usual way, yielding a single 'emotionality' factor, and a subsidiary extroversion/introversion factor (N.B. this work, of course, pre-dated Eysenck's by many years). Because a number of different teachers were involved in the rating procedure, Burt also carried out an inverted factor analysis on the ratings, to check out whether there had been inconsistency between judges. Burt describes what he did thus :

"Each child had a figure alloted to him for each of a dozen basic emotions, indicating the frequency with which (according to a competent observer) he(sic) displayed each emotion during the periods he was under observation - out of school as well as in. This method, I fancy broadly corresponds with what Stephenson calls a 'Q sort'. The chief difference is that, although in our case the frequencies usually approximated to a normal distribution, this distribution was not forced on the observers, whereas Stephenson, to make the procedure more precise, insisted that every observer should adhere to exactly the same normal or near-normal distribution that was specified in the instructions."
(1972: 42) (My emphases)

This description of what Burt imagined a Q sort to be totally missed the point that responses to Q sorts are always self-referent, and concerned with subjectivity, and are always procedures in which a person ranks estimates of various kinds, they do not purport to measure them. Whereas in Burt's study the data were counts of observed, operationally defined events (i.e. were assumed to be independent of, and isolated from one another) the data from a Q sort are always relational; the essence of the data is that it is ordinal, each datum dependent upon the other data, and meaningless in isolation. It was therefore quite wrong to treat as equivalent Burt's 1915 inversion, Thompson's (1935) speculations that there are interesting statistical insights to be gained by inverting matrices, and Stephenson's Q factor analysis of Q data. The observation that all three apply a statistical technique in a similar manner is as instructive about Q method as the observation that computer programs, music and visual images can all be encoded by a similar technique onto magnetic tape. That the technique is similar tells us nothing about the massive and fundamental differences between the purposes of such encoding.

3.2.3 The appropriation of Q as an essentialist methodology

In 1948 Stephenson moved to the University of Chicago, and introduced Q method to the Counselling Centre Group working there (led by Carl Rogers). Kohlberg, among others, was encouraged by Stephenson to try Q method, and carried out a study of alternative interpretations of Dostoevsky (Kohlberg 1963). Beck, Molish and Sinclair (1956) used it to explore something that had been concerning clinicians for some time - the divergence of clinical judgement between different social workers. Using a Q sort devised by Stephenson, they were able to make explicit the ways in which family case studies were interpreted and childhood schizophrenia diagnosed in different ways by different individual social workers.

However, not all of Stephenson's colleagues at Chicago were content to retain the principles of Q theory along with Q technique. Butler and Haigh (1954) devised a 100 item Q sort to explore patient's self-esteem, by comparing the degree of correlation between their Q sorts for myself-as-I-am and myself-as-I-would-like-to be. This Q sort was subsequently used in a large number of studies (e.g. Chase, 1957; Engel, 1959; Lepine and Chodorkoff, 1955; Reznikoff and Toomey, 1958 and many others). Butler and Haigh stayed true to Stephenson's principles of subjectivity and self-reference in that they accepted as credible and important a person's self-definitions, but they transgressed them in that they used the estimate of agreement/disagreement between the two Q sorts as a measure of self-esteem, and consequently of 'mental health', utilizing it, for example, to assess the success of therapy.

Dymond (see for example Rogers and Dymond, 1954) went further. She was disconcerted that the measure of 'mental health' was in this way defined entirely within the person's own frame of reference (e.g. a mentally unhealthy person could get a high mental health score by having very low expectations of their ideal self) and so she had two clinical psychologists, as 'experts', sort Butler and Haigh's statements into categories of 'adjustment' and 'maladjustment'. These psychologists selected 37 for each category. Dymond (and indeed many subsequent researchers) therefore used just these 74 statements, and estimated each person's adjustment score by counting the number of 'adjustment' statements sorted as 'characteristic of me' and 'maladjustment' statements sorted as 'uncharacteristic of me'. Lepine and Chodorkoff had their judges define 'adequacy' and 'inadequacy'; Engel had them define positive and negative attitudes. The Q sort was thus appropriated as an objective instrument to test people, and it is unfortunately this version that has often been presented as the Q sort technique, with no reference to Stephenson's work at all.

Kitzinger (op cit; who provides a far more comprehensive review of such studies) notes that in all uses of this kind :

"... the Q sort is forced from its use as a measure of operant subjectivity, into a typical essentialist test in which items are assigned a priori meanings, in terms of which people are ranked along a pre-defined continuum. The imposition of meanings on Q sort correlations or items represents the appropriation of a constructionist methodology and its assimilation into mainstream psychology as an essentialist tool." [97]

3.2.4 Q method as a means to study popular discourse

After a year spent in advertising in New York, and short periods spent working in Washington and Berkley, Stephenson moved in 1958 to the University of Missouri (where he still retains the position of emeritus professor), shifting from a Department of Psychology to a School of Journalism. This change marked a point at which he became more interested in Q method in its relation to mass communication, in particular in the spheres of market research, social and public policy, journalism and political science.

Apart from encouraging voluminous research in addition to a steady flow of his own which continues up to the present day, in his time at Missouri Stephenson produced his second major book The Play Theory of Mass Communication (op cit), devoted specifically to the application of Q method and theory to such areas as the impact of mass media and processes of communication. It was in Missouri that Steven Brown became his student, and it is Brown (now at Kent State) who has emerged as his most energetic supporter and who has been responsible for introducing Q theory and method into political science, where today it is better known and more used than in psychology. It is also he who has provided (1968; 1977) and continues to provide (in the Q methodological journal he edits, ´Operant Subjectivity´) bibliographies of Q studies. Brown´s book ´Political Subjectivity : Applications of Q Methodology in Political Science´ (1980) remains the standard guide to its techniques and applications.

3.2.5 The current status of Q research

Other than that of Stephenson himself, currently Q research in North America tends to be carried out by people like market researchers (e.g. Levy, 1985, 1986; Maudlin, 1985, 1986a, 1986b; van Taubergen, 1986), communication theorists (e.g. Barchak, 1985; Brenner, 1985; Goldman, 1984. 1985, 1986; Parker, 1986), educationalists (e.g. Caldwell, 1985), policy theorists (e.g. Asher, 1986), therapists (e.g. Rohrbaugh, 1986) and particularly political scientists (e.g. Brown, 1984, 1985, 1986; D'Agostino, 1986; Koshansky, 1985; McDonnel, 1986; Peritore, 1986). Apart from a few exceptions (e.g. D'Agostino's work and that of Peritore) this research is predominantly pragmatically based, particularly in areas like Market Research, therapy and education.

In Britain Q methodology is currently the domain of a small group, mostly psychologists, who have adopted it as a deconstructionist social epistemological methodology, to explore and open up taken-for-granted constructs such as lesbian identities (Kitzinger, op cit and 1987, forthcoming; Kitzinger, C. and Stainton Rogers R., 1985), human rights (Stainton Rogers R., and Kitzinger C., 1986), moral development (Kitzinger C., 1986), the social construction of insanity (Gleeson, 1986), the womens' peace movement (Kitzinger, J., 1986), childbirth practices (Kitzinger, J., 1987) energy policy (Stainton Rogers, W., Stainton Rogers, R. and Lowe, 1986), addiction (Stainton Rogers, R. and Stainton Rogers, W., 1986) and gender (Thomas, forthcoming).

The cross-Atlantic distinction is thus more than just one between psychology and other disciplines, and reflects an emerging divergence between two academic discourses. The majority of North American Q researchers are tending to utilise Q methodology as a useful technique for identifying and describing alternative images, viewpoints, responses to advertisements etc. By contrast, most Q researchers in Britain and some in North America (notably D'Agostino and Peritore) are at the time of writing this thesis working within a social epistemological framework as described in Chapter 1, focussing on the potential within Q theory to develop an epistemological social psychology much more within the European than the North American tradition, with roots as much within the work of people like Berger (1972, 1977), and Schultz (1962, 1967, Shultz and Luckmann, 1973) as in the work of Stephenson.

They view Q as a radical methodology, providing opportunities to work within wider politico-economic contexts. For example, Kitzinger's (1984) detailed study of lesbian identities was conducted as part of a deconstruction of prior essentialist theorisation about lesbianism. She argued that research in the past has been used as a justification for portraying lesbianism within a patriarchial analysis which excluded lesbianism from the political arena by pathologising it or presenting it in terms of 'personal choices' and 'private lifestyles'. D'Agostino is similarly working within an explicitly Marxist framework, and Peritore within that of the radical left.

Q method and theory are thus proving to a new generation of researchers to have strong resonances with politico-economic theories that conceive of social processes in terms of power inequalities, in broad societal terms (e.g. Marxist analyses), within gender politics and analyses of professional hegemonies. As Marxism questions the 'givens' of structural functionalism, feminist theory questions the imposed assumptions of patriarchy, and the cultural critique of medicine, (cf Ehrenreich, 1978; Zola, 1972) questions the medicalisation of health and illness, Q theory questions the whole objectification of mental life, and has therefore been adopted as a basis for radical critiques of traditional psychological theorisation and praxis.

3.3 CRITICISMS OF Q METHODOLOGY

Criticisms of Q methodology fall into six main categories: its focus on subjectivity; statistical problems to do with the non-independence of data; the constraints imposed by specifying the distribution of responses; its restricted utility because of the time-consumingness and intellectual demands of carrying out the sorting procedure; the potential to introduce bias within the Q sample; and potential bias arising from participant sampling. I will deal with each of these in turn in this Section.

3.3.1 The critique of Q's focus on studying subjectivity

I have already described (Section 3.2.3) the way that many of the clinicians who adopted Butler and Haigh's (1954) actual-self/ideal-self comparison version of the Q sort appropriated Q method as an essentialist test. To make its use more acceptable, its focus on subjectivity and its primary

purpose to enable people to make operant myself-as-I-see-me were rejected in favour of turning it into a technique for measuring their (the researchers´) version of the-self-as-it-really-is.

Kitzinger provided a convincing illustration of the way Q sort responses demonstrate that the search for such objectivity is one that is doomed to fail because statements ´mean´ only what the reader perceives them as meaning, and indeed often ´mean´ different things to different people. In her study of accounts of lesbian identity, she included the following item in one of her Q samples :

37. Lesbians pose a threat to the nuclear family and society as we know it.

The item was chosen to embody some of the sentiments of mental health theorists who view lesbianism not so much as ´inherently sinful´ (as a patriarchial analysis suggests) as a threat to social stability because it is "...disruptive of family life" (Socarides 1965). Kitzinger noted that two of the accounts she obtained from her Q study endorsed this statement : Factor A allocated it +3 and Factor B +4. In objective terms, the agreement between the two suggests that both support the ´threat to social stability´ interpretation. But consider the differences between the two factors´ placements for the following items :

	Factor scores	
	A	B
24. I think sadness and regret are the appropriate emotions of any parents who find they have a lesbian daughter.	+2	-2

Factor scores

	A	B
47. If a lesbian genuinely wishes it, facilities should be made available to help her to change.	+4	-5
59. Lesbianism is a personal tragedy and lesbians deserve sympathy and understanding.	+4	-4
7. Lesbianism is a blow against the patriarchy (i.e. society structured by men for men).	-2	+5
36. Lesbianism is fundamentally a political statement, not a sexual preference.	-3	+4

Clearly it is only the account identified by Factor A that interpreted item 37 within a pathologising ethos, reading the statement as a criticism of the 'danger' of lesbianism. The account identified by Factor B adopted a radical interpretation of lesbianism, seeing it as an explicitly political, and superior choice to heterosexuality. Within this account endorsement of item 37 was one of approval; that the capacity for lesbianism to threaten the nuclear family is a 'good thing' - the nuclear family is something that should be challenged.

Brown argues the case against spurious objectivity, explicitly :

"... an individual's relationship to his(sic) words is wholly different from everyone else's. When a subject responds to a scale item, therefore, the meaning and significance his response has for him may differ in major respects from the meaning assumed by the observer or anyone else, and to ignore this possibility is to be unwilling to accept what is before one's eyes, to be aspect blind, and to prefer the artificial to the natural. Language-in-use is by its nature symbolic and self-referential, with each combination of words being capable of carrying a wide range of meanings. For an investigator to regard his own understanding as in some sense objective or correct is therefore pretentious in the extreme." [p3].

Q theorists therefore refute the criticism that Q method is 'not objective' as inappropriate, because Q method is not intended to be objective. However, radical Q theorists like Kitzinger (1984; 1987 forthcoming) go further, and along with other contemporary social theorists (e.g. Cohen 1971; Hall, 1986; Riegel. 1978) including several working in the area of health (e.g. Press, 1980; Taussig, 1986; Young, 1980, 1982) argue that the strivings of social scientists to be 'really scientific' by being 'objective' have been motivated by more than mere pretension or the seeking for upward intellectual mobility of an academic nouveau riche. Kitzinger (citing Cohen) stresses the self-serving nature of being a 'trader in definitions'. For a profession to claim that there are truths, techniques and insights to which only they have access, and solutions to problems that only they can provide is a well established ruse by which professionals justify their existence and build upon their power-base (cf Illich, 1973). Psychologists have had every motivation to convince the wider public that attitudes, beliefs, opinions and personality differences are phenomena which only they have the knowledge and competence to uncover.

Claiming to be able to objectively define psychological 'reality', from a radical perspective, is a route by which psychologists have gained not just status, but power and livelihood. The last fifty years, in Europe and North America, has seen a proliferation of practitioner roles within such areas as clinical and educational psychology (See, for example, Figure 3.10) and ever increasing pressures to create monopoly status for initiates (as evidenced, for instance, by attempts within the

Figure 3.10 Number of PhDs Granted in Health-Service-Provider and Academic/Research Subfields in Psychology in USA 1960-1984
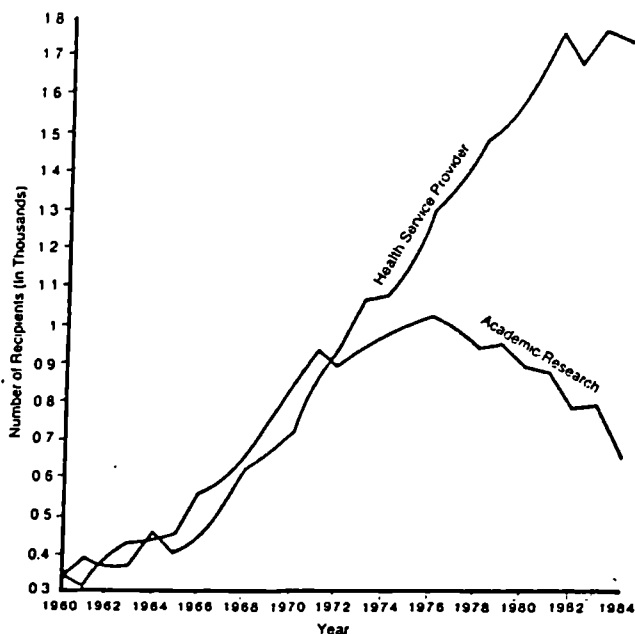
Note. Data for 1960–1982 PhDs are from *Science and Engineering Doctorates: 1960–82* by the National Science Foundation, 1983, Washington, DC: U.S. Government Printing Office. Data for 1983 PhDs are from *Summary Report 1983: Survey of Earned Doctorates* by the National Research Council, Office of Scientific and Engineering Personnel, 1983, Washington, DC: National Academy Press. Data for 1984 PhDs are from *Summary Report 1984: Survey of Earned Doctorates* by the National Research Council, Office of Scientific and Engineering Personnel, 1986, Washington, DC: National Academy Press.

(From Howard et al, 1986 'The Changing Face of American Psychology', American Psychologist, 41(12) 1311-1327, p1313)

British Psychological Society for registration, see Stainton Rogers, R. and Stainton Rogers, W, 1984). Operational definitions are therefore not just pretension dressed up as objective reality, but are the tools of self-serving power ploys.

The desire to carefully regulate and control research conditions, however, is not just pretention or power mongering. It has a valid motive, which is paradoxically (in view of the points just raised) to prevent the researcher from biassing their results. Stripping away spurious objectivity does not solve this problem but replaces one problem with another. The task facing interpretational social psychologists, including Q methodologists, is how to conduct research in ways that do not pretend objectivity, but which nevertheless offer some kinds of external checks. It is for this reason that Q method has been adopted as a radical methodology. As it studies operant subjectivity, it enables disciplined enquiry based not on the researcher's implicit theories, but on the everyday understandings expressed by ordinary people. But, as will be apparent within the research presented in this thesis, it does not make the problem of researcher-bias 'go away'. Rather it places upon the researcher the duty to construct Q samples that are truly representative of the concourse of ideas about the topic under study, so that participants in the study are given adequate opportunities to express their accounts, and to provide checks against imposing their own understandings (e.g. to negotiate account interpretations with participants).

3.3.2 Inapplicability of statistical tests

A number of people (e.g. Cronbach and Gleser, 1954; Sunderland 1962; Kerlinger, 1964, 1972; Lemon, 1973) have criticised Q methodology because of the difficulties of applying traditional statistical tests for significant difference to Q data. For example Kerlinger (1972) has noted that it is impossible to "...calculate the means of two different groups on subsets of Q items".

Though it is true that the properties of Q data make them unsuitable for some forms of statistical analysis, that is not a ´problem´ with the data, but a quality of it. As Kitzinger´s illustration (Section 3.3.1) demonstrated so well, items in a Q sort can be accorded no essentialist, objective ´meaning´. They mean different things to different people in different contexts. The observation that two people place a particular item in a particular position in a Q sort does not mean that they are doing so for the same reason, or are interpreting the statement (or whatever) in the same way.

Thus criticism about the inapplicability of some of the standard statistical procedures is ill-founded, based within a misunderstanding of the nature of Q data. Q method makes just one (and only one) claim for statistical analysis : that by-person factor analysis of placement categories identifies statistically independent, alternative response patterns that represent statistically independent, alternative configurations of operancy. It does not assert that an individual datum within factors can be subsequently compared across factors. This is

illustrated by Kitzinger´s example. Her respondents´ placement of Item 37 : "Lesbianism poses a threat to the nuclear family and society as we know it" provided data of which only part was the allocation of a similar position (+3 and +4) in two factors. Also crucial (as the later consideration of other placements of other statements made explicit) was the subjective aspect of what, in different accounts, the statement was construed as meaning.

It should now be clear why some statistical approaches to Q data are innappropriate. It is not so much, as Kerlinger argues, that they try to apply normative techniques to so-called ipsative data, but that they ignore the subjective qualities of Q data, and thereby attempt to impose manipulations which are fundamentally out of place. This is not, as Kerlinger suggests, a ´serious loss´ of information, nor is it, as Lemon argues, a reason for lowering the acceptable level of statistical significance assumed when certain statistical tests are applied. Quite simply, they should not, and do not need to be used.

3.3.3 Specifying response distribution

Q studies usually specify, precisely, how many categories of response a person should use and precisely how many items should be placed in each category (as in Figure 3.1). This enables factor extraction to be carried out with precision, but it also inevitably constrains response. The difficulties of this constraint are of three kinds: statistical, interpretational and procedural. The statistical problem is more apparent than real,

for the correlational analysis that provides the factors takes account only of relative position, and is itself not tied to the metrics accorded to placements. In practice, specification does not distort the results appreciably from what they would be if the subject were allowed free choice. Comparisons made between Q sorts using grids like the one shown in Figure 3.1 and where respondents are allowed complete freedom to specify their own categories show no significant difference between the data obtained (Jones 1956). What response specification does is make the factors more reliable, because respondents typically assume fewer categories if left a free choice. The more specific and discriminatory the matrix, the more reliable the factors obtained (Livson and Nichols, 1956).

However the procedural and interpretational difficulties are real. The whole issue of response specification and its impact upon data is complex, and presents some interesting questions about the nature of Q data. It is taken up in more detail in the empirical chapters, particularly Chapter 6, in the context of a study designed to explore (among other things) alternative ways of collecting data.

3.3.4   The demands of Q sorting

Many participants enjoy completing Q sorts (cf Burns, 1979; Kerlinger, op cit; Lemon, op cit), but Livson and Nichols (op cit) reported that in their study acceptance of the procedure was 'somewhat strained' and Gaito (1962) noted 'hostility towards the experimenter' in his. Kitzinger (1984) reported that her

participants varied in their response to Q sorting, with those who saw it as a 'test' antagonistic, whereas those who regarded it more as a 'game' responding positively. She noted that in order to gain willing co-operation, the Q researcher needs to convince participants that the method is not an essentialist tool for classifying people, and reported that most of her initially antagonistic participants became much more favourable once shown the results and offered opportunities to discuss and negotiate the account interpretation.

It is the demandingness of Q sorting that is usually criticised, because this restricts Q method to those people who are sufficiently competent to carry out the procedure. It has been argued that this limits the use of Q methodology to just those people who are highly articulate, persistent and intelligent (Blaxter, personal communication). Such criticisms, I believe, underrate the competence of ordinary people. Stephenson (1962) has obtained Q sorts from a wide diversity of people, including the very poor and educationally disadvantaged, and the severely physically challenged; he has also obtained one from a four year old (Stephenson, 1980).

Obviously the ease with which people can perform a Q sort depends a great deal upon the language used in statements. To enable a wide variety of people to participate, items must be worded clearly, expressed in everyday not technical language, short and to the point (though there is some debate about this; very long items have been used by some Q researchers, e.g. Peritore 1986). When items are carefully prepared, although the task is

more demanding than completing other kinds of questionnaire or responding to an interview, there should be no reason to limit its use appreciably. The time demanded for Q-sorting (often an hour or more) has also been a criticism, although this is considerably shorter than many interviews.

However, for some people the main drawback was the task of Q sorting itself. As Kitzinger says :

"... Q imposes the problems of categorization <u>on the Q sorter,whereas in purely qualitative research the problems of</u> categorisation remain the exclusive province of the researcher. In using Q methodology participants are experiencing all the dilemmas, confusions and decision-making traumas that researchers usually relieve them of when they undertake content analysis or other research techniques in which the burden of categorisation is not shared by the people researched." [pp 133-4]

For some people Q sorting is very frustrating; certainly for most people it is effortful, demanding complex judgements comparing a large number of statements with each other. A Q sort is <u>meant</u> to be effortful because of what it is seeking to discover. It is the ´effortlessness´ (i.e. ´mindlessness´) of conventional questionnaires that make them poor instruments for studying accounting. With Likert type scales responses are isolated from one another, and co-variance reconstructed via statistical manipulation. With interviews, it is the researcher´s interpretational and analytic skills that tease out the ´main themes´, ´metaphors´ and ´schemata´. Q sorting enables people to articulate relatedness explicitly and intentionally. It is this which makes Q data able to convey rich information about the participant´s subjectivity. The researcher no longer has to work just from statistical criteria, or on hunches about what seems

to link the various ideas expressed in an interview, but has direct access to information provided by the participant about item relatedness. But inevitably, by transferring the responsibility to make decisions about integration and relatedness to the participant, (i.e. making them their own ethnographers) the task of Q sorting is made demanding and time consuming.

3.3.5 The problem of bias within item samples

Q method is vulnerable to the argument that factors (and thereby accounts) are no more than products of the Q sample. The argument is that if the Q sample is restricted or biassed, then the accounts may reflect more the limits of the concourse sampled by the researcher than the participants´ constructions. The researcher, as any other person, draws upon socially and culturally constructed ways of ´making sense of the world´ and may, by emphasising that perception within the Q sample, deny participants their full voice. In part this concern is allayed by the data obtained in Q studies, which seldom fail to discover several alternative accounts (even in studies conducted by relatively inexperienced researchers like undergraduates), including ones antagonistic to the researcher´s own (which can be empirically tested by the inclusion of the researcher´s Q sort in the analysis). Most also elicit accounts which are unexpected (see, for example, Brown, 1980 who provides a large number of examples). However, this drawback is sufficiently problematic to demand a careful process of sample selection, using a variety of sources (e.g. interviews, mass media and literature about the topic in question), careful pilot testing, and account

negotiation.

There are two methods of constructing Q samples, unstructured and structured (Brown, 1980 pp 186-194 provides full details). Unstructured samples are selected atheoretically, on the basis of providing as representative and comprehensive a selection as possible from the concourse overall. They are used when the study is intended to be primarily abductive - i.e. exploratory. Structured samples are based upon pre-existing theories or conceptual frameworks. Although there has been debate within the literature about the most valid means of ensuring consistent sample structure (see for example Neff and Cohen, 1967), Q methodologists refute that such objective consistency can be ensured. As Brown asserts : " the ´operational definition´ of a person´s attitude is not <u>in</u> the items, but in terms of what he(sic) does with them" (Brown, 1980). However, sample structuring can be used as a guide, to facilitate comprehensiveness and to enable theory testing. Both unstructured and structured samples have been used in this thesis, and their derivations are described in more detail in the relevant Chapters.

3.3.6   The problem of bias within participant selection

The non-randomness and small size of participant samples used in many Q studies have often been criticised (see, for example, Kerlinger, 1973 and Wittenborn, 1961). However, since Q method samples items not people, the principles of comprehensiveness and representativeness have to be applied to the items that make up

the Q-pack, not the people that participate in the study. However, this does not overcome the fact that the only accounts that can be identified are those expressed by the people who perform the Q sorting. There is a continuing controversy among Q researchers about the scale of this problem, and how it should be tackled. Stephenson has repeatedly argued that for any topic there exist only a small number (two, three or four, but seldom more) of alternative accounts, and that participant samples of thirty or so are adequate to ensure that all are expressed, any more people than this adding no additional information (i.e. simply lining up among the factors already identified). Those of us working in Britain assume that there are usually more accounts to be found than this, if participants are selected for diversity of viewpoints.

However, there is agreement between all Q researchers that just as item sampling should be carried out along the principles more generally applied to subject sampling, participant sampling usually needs to be theoretically guided, though abductively rather than hypothetico-deductively. In other words, Q participant sampling is seldom random, but deliberately based on hunches and expectations about the presumed interests, viewpoints or stances of the participants, hunches used not to predict what account any individual will proffer, but simply to increase the probability of discovering a variety of accounts.

For example, Stephenson (1987) in a study of responses to the Nixon-Kennedy television debates of the 1960s took political allegiance, expertise in political science and gender into

account; Kitzinger (1984) ensured that in her study of accounts for lesbianism her participant sample included feminists and non-feminists, women and men; and Stainton Rogers, R and Kitzinger (op cit) in their study of accounts of 'human rights' used a number of methods. They included MPs who had stated 'rights issues' within their listed interests, and representatives of various religious and rights groups (e.g. Amnesty International). Many Q researchers also use 'snowballing': asking participants to suggest relatives, friends and other contacts known to them who they think may have particularly interesting or 'different' views on the topic. In this way, the Q methodologist, like a biologist searching a habitat for different sympatric species, seeks out the accounts that comprise the discourse of a particular group (as Kitzinger's study of lesbians) or a broader collectivity (in which case, the sample must include a proportion of 'ordinary people', to make sure that popular discourse is sampled). Like the biologist, she or he can never be certain to have found everything that there is to be found (as with the classic 'black swans' of the philosopher) but only to be building a taxonomy. For ultimately, the abductive approach of Q methodology is taxonomic.

CHAPTER 4 : STUDY 1
AN INITIAL Q INVESTIGATION OF ACCOUNTING FOR HEALTH AND ILLNESS

4.00 INTRODUCTION

In Chapter 2 it was concluded that what distinguishes popular accounts for health and illness (including the everyday accounting of professionals) from the biomedical model of disease aetiology, is that they are articulated within the context of much broader discourses (such as religious belief or folk wisdom). Furthermore, they are seldom psychologically neutual, but often, say, reflect an individual's self-definition (e.g. as 'winner against the odds' rather than 'victim'). The aim of the first two studies conducted for this thesis was to begin to develop a taxonomy of these kinds of broadly based accounts. Such an objective is exploratory rather than theory-testing, and consequently unstructured Q samples were appropriate.

While it was argued in Chapter 3 that it is impossible to ever fully define a concourse, the clarity and range of accounts that can be identified using Q methodology are products of the extent to which the concourse has been comprehensively defined and representatively sampled. This Chapter describes Study 1, an initial investigation, conducted both as a Q study in its own right, offering a 'first estimate' of the account taxonomy; and as the basis from which to construct a more participant-led Q sample for the subsequent, more detailed Q study (Study 2, described in Chapter 5).

Study 1 consisted of two phases. The first was the construction of the Q sample. The main basis for this was a series of in-depth, semi-structured interviews with fifteen people, selected for their diverse access to alternative contextual

discourses. Items were also derived from a research notebook. The second stage was the Q study itself, using a 54-item Q pack sorted by thirty participants. The results of the Q analysis, together with open-ended responses and suggestions made by participants were utilised to refine the Q sample for use in Study 2.

4.1 CONSTRUCTION OF THE Q SAMPLE

In principle Q samples should be constructed by sampling the concourse of items pertinent to the research topic in question. However, while a concourse is a theoretically useful concept, it is not definable in practice. As Chapter 3 made clear, Q theory assumes a researcher cannot use any objective criteria to specify such a conceptual universe. Thus, in practical terms, constructing a Q sample consists of gaining a 'best estimate' of the concourse from as many diverse sources as possible, recognising that this is inevitably an intuitive process (based upon the researcher's store of 'pretheoretic knowledge', as Rosenwald, 1986, would call it), and then subsequently selecting a Q sample, again intuitively, from this 'concourse-estimate'. The interviews and data gathering within this phase of the study were thus regarded as means by which these impressions could be better informed - not as a means of empirically validating or defining the concourse.

4.1.1. Interview sample

Thus the motivations for carrying out an interview survey were both general - a means of gaining entry into a new field of

investigation, providing exposure to a diverse range of different viewpoints and ideas in order to develop a better understanding of the concourse; and specific - to provide a 'concourse-estimate' of statements from which the Q sample for Study 1 could be selected. Consequently, interviewees were not selected according to principles of representativeness, but rather to include people who were likely to draw upon diverse worldviews, as different from each other (and my own) as possible. Fifteen people were selected for the interview sample on the criteria of including : 'laypeople' and professionals; a range of interests in health and/or illness; and different ages, social classes, cultural backgrounds, political views, religions and demographic characteristics (urban/rural; north/south). There were six women and seven men; their ages ranged from sixteen to seventy two.

Two interviewees described themselves as 'health theorists', a sociologist researching into health beliefs [1]*, provided information both about her own views and about her understanding of the views of the people she had been studying; and the director of an organisation concerned with health promotion [15], chosen to tap views about the links between lifestyle and illness. Two interviewees were 'working class', a pensioner [11] who had been a housewife all her adult life, widowed and living on her own in an 'inner city' area, and a farmworker [13], an active trades unionist, living in a rural setting.

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* These numbers are for reference when describing the derivation of the Q samples for Studies 1 and 2.

A computer technician was chosen as a representative of the 'new right' and because he lived in the north of England. A fitness teacher [7] who ran 'Keep Fit' classes at the local Sports Centre, was selected for her particular interest in 'health-as-beauty' and as someone who was upwardly socially mobile - she was from a very poor, working class family but spoke of her desire to 'better herself'. The Grocer [10] was the proprietor of an 'upmarket' food shop, chosen as a 'traditional conservative' and as a 'foodie'. The school student [14], also from the north, was included as a younger person and somebody holding 'left-wing' views.

A range of different health professionals were also included in the interview sample, including a retired pharmacy technician who had worked in large hospitals throughout her working life [2], a Health Visitor [3], a medical student (a member of an ethnic minority, from a Muslim background) [5], an occupational physician [6], two GPs, one fairly traditional [8], the other a trained homeopathist [9] and a dentist [12]. As well as sampling different professional interests, these people also reflected different class, political, religious and cultural backgrounds.

4.1.2 Interviews

Details of the interview schedule, and an interview summary are provided in Appendix 1. The interviews were semi-structured, in that I set an agenda of issues and topics to be covered and specific questions to be asked, but were largely open-ended. Given the diversity of the interviewee sample, different people

naturally focussed on different aspects of 'health and illness'. For example, the occupational physician worked for a large food manufacturer, and had a lot to say about the relationship between 'big business', government policy, diet and health. At the time of interview he had just returned from a visit to the USA, and provided a great deal of information (and expressed firm views) about the comparison between attitudes to health here and in North America.

Each interview lasted between one and three hours, the average being about two hours. I transcribed the interviews selectively, focussing on choosing statements to build up the 'concourse-estimate'. In several cases I telephoned the interviewees to clarify particular points. In two cases (participants 6 and 8) I conducted a second interview, to enlarge on topics raised. From the interviews I generated 327 statements, as close as possible to the words actually used, as a basis for the 'concourse-estimate'.

4.1.3 Other sources

During the period of four months during which the interviews were taking place, I kept a research notebook. Into this I recorded statements about health and illness from a variety of sources : from my reading of the academic literature, discussions (e.g. at academic conferences) with other colleagues working in this area, conversations in informal social settings (e.g at the hairdresser and waiting in queues at the post office), media sources including television, radio, newspapers and magazines, and by reading or re-reading novels (e.g. Butler's 'Erewhon',

1872,and Axel Munthe's 'The Story of San Michele', 1929) and 'popular' texts with a medical or health theme, including old books (e.g. 'The Practical Doctor' by a Harley Street Specialist, undated). As with the interviews, the intention was both to generally 'immerse' myself into as many different pertinent discourses as possible, and specifically to look for items with which to build up a 'concourse-estimate'. I took the notebook with me wherever I went, and actively sought to read as many different magazines, newspapers and books; to watch as much television and listen to as much radio; and to enter into as many informal conversations about 'health and illness' as I could. From this notebook, 179 statements were selected to add to the pool.

Unfortunately, I did not obtain a copy of Stephenson's (1962, 1963) unpublished Q studies of 'images of public health' until some years later, and was therefore unaware of the Q samples he had used, which would have been valuable in setting up my own.

4.1.4 Derivation of the Q sample

At the end of this phase of data collection I had gathered over 650 statements about health and illness. Of these about 150 were concerned with social policy issues and/or matters of funding. These were excluded, focussing the study on accounts for health and illness, albeit linked to other contexts like politics and morality. I thus arrived at 506 statements, derived from the interviews and other sources, which formed my first 'best guess' at the concourse. These were reduced in number by procedures similar to those used in public opinion research (e.g. by

eliminating highly complex, double-barreled, duplicating and floridly idiosyncratic material), and by seeking to select as representative a coverage of what appeared to me to be the different ideas and views being expressed. Full details about the derivation of the 54 items selected for the Q sample are provided in Appendix 2.

4.2 STUDY 1 : METHOD

4.2.1 Materials

The full materials provided to participants are included in Appendix 3. The fifty four statements which comprised the Q sample were typed out 16 to a page, . for participants to cut up to make a Q-pack. Written instructions, a response grid, and a participant's details form were provided, also a comments booklet containing the statements with spaces beside each one. As can be seen from the instructions, participants were asked to make comments about the statements (i.e. about their wording and comprehensibility, any problems, and any more detailed reactions to them) and to make suggestions for additional statements.

4.2.2 Participants

Thirty people participated in this pilot study, the main selection criteria being to find as diverse a group as possible while ensuring that a proportion were 'ordinary people'. The participant sample included twenty one women, eight men and one anonymous person; their ages ranged from thirteen to sixty four; eight were or had been health professionals, other occupations included a lawyer, researchers, teachers a cook and a factory worker; included were people known to express a range of

political views/ideologies, and to have had a variety of experiences of illness and 'disability'. In this initial study, all participants were either known to me, or were contacts of friends or other Q sorters. In this way, all participants were either familiar with Q sorting, or could be given oral instructions and demonstrations if necessary. Participants were all unpaid volunteers.

4.2.3 Procedure

Each participant was handed the materials, and instructed (as needed) about how to carry out a Q sort. They were asked to read through all the statements first, next cut up the statements and sort them into three piles ('agrees', 'disagrees' and 'uncertains') and then sort them into eleven categories, from -5 to +5 along a disagree strongly/agree strongly dimension, allocating items according to the matrix shown in Appendix 3. Having completed the Q sort, participants commented on the statements in the booklet provided. Although generally briefed when the materials were handed over, the majority of participants took them home and completed them and the comments forms in private. Response grids, participant's forms and comments forms were returned by post, or via my contacts.

4.3 RESULTS

The Q sort data were coded (i.e. -5=1, -4=2, etc up to +5=11), entered into the computer, and subjected (via SPSS) to factor analysis by person, factors extracted by varimax rotation. The factor loadings obtained (listed in Appendix 4) were used to

identify exemplars for each factor, using criteria of a loading >0.6 on the relevant factor, with no loading >0.35 on any other factor. The usual convention among Q methodologists was followed of only examining those factors with eigenvalues greater than unity and at least one exemplificatory loading. The exemplars, and details of the people providing the Q sorts which produced them, are summarised in Table 4.1. Using Creaser's (1935) procedure (Brown, pp240-243 provides full technical details) factor scores for each item were calculated, using a process of weighting and averaging of the exemplar's scores, to generate 'idealised' Q sorts which best represent the response configuration for each factor. These are listed in Table 4.2.

As can be seen, five interpretable factors were derived from the analysis. By reference to the factor scores for each factor, they can each now be interpreted.

4.3.1 : Factor 1

The account identified by this factor stressed the influence of structural factors upon health and illness, implicating poverty, inequality, disadvantage and environment (e.g. pollution) as the main reasons for illness and poor health. Health was seen as a product of wealth and privilege (Item 30 = +5)[1] and tranquillisers seen to be prescribed to help people put up with intolerable conditions (Item 52 = +4). Individuals were regarded as having little choice about their lifestyles (Item 35 = -5), and the idea that working class people are to blame for their illness rejected (Item 12 = 5). Pollution was seen as a pervasive threat to health (Item 51 = +5). This account

1: The list of items provided in Appendix 2 is convenient for checking them against these reports. Note that some items are expressed in the negative, and hence, where the factor score is also negative,careful interpretation is necessary.

Table 4.1   Summary of exemplificatory Q sorts, Study 1

| Factor | Loading | Participants providing Q sort | |
		No.	Description*
1	.85	5	Student, lesbian feminist
	.68	12	Nurse, feminist
	.74	17	Graduate student
	.87	23	Researcher,lesbian feminist
	.74	26	Teacher, lesbian feminist
2	.72	20	University lecturer,psychologist
	.78	30	Nurse
3	.68	27	General Practitioner
4	.72	22	Factory worker
5	.76	14	Graduate student

* These are the descriptions participants gave of themselves

Table 4.2   Factor scores obtained in Study 1

Item number:	Factors				
	1	2	3	4	5
1	0	+1	+5	-5	-2
2	+2	-3	+1	-2	-3
3	-1	-5	-3	-3	-1
4	-2	+1	-3	0	0
5	+1	-3	+3	+3	+3
6	+1	-3	-3	+5	-1
7	-2	-1	+4	-3	+3
8	-2	-4	+1	-1	-1
9	+3	+3	0	+1	+1
10	-1	-3	-5	-5	0
11	-5	-3	+3	-1	+1
12	-5	-4	-2	-4	-4
13	-1	-1	+4	0	-1
14	-4	-5	-1	-1	-2
15	+2	0	-4	0	-2
16	-4	-4	+2	-2	-1
17	0	-1	0	+1	-2
18	-2	-2	+1	-4	+2
19	+3	+1	0	+4	0
20	-3	0	-2	+1	+2
21	-3	-2	0	-4	+2
22	-2	-4	-1	-2	-3
23	-3	0	-4	-5	-3
24	-3	-1	0	-1	+4
25	+4	+2	+5	+2	+1
26	+3	+2	-1	-2	0
27	+3	+4	0	+3	-2
28	-1	0	+4	-3	+1
29	+5	+1	-5	+3	-3
30	+5	+2	0	-4	-5
31	+2	+4	+5	+3	-2
32	-1	+3	-3	+5	-4
33	+1	+3	0	+3	+5
34	+2	+3	+2	+5	0
35	-5	+1	-4	+2	-4
36	-4	-2	-5	0	+3
37	-1	-5	-4	0	-3
38	+1	-2	+3	+1	+2
39	-3	0	-2	-2	+3
40	+1	-2	-2	0	+2
41	-4	+1	-1	-3	+4
42	0	+5	+3	0	+4
43	+4	+4	+2	+1	-5
44	+3	+5	+2	+4	+5
45	+4	-2	-3	-1	-5
46	0	+4	+1	+4	+5
47	0	-1	+2	+2	0
48	0	0	0	+1	-4
49	+3	0	-3	+4	+3
50	0	+5	0	0	-1
51	+5	+3	-1	+2	0
52	+4	+2	+1	+2	0
53	+1	+2	+4	-3	+1
54	+2	+1	0	-2	-1

was, however, more than just a recognition of structural influences, demonstrated by the strong endorsement of Item 29, which asserts that treating people as mentally ill is a form of social control (= +5). It couched issues relating to health and illness within a radical, 'dominance' model of society, of the kind described by Doyal (1981) and Ehrenreich (1978), in which the poorer health of the disadvantaged is viewed not just as a product of inequality but of oppression.

Consistent with such an analysis, the account was also strongly antagonistic to orthodox medicine. Doctors were seen to have little sympathy with their patients (Item 45 = +4), modern medical 'triumphs' were not seen as major achievements (Item 11 = -5) and modern drugs not seen as effective (Item 36 = -4). Rather, health care was taken to be a social responsibility (Item 25 = +4), and there was rejection of the exclusivity and protectionism of orthodox medicine (Item 16 = -4; Item 14 = -4) including compulsory medical checks (Item 41 = -4).

The written comments made by three of the five women whose Q sorts exemplified this factor (all of whom identified themselves as lesbian feminists) demonstrated that the Q sample did not offer them enough opportunities to express a sufficiently radical viewpoint. For example, in response to Item 23, Participant 26 suggested :

"An item is included on exploiting animals for medical research but no items on exploitation of the 3rd world countries for drug dumping."

However, the most critical statements of these three women were reserved for the inadequacy of the Q sample for expressing their radical feminist perspective. For example, the following suggestions were made :

"My prevailing view at the moment, which I don't feel comes across in the Q sort, is that there are more important (and, for those in power, more threatening) ways in which I can direct my energies than the struggle to maintain my own individual body against the onslaughts of the man-made world and the natural order - especially as this is a battle I'm doomed to loose. Ruling men create a stressful, polluted, noxious environment for me and then try to sell me the notion (along with the equipment) that I can counteract it if I do press-ups and eat brown rice. And if I'm unhealthy it's therefore my fault ! In this context I feel that concern with my individual, personal health is a dangerous indulgence. Also utterly futile as long as I must breathe their air, drink their water, eat their food and walk in their streets ... Also I didn't feel this sort expressed my views on medicine as interventionist and intrusive - causing iatrogenic disease etc. Stuff on childbirth has lots of this (epesiotomy, forceps deliveries, induced labour, etc.). (Participant 23).

"Social responsibility' yes but it mustn't rest solely on womens' shoulders as it has tended to do so far." (in response to Item 25)

"Male medicine often refuses to take women's illness etc. seriously e.g. menstruation pain is merely the grief at the loss of an unborn child, menopause is merely psychosomatic etc." (in response to Item 37)

(Participant 5)

In contrast, one of the other women providing an exemplificatory Q sort for this factor pointed out the lack of coverage of class issues :

"To me the crux is a question of the class struggle ... the exploitation of the working class within a capitalist system." (Participant 17).

Thus Factor 1, because of lack of discrimination within the Q

sample, grouped together two accounts which shared an overall 'dominance' perspective on health and illness, but which differed in their interpretation of the primary source of oppression : patriarchy (for the lesbian feminists) or capitalism. These contrasts are to be found in the literature; Marxist analyses (e.g. Navarro, 1977; Waitzkin, 1981) differing markedly from feminist analyses (e.g. Barrett and Roberts, 1978; Ehrenreich and English, 1978; Graham, 1984).

4.3.2 : Factor 2

The account identified by Factor 2 was far less concerned with 'politics' than that identified by Factor 1. Rather it stressed definition of health as overall physical and mental wellbeing (Item 44 = +5) and offered a broadly psychosomatic perception of aetiology. Item 50, that worry and stress are major health hazards, was accorded +5, and Item 31, that the body has self-healing properties accorded +4. Item 37, that psychological explanations of illness are 'rubbish' was denied strongly with a -5 placement, and Item 8, that many mental illnesses are 'just signs of weakness' placed -4. This account regarded professional medical care (both orthodox and 'alternative') much more favourably than that identified by Factor 1, viewing teamwork between medical professionals as crucial (Item 42 = +5), not seeing doctors as unsympathetic (Item 45 = -2) and decision-making as a common social responsibility (Item 27 = +4).

In contrast to the account identified by Factor 1, this account construed the individual as both responsible for their own health and capable of affecting it through a sensible lifestyle (Item

46 = +4), which doctors were seen to have a duty to encourage (Item 22 = -4). It did not deny structural factors (Item 12 = -4), but did place upon the individual the right and the duty to actively participate in the health-seeking and maintaining process (Item 16 = -4).

The general picture that emerged is one of liberal-humanist, individualist values coupled with a view that illness is as much ´in the mind´ as ´of the body´. The emphasis was on personal responsibility and autonomy, and a view of health as wholistic, a product of both physical and psychological forces contributing - according to circumstances and the individual´s willingness to adopt healthy habits - either to a positive state of wellbeing or to depression, stress-induced and dysfunctional lifestyle-induced ill-health.

Comments from the participants who provided the exemplificatory Q sorts indicated their desire for more coverage of these areas. For example, in terms of psychosomatics :

"I would have liked to have seen much more about the role of psychological factors... e.g. ´Doctors should be encouraged to look for underlying causes for so-called spontaneous recovery´. ´Methods which utilise psychological factors in treatment e.g. imaging, relaxation should be more widely encouraged´. ´There is an intimate relationship between psychological and physical wellbeing.´". (Participant 20).

"There is not really enough about the psychological and emotional influences. For example, with many minor illnesses, often just going to the doctor can make a person feel better. Often what people need is just a little reassurance that their symptoms are nothing to worry about. Once they stop worrying, the symptoms often clear up " (Participant 30).

Participant 30 also wrote, in response to Item 16 about the

responsibility of the individual :

"Quite the opposite ! Patients don't get half enough involved,
they are very passive. I worry a lot about the way people seem to
want medical treatment simply to legitimise their illness. For
example, far too many drugs are prescribed because people need to
feel that the doctor has 'done something' about their illness.
Yet there is a great deal they can usually do themselves. And for
some people illness becomes a way of life. They should be
prepared to look for more functional ways of giving meaning to
their life."

The written comments also made it clear that agreement with a

woman's right to medical treatment from a woman doctor (Item 43 =

+4) was endorsed here for rather different reasons from the

previous account (where it was similarly placed +4). Whereas

that endorsement was presumably within the context of distrust of

male doctors as agents of patriarchy, here the rationale appeared

to be motivated by the focus on psychological aspects. For

example, Participant 30 commented about this item :

"... because the relationship between the doctor and the patient
is crucial to healing and care, obviously patients do better when
they have a doctor they can trust. For some women, this means
having a woman doctor to turn to, often particularly about
gynecological matters, where they feel another woman will have
more understanding and sympathy."

4.3.3 : Factor 3

A number of themes were interwoven within the account identified

by this factor. Most noticeable was strong endorsement for

current medical practice in the NHS (Item 7 = +4). Doctors were

perceived not merely as good diagnosers (Item 1 = +5) and

treaters (Item 15 = -4) of symptoms, with access to particular

expertise (Item 13 = +4), but as humanitarian and caring,

offering reassurance and emotional support more than medicine.

This aspect was elucidated by comments (which were tape recorded

by dictaphone) from Participant 27, the GP whose Q sort

exemplified the factor. In response to Item 25, he said :

&

"Medicine is not about technology but about human caring. Of course a doctor has his(sic) job to do in care of the elderly, but only in the context of supporting the family."

In response to Item 34 :

"I don't like the wording here at all. 'Dispatched' sounds like getting rid of a useless person. It is much more a question of a willingness to overcome our obsession with seeking to cure people regardless of their quality of life. If somebody is suffering with an incurable illness, the doctor should be willing to let them die with dignity if this is what they choose ... The ability to intervene with high technology does not mean that this is the doctor's sole response, we must never forget basic human qualities like compassion and respect ... medicine seems to me to have become far too fascinated with its own technical cleverness."

While this account, like the previous one, incorporated

psychosomatic elements into its explanation of health and illness

(Item 53 = +4; Item 37 = -4) the stress in this case was less

on the the positive benefits of psychological processes (e.g. the

capacity for relaxation techniques to reduce stress) and more

on the negative aspects. Participant 27 again, in response to

Item 53 :

"I really believe that people can die 'of a broken heart' or because they have simply lost the will to live."

In response to Item 37 :

"A lot of illness is worry. People see themselves as ill because their marriage is going badly, or they are overtired, or under stress. Things get on top of them, and they use illness as a way of asking for help or for somebody to take notice."

In response to Item 45 :

"It is sometimes difficult to be sympathetic all the time. People today expect somehow they have a right to be fit and well all the time, and when they get minor symptoms they are convinced that they need antibiotics. Most minor illnesses are self-limiting and would clear up if people simply ignored them. But they get worried about them, and so in the end I often give them what they want to stop them worrying."

This last comment helps to explain the superficial ambiguity between the endorsement of testing new drugs on animals (Item 23 = -4) and yet a rejection of modern drugs (Item 36 = -5) as lacking in efficacy and causing side-effects. Drugs and high technology were seen as appropriate and useful in some, strictly limited situations, and in those cases the best of what modern medical science has to offer should be available. But for the majority of minor illness that a GP sees, all that was assumed to be required was reassurance that the body can heal itself (Item 31 = +5), and that most ordinary illnesses do not need medical intervention (Item 28 = +4).

Finally, this account rejected any political interpretation of medicine (Item 29 = -5), that illness has supernatural causes (Item 10 = -5), or that people have a great deal of choice (Item 35 = -4). Basically, illness was seen as a product of the natural world and the human condition.

4.3.4 : Factor 4

This account contained elements of the 'medical model' view of health and illness in that medicine was seen as a science (Item 6 = +5) and diagnosis as well done by computers as by doctors (Item 1 = -5). It has been included in the results because it is the only account to hint at the biomedical perspective, but I

found the account overall impossible to interpret at this stage, particularly difficult as there was only one exemplar, and the person whose Q sort provided it wrote no comments. I therefore regarded its emergence as encouragement to seek for such an account in the next study rather than as a basis for explicating a ´medical model´ account at this point.

4.3.5 : Factor 5

The account identified by Factor 5 strongly endorsed health education (Item 33 = +5), health promotion (Item 46 = +5), preventive care, compulsory if necessary (Item 41 = +4) and good teamwork (Item 42 = +4). It rejected any politico-economic analyses of inequality (Item 30 = -5), personal choice about a woman doctor (Item 43 = -5) and the notion that health is a human right (Item 32 = -4). It saw medical professionalism as benign (Item 24 = +4, Item 45 = -5). It shared the ´individual responsibility´ theme with the account identified by Factor 2 (e.g. Item 46 = +5), but construed psychological aspects as a lot less salient. Item 50 about worry causing illness was allocated -1 and Participant 14, whose Q sort acted as exemplar for Factor 5, wrote "This is just an excuse". Although Item 37, that too much rubbish is written about psychological aspects of illness, was designated -3, she wrote : "But there is a lot of rubbish !". And in response to Item 35 : "You don´t choose to be bitten by a rabid dog, break your leg or catch a cold"

4.4 DISCUSSION AND CONCLUSIONS

So far the accounts have been referred to by the number of the factor which identified them. Despite the fact that this is somewhat clumsy when writing about them, it is a deliberate policy of many British Q methodologists not to label accounts, as this is seen to over-simplify and reify them in a way that cannot convey their subtlety or complexity. Instead we have adopted a practice of deriving account summaries which are then negotiated with representatives of those people who provided the exemplificatory Q sorts for the factor. North American Q methodologists do use labels (e.g. Stephenson´s term 'bitter-enders´ to describe the first account in his 1963 study of images of public health), and there is a continuing debate between us about this issue. Brown (personal communication), for example, has written :

"I would like to disagree with you about labelling factors, not so as to uphold the idea of labelling itself (a minor matter), but because I think not labelling factors is no defense against essentialism, any more than negotiated summaries are."

This debate continues, but for the time being I have retained the practice of using account summaries. The summaries for the three accounts clearly identified by this study are listed in Figure 4.1. As can be seen, Account 1 is sub-divided into two versions. The reason for this will be described later.

4.4.1 Account sympatricity

What is perhaps most striking about the accounts   is just how diverse were the allocations of items. There were, within the 54 items, only three (Items 25, 31 and 44) which were allocated positive scores within the accounts described by all five

Figure 4.1 : Account Summaries for Study 1

Account 1a

Health and illness in our society must be seen in terms of broad
social, economic and environmental forces. Although everybody's
health suffers from influences like pollution, the poor and
otherwise disadvantaged have little choice about the unhealthy
lives they lead, and the ill health that results. Modern
medicine does little to help; many doctors have little sympathy
with their patients; modern drugs and treatments are often
ineffective; and medical care and diagnosis are often used as
social control. Medicine does not tackle any of the real health
problems people face. Doctors have far too much power, and our
health would be improved if patients gained more autonomy and
control, and many aspects of our lives (e.g. the process of
ageing) which are currently 'medicalised' were to become regarded
as ordinary life experiences, for which society as a whole should
take responsibility.

Account 1b

Health and illness reflect the dominance of the patriarchy in
our society, and of imperialism in the Third World. Although
everybody's health suffers from influences like pollution, women,
forced to live in the stressful, noxious man-made world, have
little choice about the unhealthy lives they lead, and the ill
health that results. Modern medicine is dominated by men who
use their power to construct women as subservient. It dispenses :
unnecessary surgery to 'medicalise' normal processes like
childbirth; harmful drugs to control diseases (like hysteria)
invented to marginalise and trivialise the structural problems
women face; and diagnoses (e.g. of lesbianism as 'sick') as forms
of social control.

Account 2

Good health is far more than the absence of disease; it is a
positive state of wellbeing. People's health or illness are
predominantly a reflection of their psychological state and
particularly the level of stress they have to cope with in their
lives. We can make no clear distinction between 'mental' and
'physical' illness, and treatment needs to be directed at the
'whole person', supporting the body's considerable powers of
self healing, offering both physical remedies and psychological
support. Good teamwork is essential. Individuals should take
responsibility for their own health, and plan their lives to
promote their own health and wellbeing.

Figure 4.1 : Account Summaries for Study 1/cont.

Account 3

Where health and illness are concerned, we cannot differentiate between 'mind' and 'body'. Consequently, diagnosis is far more of an art than a science; illness usually requires good 'care' rather than medical treatment; and the will to live is a major factor in recovery. The body has strong powers of self-healing, and it is often better to let nature take its course than to meddle with self-treatment (e.g. by taking medicines which may have serious side-effects) or run to the doctor with every little ache and pain. We have every reason to be proud of our National Health Service, and are lucky to have doctors who are able to tackle the underlying causes of illness.

Account 4

We are lucky to live in a world of medical excellence, with all the powers that modern medicical science has to cure illnesses that were killers fifty years ago. Good health is both everybody's basic right, and their own responsibility.

Account 5

Health Education enables people to promote a positive state of health and wellbeing, and regular medical check-ups help to prevent illness. Doctors are usually highly competent, and provide expert advice and treatment; but teamwork is essential, medical professionals working together to provide an effective service. Health is not a right, but something you have to work for - rich and poor alike have the   to be healthy if they adopt lifestyles that are health promoting.

factors, and only four (Items 3,12,14 and 22) which were allocated negative scores within all. Stephenson calls these 'consensus items', but I prefer not to use this term, as it implies that similar allocation scores arise from similar interpretations of meaning, an assumption refuted within radical Q theory as essentialist (See Section 3.3.1 in the previous Chapter).

With the remaining 47 items, there was always at least one account in which each one was placed neutrally, or antipathetically to the rest. Often the spread of responses was very wide indeed. For example, Item 1 was placed at both extremes of the Q sort :

	Factors				
	1	2	3	4	5
1. However complex the programming, computers will never be as good at medical diagnosis as doctors.	0	+1	+5	-5	-2

Item 6 was similarly diversely placed, ranging from the 'strongest agree' slot to fairly strong disagreement :

	Factors				
	1	2	3	4	5
6. Medicine is first and foremost a science, and must be based on rigorous scientific principles.	+1	-3	-3	+5	-1

So too Item 29 about medicine as a mechanism for 'social control'. Although this statement was strongly endorsed within Account 1, it was rejected equally strongly by Account 3, with

the rest falling between :

	Factors				
	1	2	3	4	5
29. Treating people as 'mentally ill' is often a means by which society controls those who don't conform.	+5	+1	-5	+3	-3

There was also, just as clearly, no consensus about the 'symapthy' of doctors - Account 1 agreed strongly with the statement they were unsympathetic, whereas all the other accounts rejected this assertion, sometimes strongly :

	Factors				
	1	2	3	4	5
45. The vast majority of doctors have no sympathy with their patients.	+4	-2	-3	-1	-5

But perhaps the item that separated out the five accounts from each other most dramatically was the item about injustice :

	Factors				
	1	2	3	4	5
30. The health of people in our society will only improve overall when we have overcome the injustices between the 'haves' and the 'have-nots'.	+5	+2	0	-4	-5

Recalling that within the Q sorts people had to select just

three items for each of their +5 and -5 placements, the responses to this item demonstrate just how contradictory and varied are the accounts for health and illness that are expressed in the discourses operating within popular culture in Britain today. First, some accounts differ strongly in the way they 'make sense of the world'. Account 1 and Account 5 take opposite positions concerning injustice and inequality. But salience too differs between accounts. Within Account 1 the impact of inequality and disadvantage is perceived as one of the major reasons for ill-health, sufficiently important to be accorded one of just three 'strongly agree' positions in the Q sort. Similarly, within Account 5, one of the three 'strongly disagree' positions were used to reject this idea, suggesting that within this account refuting inequality as an explanation for ill-health is very pertinent. But although they express diametrically opposite evaluations of the item, within both accounts the issue of inequality is perceived as salient. But for Account 3 the neutral allocation of this item suggests that the issue is simply not very important.

No claims are made at this point that all or even most of the competing accounts to be found were identified and described. But despite its explicitly exploratory nature, this initial study did offer convincing evidence for cultural sympatricity. There exists no single, consensual 'popular account' for and about health and illness, but a variety of accounts in which what is salient differs from one to another; and what are taken-for-granted 'truths', or deeply held convictions in one account are refuted as 'untruths' with conviction in others.

4.4.2 Implications for Study 2

As well as demonstrating account sympatricity and begining an account taxonomy, an equally important purpose of the study was to gain information from which to construct a more comprehensive and systematic 'concourse-estimate' as the basis for subsequent, more detailed investigation, and Study 1 did offer considerable guidance for Study 2.

The account identified by Factor 1 raised interesting but difficult research questions. As described in Section 4.3.1, this account was distinguished from the others by the theme which Ehrenreich (1978) has termed the 'cultural critique' of medicine (to distinguish it from the other critique expressed within the 'left', which focusses on inequal distribution of resources, termed by Ehrenreich the political-economic critique). Within such a critique health and illness are construed within the context of power inequalities between dominant and marginal groups :

"(M)odern medical care ... does not consist of the administration by doctors of a group of morally neutral, essentially benign and effective techniques for curing disease and reducing pain and suffering. The techniques themselves are frequently useless, and all too often actually physically harmful. The 'scientific knowledge' of the doctors is sometimes not knowledge at all, but rather social messages (e.g. about the proper behaviour of women) wrapped up in technical language. And above all, both the doctor-patient relationship and the entire strength of the medical services are not mere technical relationships, but social relationships which express and reinforce (often in subtle ways) the social relations of the larger society : e.g. class, racial, sexual and age heirarchy."(p 15)

Even given the limited opportunities within the 54-item Q sample, this critique was clearly identified and expressed, and

articulated in more detail by the open-ended responses. However, it was equally clear that within the account were melded at least two versions : the feminist and the marxist. The feminist critique is predicated upon the assumption that :

"... the taken-for-granted understandings of the world, particularly insofar as they relate to gender and sexuality, rely on a construction of reality which oppresses women." (Kitzinger, 1984, p40).

Marxist analyses, in contrast, focus upon the impact of capitalism. McKinlay (1984), for instance, couched his critique upon a perception of capitalism as a 'predatory' force within Western society :

"... the rapinous activities of large-scale capitalist institutions (mainly banks, insurance companies and industrial corporations): the act of invading, exploiting and ultimately despoiling a field of endeavour - with no necessary commitment to it - in order to seize and carry away an acceptable level of profit." (p 2).

He argued that within such a system, the business of medicine has been rendered a highly desirable source of profit, and in consequence, particularly in North America, predatory organizations have invaded and now dominate 'health care'.

These two worldviews, the feminist and the marxist, do share elements in common (as exemplified by Participant 26's suggestion that issue of exploitation of the Third World for profit had been omitted from the Q sample). However, they differ fundamentally in their interpretation of the forces at work. To the feminists, the predation is that of 'ruling men' who "...create a stressful, polluted and noxious environment for me, and then try to sell me the notion (as well as the equipment) that I can

counteract it if I do press-ups and eat brown rice." (Participant 23). The ´invading, exploiting and despoiling´ are acts perpetrated by men, and the ´polluted, noxious environment´ they have produced is a <u>man</u>-made world. My attempts to negotiate with Participant 23 an account summary which stressed the communality of the ´cultural critique´ was met with rejection - for this woman, only an explicitly feminist analysis would suffice to provide what she saw was an accurate account of her views. But Participant 17 as strenuously denied the feminist analysis. For her the blame could equally well be placed upon women as men :

"That women have played only a small part in the oppression·of the working class reflects, true, that women have been pretty powerless throughout most of history ... but living within a Thatcherite economy, with that --- woman the prime architect of the most strident and vicious form of capitalism we have ever seen, don´t --- talk to me of <u>man</u>-made misery." (expletives deleted).

At this stage I therefore faced a difficult decision. The technical demands of Q sorting limit the number of Q items in a sample. Within these limits, it would heve been difficult to have selected sufficient items to enable these two accounts to be well articulated, pursue the other promising alternatives hinted at by the results (particularly the ´medical model´ and ´health promotion´ accounts), and seek for evidence of additional accounts not discovered by Study 1 (e.g. the politico-economic critique, as described by Ehrenreich, op cit).

Consequently I decided against the possibility of a study like Peritore´s (1986) investigation of the alternative accounts within the discourse of the ´New Left´ in Brazil, restricting my

Q and participant samples to just those issues relating to, and just those people concerned about ideological and political aspects of ´health and illness´. My reasons were threefold. First, I saw the overall objective of this research, at this initial stage, as one of developing a broad account taxonomy, and did not want to become sidetracked into consideration of just one set of issues or forms of understanding. My interest was as much in the processes of and psychological functions of accounting themselves, as in the content of the accounts, and such a diversion would have limited my ability to explore accounting across a range of viewpoints, social and cultural situations, etc...Secondly, I felt that the discriminations between the variants of the ´cultural critique´ were already well documented in the literature, and as a growing field of academic interest, this area was likely to be covered extensively elsewhere.

Most importantly, however, although Q methodology is not intended to provide information about the segmentation of opinion within any population as a whole, I did want the research to offer a basis for a better understanding of popular accounting. While the ´radical critique´ is of great interest within an academic discourse, it is not generally salient within the accounting of ´ordinary people´. Academics do not lack opportunities to express their views, and I did not want to be persuaded to develop the ´cultural critique´ at the cost of denying a voice to others less privileged.

I have devoted space to explaining what is often ´hidden´ within research reports (cf Reason and Rowan, 1981) - the thinking

behind decisions made about what to <u>exclude</u> from study –
because it is a crucial issue for Q as an emancipatory
methodology. Like any other technique, it is not neutral, nor can
it be utilised outside of the power-relations of researcher and
researched. In choosing to study one thing, inevitably the
researcher chooses not to study others. Q has its own
methodological constraints that demand of its user selection of
research questions based upon judgements like the ones I have
described above. The researcher decides what opportunities will
be provided within the Q-sample, and what people to invite to
participate; these inevitably <u>control</u> the accounts that will be
published as the ´results´ of the study. The results are not mere
products of the data obtained, but are products of these
decisions.

My desire to pursue a broadly based account taxonomy meant,
therefore, that I chose to develop a Q sample for Study 2 that
tried to extend opportunities for Accounts 4 and 5 to be better
articulated, to open up opportunities for other kinds of account
(e.g. the political-economic), but most of all, to use it as an
abductory methodology, seeking to discover the unexpected and
unpredictable rather than merely further refine the divisions
within a particular account.

CHAPTER 5 : STUDY 2
A INVESTIGATION OF ACCOUNTING FOR HEALTH AND ILLNESS

5.00 INTRODUCTION

This Chapter describes the second, extended study carried out to identify and describe the alternative accounts for health and illness currently operating in British culture. It was built upon Study 1, employing feedback from it to devise a more comprehensive and representative Q sample. Also modifications were made to improve the administration of the Q sort, to make the task more acceptable to participants, and to gain more detailed additional information to aid the interpretation of factors.

5.1 DERIVATION OF Q SAMPLE

In this study, because of its taxonomic objective, an unstructured rather than a structured Q-sample was appropriate. To ensure that the Q sample was able to offer a wide range of people ample opportunity to express diverse accounts for health and illness, the Q-sample was built upon the results of, and insights gained from Study 1, (including its 'concourse estimate' sources, viewed anew after factor extraction and account interpretation) and by pilot testing.

5.1.1 Derivation of a new 'concourse-estimate'

Of the 54 items in the Q sample for Study 1, thirty nine which had demonstrated the most utility for the expression of different accounts (i.e. been allocated the greatest spread of responses) were retained in the concourse estimate, some worded as before, others rewritten in response to feedback. Further items were added from suggestions made by participants, from the pilot interviews for Study 1, and from the updated research

notebook. By reference to the results of Study 1, a pool of 196 items were selected as a 'concourse estimate' for pilot testing.

5.1.2 Pilot testing of Q sample

The 196 items were typed out and given to seven associates (including other Q researchers, a Lecturer in English Literature, and colleagues and friends who express views different from mine). They were asked to comment on the items for comprehensibility, wording and general 'acceptability' and clarity of the English used; to pick out any items which seemed to them to be strikingly different from the others, or not salient to the topic of health and illness; and then to indicate any that seemed to them to be saying much the same thing.

In this way, the 196 item-pool was reduced considerably in number, excluding items that the pilot-testers saw as 'too similar', of limited salience, or as in some way strikingly outside of the domain of the other items. Stephenson (1953) has stressed the need for Q samples to be homogenous. While, from a social epistemological perspective, this is not something that can be operationally defined, the pilot testing was used to weed out at least the most glaringly irrelevant and anomalous items, to avoid obvious duplication, and to ensure that wording was clear.

Stephenson (1953) asserts that when constructing a Q sample, "... the sample should be balanced with respect to at least one effect" by ensuring that "... for every statement with a

positive assertion or meaning, there can always be chosen another with a negative (meaning)... But mere negations are not recommended." (emphases in the original). Radical Q methodologists do not share Stephenson's conviction that the researcher can, a priori, assess the meaning that will be applied to any statement because different participants are likely to interpret the same statement in different ways. Therefore 'balance' within the Q-sample was based upon asking these people also to sort the items into three piles : agrees, disagrees and ambiguous/don't knows. They were asked to do this for their own opinions, and to personate (cf Semin and Rogers, 1973) the views expressed by their perception of two or three people they knew, with different views from their own. Including my own actual and personating sorts, this provided eight personal sorts and nineteen personated sorts. It was these 3-category sorts that were used to 'balance' the Q sample. The items chosen were those which, for a range of accounts, offered roughly equal numbers of 'agrees' and 'disagrees'. As a result of this procedure, some items were recouched in converse terms.

Via the procedures outlined above, the 196 initial items were reduced to a set of 80 which offered a broadly homologous, comprehensive, non repetitious, clearly expressed and balanced sample. These items are listed in Appendix 5, together with details of the derivation of each item.

5.2 METHOD

5.2.1 Participants

In all 121 people were asked to participate in the study and

sent materials, 74 of whom returned completed Q sorts, of which three were unusable (because the responses were not made according to the response grid) and one was returned too late to be included. Thus the study was based upon the data provided by 70 participants, 26 of whom were men, 42 were women, the remainder not providing information about gender. Their ages ranged from 14 to 63 (the majority in their 30s and 40s), and occupations included students, teachers, lecturers and researchers, administrators, an architect, a social worker, a police officer and an army major. Twenty four were health professionals, including nurses, GPs, hospital doctors, physiotherapists and a dietitian.

The aim was to find as diverse a group as possible, as before, but again also to include a proportion of 'ordinary people'. Thus about half of the participant sample were chosen theoretically, as people who would be expected to express particular kinds of accounts (e.g. in terms of professional expertise and experience, religious affiliation and political views) and about half recruited in a variety of manners to ensure a broad spread of 'ordinary' viewpoints. 'Snowballing' was used, both by seeking contacts from participants in Study 1, and by asking those who had participated in this study to nominate others. A number of participants in Study 1 agreed to take part in this study too.

5.2.2 Materials and Procedure

The materials used in Study 2 were very similar to those used in Study 1, except that : additional instructions were provided (as most participants worked entirely from these); the response

grid was enlarged to accomodate 80 items, with responses ranging from -6 to +6, 13 categories in all; and the instructions for completing the Q sort were amended in response to comments made by participants in Study 1. In particular, participants were given more reassurance about the balance of their responses, and invited to mark off their responses to show where agreement ended and disagreement began. The reason for this was partly to make any imbalance more acceptable, but it also provided additional information for factor interpretation. These new materials are shown in Appendix 6.

In addition to the Q-sort, two additional booklets were provided, each listing all the items with spaces for comment (both identical in form to the comments sheets provided in Study 1, See Appendix 3). Booklet A, with which participants were instructed to begin, was intended to familiarise them with the items, encourage participants to consider them in relation to each other when Q sorting, and provide additional open-ended material to aid factor interpretation. The Q-sort was completed next and finally Booklet C was used to indicate reasons for sorting placements and interpretations made of items regarded as ambiguous. (A full set of experimental materials is available from the author).

5.3 RESULTS

The 70 completed Q sort response grids were coded as before, and subjected to a Q factor analysis (principle components) using SPSS, with varimax rotation. There were twelve factors which had eigenvalues greater than unity. Of these nine contained at least one Q sort with an exemplificatory loading, the criteria used in

this study being loadings >0.60[1]   with no other significant loading (>0.30). Factor Loadings are provided in Appendix 4, a summary of exemplificatory Q sorts in Table 5.1, and factor scores calculated as before in Table 5.2. By examination of the configuration of scores for each factor, the account each one identified can now be interpreted.

5.3.1   The account identified by Factor 1

This account is similar to the account identified by Factor 1 in the previous study, with three of the same participants providing exemplificatory Q sorts, but, with a larger participant pool, an additional four exemplificatory Q sorts, including my own. It is a re-statement of the ´cultural critique´ of medicine (cf Ehrenreich, 1978), indicated by strong endorsement of ´mental illness´ as a form of social control (Item 17 = +5)[2] health as determined by inequality (Item 19 = +6); and the worst off in our society as having very little choice about the unhealthy lives they lead (Item 48 = +5). Two new items increased the stress on a Marxist analysis : capitalism is inherently anti-health (Item 45 = +5) and drug companies are more concerned with profits than making people well (Item 72 = +4). Participant 59 wrote about this item :

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1 : The purpose of factor extraction in Q methodology is to identify the alternative accounts within the data, and this is the pre-eminent criterion against which factors are selected for interpretation. With an 80 item sample, all loadings above 0.30 are _statistically_ significant, which is why a loading of 0.30 on another factor was chosen as the cut-off point for rejecting an exemplar. However, the 0.60 criterion is more arbitary, and was utilised to simplify the task of selecting exemplars. It was used because it was found to provide clear-cut factors which were interpretable. Given that even this stringency nonetheless offers nine factors for consideration, while it excludes other potential accounts which the data may contain, it at least reduced account reporting to manageable levels.

2 : The list of items provided in Appendix 5 is a convenient way of checking against these results. Once more double negatives need careful interpretation.

Table 5.1 Summary of exemplificatory Q sorts, Study 2

Factor	Loading	Participants providing Q sort	
		No.	Description
1	.88	6	Student
	.69	16	Hospital doctor, radiology
	.90	25	Researcher (EF1, Study 1)
	.85	44	Myself
	.67	46	Student
	.84	50	Teacher (EF1, Study 1)
	.79	59	School student
2	.67	52	Secretary
	.69	68	Student
3	.71	48	Nurse
4	.72	27	Dietitian
5	.63	20	Lecturer
	.60	43	Physiotherapist
6	.67	69	Environmental Health Officer
7	.66	37	Social Worker
8	.71	53	Lecturer
9	.69	38	Personnel officer

*EF1 = Exemplar, Factor 1 in previous study.

Table 5.2   Factor scores obtained in Study 2

Item no :	Factors								
	1	2	3	4	5	6	7	8	9
1	-5	+1	-2	0	-6	-5	0	-4	+1
2	+3	0	-4	+1	-1	-2	0	+2	-6
3	-2	-4	+1	+2	+3	-1	0	-2	0
4	-5	-1	-3	-3	+2	-3	-3	-6	-2
5	-1	-4	-1	-2	-4	0	-1	-1	0
6	-6	+1	+1	-2	+6	+3	0	+2	+2
7	-3	-3	-5	+2	-4	-4	-3	0	+3
8	-3	-3	-6	-4	-5	+2	-4	-3	-2
9	+4	0	+2	-1	-3	-2	+1	0	+1
10	+1	+6	+3	+1	+1	-1	+6	0	+1
11	+1	-2	-3	-1	0	-1	+6	0	+2
12	-2	0	+1	0	0	0	+1	-1	+1
13	+3	-1	-3	+2	-4	-4	-5	-2	0
14	-6	+1	0	+3	-2	-4	-2	-3	-3
15	-5	+5	0	-1	+1	-5	-1	-5	0
16	+5	+4	+2	-3	0	+5	+1	+3	+6
17	+5	-5	0	-2	-4	0	+5	+3	-5
18	-2	+5	-1	+2	+4	-1	-5	0	0
19	+6	-5	+6	+1	-2	+5	+1	+6	-3
20	+1	+3	+5	+6	0	-1	+2	+1	+2
21	+1	+2	+6	+1	-3	+6	-1	+5	0
22	-3	+5	+2	+2	+5	+3	+4	+2	+2
23	+2	+4	+1	+4	+6	+1	-5	+6	0
24	0	0	+4	+2	+1	0	+6	+5	+1
25	+3	+6	+4	-1	+2	0	+2	-1	+1
26	-5	+3	+1	0	-5	0	+1	0	-3
27	+1	+2	+6	-1	+2	-2	+5	0	+2
28	0	-4	0	-2	-3	+1	+5	+1	-2
29	+3	0	-2	-3	+2	-1	+1	-6	0
30	+1	+6	+1	+5	+1	+3	+3	+3	+3
31	-2	+4	0	+1	-4	-3	-4	-2	-4
32	+2	-6	-2	-5	-5	+6	+1	+5	-6
33	-1	+1	-1	-6	-3	-5	-6	+6	-1
34	-1	-1	0	-2	-1	-1	+2	-1	-3
35	+4	-3	-5	-5	-3	-1	-2	-1	-2
36	-2	+3	0	+3	+1	-2	0	-3	+3
37	-4	-5	-4	-5	-1	-4	-2	+4	-2
38	-1	+1	-2	+1	-1	0	-2	-4	-1
39	-1	-4	+2	+1	+4	0	-3	-3	+3
40	-3	-2	-4	-6	-4	-4	-5	+4	0

Table 5.2 Factor scores obtained in Study 2/ cont.

Item no.	Factors								
	1	2	3	4	5	6	7	8	9
41	0	0	0	+2	+6	+1	+4	+1	+4
42	+4	+5	+3	0	+3	+5	+2	+5	0
43	+6	+1	+2	+4	-1	-3	-1	-3	+2
44	-2	+3	+3	+3	+5	+2	+3	0	-1
45	+5	-6	-1	0	-1	+5	-3	+1	-5
46	0	0	-5	0	-2	-3	-1	-3	-4
47	-2	-1	+5	+4	+5	-6	-2	+1	+6
48	+5	-2	+4	+3	-4	+5	+2	+1	-5
49	0	-1	-2	+4	0	+4	-1	-1	-1
50	-4	-6	-6	-6	-6	-6	-6	-5	-4
51	0	-2	-1	-3	-1	-2	-6	+2	-1
52	-1	-1	-3	-4	0	0	0	+2	-5
53	+2	+1	-5	-1	+1	+5	-1	-4	-2
54	+3	-2	-2	0	+2	+1	+3	-1	+4
55	+2	+2	+5	0	+3	+1	+3	+3	+3
56	+1	+3	-1	+5	0	-3	-3	0	-2
57	+3	0	-3	-3	0	+2	0	+2	-4
58	+4	-2	+1	0	-1	+4	+3	+1	-2
59	-6	+1	+4	0	+4	+2	+5	-4	-1
60	-1	-2	-1	-1	+1	+4	0	-1	-1
61	0	-1	-1	+5	+3	+6	+1	+4	+5
62	+3	-1	+3	0	-2	+3	0	+1	-4
63	-4	-3	-4	-3	-3	-3	-1	0	+1
64	0	-1	-1	-2	0	0	+3	+2	+4
65	-4	+2	+3	+5	-2	+3	+4	0	+5
66	-4	0	-4	-4	-2	+2	-4	-4	+5
67	-3	-5	-6	-4	-6	-6	-1	-2	+1
68	+2	-1	+2	-1	+3	+3	-2	+4	0
69	-3	-3	-2	-3	-2	0	+2	+3	+2
70	+2	+3	+4	+6	+2	+2	-2	-2	-3
71	+2	+2	+2	+3	0	0	+4	-1	+3
72	+4	-1	+1	-1	+4	-1	+4	+1	0
73	0	0	0	-4	+1	-3	-3	-5	+4
74	+1	+2	+1	+4	+3	+1	0	-2	+1
75	-4	+4	-1	-5	-1	-2	0	0	-1
76	-1	+2	-3	+6	+1	+1	0	-2	+6
77	+2	+4	+3	+3	+5	+1	-4	+3	+5
78	0	-3	0	-4	-5	-5	-4	-5	-5
79	-1	-4	0	+1	+4	+2	-3	-6	-3
80	+6	+1	+5	+1	+2	+3	+2	+4	+4

"Yes, Doctors are bribed to prescribe more brand named drugs by companies offering incentives - e.g. holidays, etc. "

However, comments again stressed that the Q sample was ethnocentric in its omission of the impact of exploitation upon, say, Third World Countries. For example, in response to Item 45 (about the relatively greater importance of public health measures) Participant 6 made it clear that this was only true "...in the West" and this additional item was suggested by Participant 16 :

"... something on the cost of developing Western medicine in terms of the suffering and death of Third World peoples (e.g. dumping of contraceptives, ... baby milk powder.)."

As before, there was rejection of the supposed benefits of modern medicine, described more fully with the increased item sample. Within account 1, modern therapeutic achievements (Item 6 = -6), medical 'excellence' (Item 44 = -2), and modern drugs (Item 22 = -3) make limited contributions to health. Medical science is unlikely to ever eradicate disease (Item 63 = -4), and many forms of treatment do more harm than good (Item 13 = +3). Doctors often treat symptoms, not the underlying causes of illness (Item 9 = +4) and frequently recommend surgery when it is not really necessary (Item 14 = -6). Going to the doctor is not something that will make you feel better (Item 26 = -5), indeed Participant 6 crossed out 'better' and substituted 'worse' ! Doctors should not 'play God' by expecting unthinking compliance (Item 1 = -5), threatening disease as retribution for non compliance (Item 75 = -4) and deciding whether, and under what conditions people should be given accurate information (Item 15 = -5). A good health service is one which respects people's

autonomy even if that puts people at risk (Item 54 = +3).

In the comments, particularly, it is clear that the account is not just about the way doctors exploit and misuse their professional power. It is couched in the context of a much more general theory of the relationship between the relatively powerless individual and powerful hegemonies of many kinds. For example, in response to Item 2, about bodily decay being inevitable, and anybody who tells you different being a liar or a fool, Participant 6 wrote :

"The second half of the sentence adds a different dimension. Agree with first half, but not second. People who tell me otherwise (e.g. promise me eternal youth) are not fools or, primarily, liars, but exploiters and oppressors."

Participant 25 made a general point in response to Item 10, about health being to do with state of mind :

"Feel uncomfortable with all these 'mental' items (Nos 24 and 30 too). Resent anyone daring to interfere with or make assumptions about my state of mind. Doctors already claim the right to administer judgements about my body; that's enough. Keep them off my mind."

Provided with opportunities within the Q sample this account now also stresses a social constructionist analysis : the experience of 'being ill' is learned (Item 29 = +3), and doctors to some extent invent diseases rather than merely 'discover' them (Item 35 = +4). Examples suggested were "Pre-menstrual tension, frigidity, vaginismus, failure to achieve vaginal orgasm and post-natal depression" (Participant 6) and "anorexia, alcoholism and drug addiction" (Participant 16).

From the written comments it is clear once more that for three of

the people providing exemplificatory Q sorts (: two   women who

provided exemplificatory Q sorts for account 1 in Study 1 plus

Participant 6. .) found limitations in the Q sample frustrated

their radical feminist analysis, and again they commented that

the Q statements did not offer them sufficient opportunity to

make their views explicit. Participant 25 argued that she had

been denied the opportunity to express a radical feminist account

because of the Q sample´s " focus on class (and capitalism) not

gender (and patriarchy) as a significant division in health

care.".

Once more, this feminist analysis contrasts with that which

asserts forces other than patriarchy as the creators and

perpetrators of exploitation and oppression, as demonstrated by

the comments of Participants 16,46 and 59 :

"... lobbied by those with the money to bribe the politicians...
and medicine, like parliament, is an ´old boys club´ serving its
own interests rather than those of patients, and keeping
promotion for members of the medical-mafia" (Participant 16, in
response to Item 58)

"... health care is increasingly becoming dominated by the firms
who market the equipment and drugs ... the NHS is increasingly
squeezed for funds by their greed." (Participant 46 , in response
to Item 72)

"...people who live in dreadful housing, who work long hours and
who cannot afford to feed themselves or their children properly
don´t stand a chance." (Participant 59, in response to Item 19)

While Participants 16, 46 and 59   agreed that women experience

oppression, the version of account 1 expressed by them

frequently mentioned other groups who they saw as equally

disadvantaged, including the poor, ethnic minorities and the old.

Item 17 provides a good illustration of the division. All of

participants who provided exemplificatory Q sorts for Factor 1

allocated this item +5 or +6. But it is clear that even <u>within</u>

a single account, interpretation of meaning can differ. The

self-defined radical feminists wrote comments against Item 17

like "...for all of us, lesbianism is the prime example."

(Participant 25). But the other participants wrote :

"Yes, medicine pathologises and controls. In Russia it is
dissidents who get thrown into mental hospitals, but even in
Britain there is a long history of using the label 'mad' for
people who are often just misfits, and soporifics used to damp
down unacceptable behaviour. A good example is their use in
Mental Handicap Hospitals to prevent masturbation." (Participant
16).

"Academics and particularly clinicians call behaviour
'dysfunctional' when what they mean is that it does not fit the
norms of what is socially acceptable. Those who don't conform are
labelled 'mad' or 'delinquent'." (Participant 46)

"At school you are called a 'loony' if you are the least bit
different." (Participant 59)

Overall, what brings these two versions together within a single

account is the challenge presented to taken-for-granted values of

individual self-sufficiency and personal choice, and the view

that being ill or healthy is largely to do with factors other

than medicine - adequate food, better housing and proper drains

have done more to improve our health than all the medical

discoveries of the last 100 years (Item 43 = +6). The major

causes of sickness and premature death are social, economic and

political disadvantage and the disease provoking physical and

social environment. Once more what distinguishes the two versions

is disagreement about the most important social forces at work.

For the radical feminists it is patriarchy which has created an

unhealthy physical (i.e. polluted) and social (i.e. oppressive

and exploitative of women) world. For the rest, patriarchy is just one among many forces, along with capitalism, class conflict and professional self-interest.

5.3.2 The account identified by Factor 2

Whereas Account 1 is sited almost entirely within the social domain, the account identified by Factor 2 is sited almost entirely within the personal and interpersonal. It is an account for health and illness which focusses upon what goes on within the individual, and like Account 2 in Study 1, offers a psychosomatic model in which the body's biological functioning (e.g. its self healing properties, Item 20 = +3) and its psychological functioning (e.g. state of mind aiding recovery, Item 30 = +6) both play important parts. Indeed, comments from participants who provided exemplificatory Q sorts are peppered with psychodynamic terms. Participant 68, offered several good examples. She wrote about Item 50 (illness is a punishment for misdeeds) :

"No, never, but if someone believes this, they may inflict it upon themselves subconsciously"

She explained her rejection of Item 40 (feeling to blame for illness) in Booklet C with the comment :

"This I found a strange concept (Because I believe that the 'desire' to be ill is not a conscious one).

And she explained her endorsement of Item 56 (that faith-healing can cure) with :

"Interpreted as the healing being a subconscious self-healing

brought about by belief in the faith-healer."

Participant 52 commented in similar vein :

"Only when the cure needs to be psychological and only physical cures or not the right ´mental cure´ have been tried."

This construal of the body as a self-adjusting biological system affected by psychodynamic forces leads to a very different perception of medical care from that portrayed by Account 1. There are similarities in that within both accounts minor illnesses are often best left to ´nature´ (Item 70: Factor 1 = +2, Factor 2 = +3), and giving birth is not illness, but a natural process (Item 25: Factor 1 = +3, Factor 2 = +6). But within Account 2 (in contrast to Account 1) modern drugs make a major contribution to health (Item 22 = +5) and medical excellence is of benefit (Item 44 = +3). It also strongly endorses the idea that health and illness are products of both bodily and mental functioning (Item 10 = +6), that state of mind can aid recovery (Item 30 = +6), and less strongly the desirability of seeing illness as a ´challenge´ (Item 36 = +3) and that researchers should look for the underlying causes of so-called spontaneous recovery (Item 71 = +2). Negative effects of ´state of mind´ are also important, evidenced by endorsement of the idea that illness can become a ´way of life´ (Item 18 = +5) and that it is quite possible for people to die of a ´broken heart´ (Item 31 = +4). Thus whereas Account 1 specifically denies many of these ideas because they ´pass the buck´ to individual responsibility, Account 2 accepts them because they do hold the individual responsible.

Another contrast is the interpretation of Item 16 about stress and pollution, which both accounts accept as strong influences upon health (Factor 1 = +5, Factor 2 = +4). For Account 1 it is (man-made) pollution and the stress of living "as a woman in a man's world" or of being a member of an exploited and oppressed group in society that is to blame. For Account 2, the emphasis is upon stress as a psychodynamic force :

"Yes, the stress of modern life has a lot to answer for, where many people let themselves get run down in the constant hurry and seeking after consumer goodies." (Participant 52).

"True - particularly stress" (Participant 68).

Similarly, Account 2 endorses the idea that people who suffer from 'depression' are often just responding to the intolerable pressures and problems of their lives (Item 42 = +5) because of its 'stress-potential':

"... and not just in layman's(sic) terms of feeling 'fed up', worry and unhappiness do affect the body, and can lead to reactive clinical depression" (Participant 68).

It is therefore not surprising, that from the construal of Account 2 medical care is seen as an 'art' more than a science (Item 3 = -4) and technical expertise seen as less important in a doctor than personal qualities (Item 79 = -4).

Constitutional determination of health is rejected (Item 5 = -4), and so too is luck (Item 7 = -3, Item 67 = -5). Rather, good health is to some extent a product of 'taking care of yourself' (Item 74 = +2) : by eating well (Item 55 = +2), and preventive measures like inoculations (Item 65 = +2) and fluoridation of the water supply (Item 76 = +2). However, again and again in the

comments, ´state of mind´ was stressed as what really mattered.

For example, Participant 68 commented :

"Of course they are eventually, but this question implies a somewhat surrendering attitude." (about Item 2, disease and decay being inevitable.)

"Often it can also be a reflection of the emotional or mental state of the person." (about Item 7, illness is a result of bad luck).

"Illness is not the ´natural´ state, therefore health has to do with positive thinking." (about item 27, health is a positive state of wellbeing.)

"This is why some people may be better off after being told of their serious illness, so they can ´switch on´ the will to live and think positively." (about Item 30, the ´will to live´. a significant factor in recovery.)

There is, then, within this account a portrayal of health as a

´resource´ (a schematization identified by both Herzlich, 1973

and Williams, 1986 a) which can either be ´squandered´ or

´mobilised´. That this construal is pre-eminently one of health

and illness under the control of the individual is further

evidenced in two ways. First, there were surprisingly similar

comments from Participants 52 and 68 about Item 33, about other

people being unpleasant ´making me ill´ :

"... I can see it might affect someone´s state of mind." (Participant 52).

"Indirectly yes - but only if one let´s it get one down mentally." (Participant 68)

Thus it is not the unpleasantness of other people, per se, that

causes illness, but the effect that this has upon the individual.

The second indication that health and illness are matters of the

individual, not social forces, is the emphatic refutal of any political dimension to health, both in the Q sort selections and the comments written about the items. For example, Item 17 (about the label of 'mentally ill' used for social control) is allocated -5 and engendered the following comments :

Participant 52 : "Not in this country.".
Participant 68 : "Russia Only !"

Item 19, that we will only improve the overall health of people in the world when we have found ways to overcome the fundamental injustices between rich and poor, was also allocated -5 and the following comments were written :

"I find this term 'injustices' makes this a nonsense. Poverty is not an injustice." (Participant 52)

"I totally disagree, this is complete rubbish." (Participant 68)

Also Item 48, that the worst off in our society have very little choice about the unhealthy lives they lead, was allocated -2, and drew the following comments :

"Even the poorest people have a lot they can do for themselves." (Participant 52)

Participant 68 : "False, almost everyone can be clean."

But the strongest rejection was reserved for the most politically overt items, such as Item 32, which suggests that as doctors are committed to preserve life, they have a moral duty to support Nuclear Disarmament (allocated -6). The written comments were :

Participant 52 : "No, as some would say that through disarmament more may die through conventional warfare."

Participant 68 : "Rubbish. Politics has nothing to do with it. Doctors have personal lives and ideals - are not doctors all the time."

And similarly, a rejection (Item 45 = -5) of the idea that

Capitalism is inherently anti-health :

Participant 68 : "Political rubbish. Must have come out of a communist manifesto."

This account, then, appears to be a more articulated version of Account 2 in the previous study, paralleling its stress on a psychosomatic model of health and illness, its focus on the individual as ´in control´ and liberal-humanistic values that refute any kind of politico-economic explanation of illness as a product of poverty, or ´cultural critique´ explanation of illness as the socially constructed outcome of oppression and exploitation.

However, although it sites the ´arena of operation´ within the individual, it is not a classic ´internal control´ (cf Rotter, 1966) account for health and illness, as has been incorporated. within the ´Health Locus of Control Scale´ (cf Wallston and Wallston, 1981). Although the individual´s actions and lifestyle are accorded salience as influences over health and illness, it is the individual´s ´self-control´ or ´state of mind´ which is construed as the major determinant.

It would be wrong, therefore to regard Account 1 and Account 2 as polar opposites (indeed, if they had been no more than that, they

would have been identified by stong positive and negative loadings upon a single factor) even though they contrast very markedly. Both in their different ways portray the individual as purposive and actively striving to resist external forces upon them. Where the main differences lie are in their contrasting perception of how much <u>actual</u> control the individual has over their health and illness, and what it is they are fighting against. Within Account 2 a person's power is seen as great – however poor, or disadvantaged they are materially, they can mobilise their 'inner resources' to wage battle against the (largely naturally occurring) sources of ill-health. Within Account 1, people have very limited powers to fight the person-made (or in the case of the radical feminists, specifically man-made) sources of illness that beset them.

5.3.3 The account identified by Factor 3

Only one person's Q sort was an exemplar for this factor, participant 48, a nurse. The account, unlike the previous two, focusses on health rather than illness, and is predicated on health as a fundamental human right (Item 21 = +6), a positive state of wellbeing (Item 27 = +6) and 'one of the most important things in life' (Item 47 = +5). Within this account health is not a matter of luck (Item 7 = -4, Item 67 = -5); disease and bodily decay are not inevitable (Item 2 = -4). Health promotion has not become just another fashion (Item 53 = -5) but an important means of improving health. Participant 48 commented :

"Though it is in itself a dangerous statement, which devalues the notion of seeking after health by one's own actions, whilst a little of me agrees - I'm unhappy that people are being led to feel you need expensive clothes to take exercise."

She commented on several occasions about "... one's own behaviour" or "one's own actions" being crucial for health, clearly indicating in her comments that at the basis of her explanation for health and illness is a conviction that it is an individual's own behaviour and lifestyle that are the major determinants of good health. As an example, Item 46 (that life is 'too short and too sweet' to spend too much time worrying about health, placed -5) she wrote :

" This is rubbish. It implies that living healthily is boring and miserable, when the opposite is true. Eating well and taking exercise are not just good for you, they are enjoyable - and feeling fit (which you can only do if you live a healthy lifestyle) is to be able to enjoy life to the full."

However, while this is an attribution of 'internal control' (as defined by the Health Locus of Control Scale, cf Wallston and Wallston, op cit) this account is not 'individualistic'. Participant 48 made the point specifically, explaining in Booklet C that she placed Item 61 (about taking responsibility) in the -1 category "...because health education is crucial, and not everybody is well enough informed ". But it is clear that given the benefits of opportunity and knowledge, within this account health can be improved by such things as diet (Item 55 = +5, Item 68 = +2).

The account is clearly concerned with the inequalities in health between rich and poor (Item 19 = +6), and the poorest having little choice about their health (Item 48 = +4). Indeed the participant directly refers to the impact of social disadvantage, although her stress is on education rather than structural inequality:

"The inequalities in health between those in Social Classes I and II and those in ... Classes IV and V are scandalous. Health ... is strongly linked to education - the more years of schooling a mother has had, the healthier her children are likely to be."

This account, certainly as expressed by the woman who provided the exemplificatory Q sort, is clearly informed by the writings of the Health Education Council. For instance, commenting on her endorsement of Item 58 with a +1 allocation (Government cares more for tobacco tax revenues than health), she said :

"The HEC has almost no funds for anti-smoking advertising compared with the tobacco companies".

And in response to Item 62 (The Government has suppressed information about food = +3) she commented :

"Yes, the reports produced by the HEC are being put under pressure by lobbying from the Food Industry".

The account contains clear concern about environmental causes of illness (Item 80 = +5) although item 16 (the effects of stress and pollution) is only allocated +2 because :

"It's too easy just to blame stress and the environment, when there is a lot you can do - excuses don't help people to strive for themselves."

There is guarded approval of modern medicine, including its therapeutic advances (Item 6 = +1) and the benefits of modern drugs (Item 22 = +2); the idea that treatment often does more harm than good refuted (Item 13 = -3). That individual health-promoting behaviour needs the support of proper medical services is evidenced by the rejection of sports facilities as more useful than hospitals (Item 11 = -3) "...this being a

cop-out for providing good health care".

Overall, then, this is an account sited squarely within the 'health promotion' discourse, stressing the benefits of health education and individual action and lifestyle while valuing personal autonomy, and concerned about inequality in a world in which health is as a fundamental right denied to many by their own ignorance, contraints of the lives they lead and cuts in medical services. It is critical of Government, seeing it as swayed by the powerful interests of 'Big Business' and its shift to monetarism resulting in reduced medical care, but it is very much less concerned with oppression and exploitation than Account 1, less concerned with medical hegemony, and more willing to accept the benefits of orthodox medical care. It thus falls between Account 1's siting of control over health and illness almost entirely within society, and Account 2's siting of control almost entirely within 'self-control'; both the personal and the social are involved, with the amount of self-determination an individual is able to mobilise a product of their education and resources and the quality of service available to them.

5.3.4 The account identified by Factor 4

Once more this account was exemplified by the Q sort of just one person, Participant 27, a dietitian. It focusses upon the biology of health and illness and construes the body's self-healing properties as crucial (Item 20 = +6), and 'letting nature take its course' (Item 70 = +6) the best response to minor

illness. Disease organisms play an important role, evidenced, for example, by comments made in response to Item 43 (about public health measures having contributed more to improvements in health than medical discoveries = +4) :

"Yes, although it depends what discoveries you mean. Insulin, for example, and kidney machines save many lives, as have the drugs like antibiotics that are real 'magic bullets' against some of the major killers."

Other aspects of this account concerned with the biological origins of ill-health were repeated mentions of the damaging effects of substances such as tobacco, asbestos and particularly food additives. Not surprisingly, given that Participant 27 is a dietitian, food is seen as very important to health (Item 55 = +5) even mental health. For instance, she commented about Item 4 (that mental illness are forms of weakness):

"More likely to be the product of stressful environment, biochemical imbalance, food intolerance /allergy, vitamin/mineral deficiencies."

This biological model of aetiology is consistent with this account accepting, unlike all but one of the other accounts (See Table 5.2), that illness is sometimes no more than a matter of 'bad luck' (Item 7 = +2). Health is not just a matter of luck, though :

"But if nutritional status good, this will go a long way to giving protection from colds, cancer, heart disease and organ malfunction. However difficult for me to determine the case re infectious diseases, insect bites and the like."

However, despite the stress on infection, the account does not present medicine as a panacea, with therapeutic achievements denied (Item 6 = -2), and treatment as sometimes doing more harm

than good (Item 13 = +2), though some modern drugs are effective (Item 22 = +2). A clear distinction is made in Participant 27´s comments :

"Antibiotics can, if used properly, do wonders. But doctors take far too little notice of the side-effects of many drugs, and often misuse drugs as palliatives when the root problem needs tackling in a different way e.g. modifying diet."

Medicine is, at best, a palliative against damage once it has been done, and one which is only effective in limited circumstances, indicated by the -5 allocation given to Item 75, that a lot of health problems are caused by people not following their course of treatment properly. Rather than rely on doctors to patch people up when they become ill, it is up to the individual to prevent illness from occurring. People should take responsibility for their own health, (Item 61 = +5), be ´moderate´ in their habits (Item 49 = +4); make use of preventive measures like inoculations (Item 65 = +5). Indeed, the comments made are quite explicit about the need to protect health by sensible behaviour - for example, obesity is not an illness (Item 66 = -4) but a lack of self-control :

"Obese people are not ill, they are those with poor eating habits. They should not be ´treated´ but rather re-educated.".

However, the account strongly denies any personal guilt for ill-health (Item 40 = -6), or that illness is a form of weakness (Item 37 = -5). The account also asserts that it is wrong and counter-productive to worry about ill-health too much. Participant 27 wrote in response to Item 38 (health is an absence of symptoms) :

"Not good to worry about one´s body. Tendency to worry about

bodily appearence worry about body - aches and pains or appearance.".

When the themes of biological mechanisms and moral culpability are brought together, what seems to emerge is an image of the body almost as a kind of warrior, beset by bugs and toxins against which it has to build up defences and fight. Staying healthy is a constant battle against a variety of forces, which must be waged by sensible defensive actions (e.g. inoculations), sensible precautions (not smoking, and having a good diet) and perhaps most importantly, by not 'giving in' to worry or the temptations of the sick role. Curative medicine, while a source of after-the-event palliatives and preventive measures, can be dangerous, not just because it causes iatrogenic disease, but because it beguiles people into a false sense of being 'let off the hook' and not needing to care for themselves.

This then, is an account which is founded on a belief in individualistic 'internal control' as is Account 2. However, it differs from Account 2 in three critical aspects. First, it sees the individual as 'in control' by way of their actions rather than their mental state. Second, whereas Account 2 gave strong impressions of internality as 'what is' (i.e. an attribution of causality), Account 4 implies internality as 'what should be' (i.e. a proscriptive formulation). Finally, it stresses prevention rather than treatment of illness, and in particular the preventive actions taken by individuals to protect their own health rather than relying on medical intervention.

5.3.5 The account identified by Factor 5

Unfortunately, although two participants provided exemplificatory Q sorts, for this factor, only one (Participant 43) sent in comments. It is the account among all nine which most strongly and consistently supports biomedicine. Within this account, modern therapeutic achievements have made major contributions to health care (Item 6 = +6), and modern drugs to fighting disease (Item 22 = +5). We are fortunate to live in a world of medical excellence (Item 44 = +5), doctors do not just treat symptoms (Item 9 = -3) and medical treatment does not do more harm than good (Item 13 = -4), against which Participant 43 wrote :

"No, proper medicine is still the best if you have something seriously wrong with you."

Of all the accounts it is the one which regards medicine most as a science (Item 3 = +3), stressing the technological expertise of doctors (Item 79 = +4) not 'bedside manner' (Item 25 = -5). It is noticeable that this account does not (as all but one of the other accounts do) construe the body's defences as important (Item 20 = 0), although there is mild endorsement for letting nature take its course with minor illnesses (Item 70 = +2).

However, the account also stresses personal responsibility (Item 61 = +3), health in adulthood depending upon building up a robust constitution when young (Item 39 = +4), and more care in adulthood able to prevent many of the illnesses of old age (Item 74 = +3). Many people suffer from illnesses caused by their own bad habits (Item 41 = +6) and the worst off in our society do have choice about the unhealthy lives they lead (Item 48 = -4).

Participant 43's comments were :

"Yes health is linked to way of life and money but some people can never be educated into health care no matter how well off." (about Item 19).

"But we have the responsibility to maintain our own health. Some people feel it up to others to make them healthy." (about Item 21).

"Education helps but people have a choice, they may not use the knowledge to their advantage." (about Item 48).

The following additional item was suggested :

"Some people don't want to participate in their treatment, they should be educated to the contrary."

However, responsibility involves making your own decisions :

When it comes to medical treatment patients should not be

expected to follow their doctor's orders (Item 1 = -6). The

comment added here was :

"Patients should decide if the advice is in their best interests."

Similarly with regard to . inoculations (Item 65 = -2) Participant

43 commented :

"The patient should assess the risks involved and decide accordingly."

And the following item was suggested as another addition :

"Doctors should explain the aims of treatment more to patients to ensure their co-operation."

Overall the flavour is one of frustration; modern medicine has a

lot to offer, and there is a great deal of sound scientific

knowledge available to inform us about how to look after

ourselves. But there are a lot of people around who are either too ill-educated to take notice, or are stubborn, and won't do what's best for themselves. People should draw upon medical advice and technical skill, but ultimately the buck rests with the individual, and each of us must decide for ourselves about health care, treatment and lifestyle. This account has parallels with Account 4 in the previous study, in its support for modern medicine, but adds a sense of annoyance that given its benefits, many people take little heed of the advice offered by medical professionals, and often expect others to 'make them well' or make decisions for them rather than taking the responsibility for themselves. It also shows some similarities to Account 4 in this study, in its stress upon the individual's duty to take care of themselves, but takes a less sympathetic view of people who do not. However, whereas Account 4 in this study stresses prevention and the body's self-healing capabilities, Account 5 sees the individual as needing to use the resources biomedicine has to offer.

5.3.6 The account identified by Factor 6

According to this account, ill-health is a product of the injustices between rich and poor (Item 19 = +5), capitalism is inherently anti-health (Item 45 = +5) and the worst off have little choice about the unhealthy lives they lead (Item 48 = +5). The Government is more concerned with tobacco revenues than people's health (Item 58 = +4), information about improving diet has been suppressed because of lobbying by the food industry (Item 62 = +3) and health foods and jogging suits are just more ways to persuade people to spend money (Item 53 = +5). Although

in these respects it parallels the 'cultural critique' of Account 1, it is much closer overall to the critique Ehrenreich (op cit) labelled the politico-economic. It construes health as a fundamental human right (Item 21 = +6) and agrees that doctors have a moral duty to support nuclear disarmament (Item 32 = +6), statements which Account 1 regards as naive.

It is when responses to modern medicine are compared between Accounts 1 and 6, however, that the distinction between the 'cultural' and politico-economic critiques is most apparent :

	Factors	
	1	6
6. Modern therapeutic achievements (like heart transplants) are important contributions to progress in health care.	-6	+3
8. Fringe medicine is a dangerous intrusion on proper health care.	-3	+2
13. Many forms of medical treatment today seem to do more harm than good.	+3	-4
17. Treating people as 'mentally ill' is often a means by which society controls those who don't conform.	+5	0
22. Modern drugs have made a major contribution to fighting disease.	-3	+3
43. Adequate food, better housing and proper drains have done more to improve our health than all the medical discoveries of the last 100 years.	+6	-3
44. We are fortunate to live in a world of medical excellence - skilled surgery, highly trained professional care etc.	-2	+2

While Account 1 is critical of modern medicine, Account 2 accepts it as a benign and effective response to ill-health. Thus

whereas the 'cultural critique' of Account 1 perceives of medicine as a socially constructed institution of hegemonic power, Account 6 distinguishes between, on the one hand, the power heirarchy and self-servingness of the State within a capitalist system, and on the other, the practice of healing as an inequitably allocated but essentially benign resource.

However, Account 6 also introduces a more 'personal' element into the 'political' discourse described by Ehrenreich. As with Account 4, Account 6 uses several of the stronger 'disagree' allocations in the Q sort to deny personal blame for ill health (Item 40 = -4), that illness is weakness (Item 37 = -4), or that illness can be a response to unpleasantness (Item 33 = -5). Together with several comments (e.g. in response to Item 4 about mental illnesses being no more than 'weakness', beside which Participant 69 wrote "Mental illness is not just hypochondria").

In combination, then, Account 6 (like Account 3) operates within the domains of the social and the individual, expressing a politico-economic analysis of ill-health as the product of social disadvantage and the inequitable distribution of the benefits of modern medicine, a perception of illness as 'real' rather than socially constructed, and a denial of self-blame for any ill health that may occur.

5.3.7 The account identified by Factor 7

This account, exemplified by the Q sort of Participant 37, emphasises the psychological aspects of health and illness. Being

fit and well depends as much on 'state of mind' as on the functioning of the body (Item 10 = +6), treatment that uses 'therapy of the mind' should be used much more widely (Item 24 = +6). Participant 37's comments also repeatedly took up this theme :

"Yes, but more room should be made for psychological and social understanding of treatment." (about Item 3).

"Doctors and practitioners need some psychological training and training in social problems" (about Item 9).

"Often going to the doctor and easing your mind can make you feel better." (about Item 26).

"I believe that it could be a state of mind leading to a deterioration physically." (about Item 31).

"Yes I believe a positive attitude aids recovery." (about Item 36).

"And having a happy healthy state of mind". (about Item 47).

She suggested the following additions :

"Doctors should have more psychiatric and psychological training."

"Doctors cannot understand the social problems underlying some mental illnesses unless they have actually worked in the community."

Overall this account portrays modern medicine as a support system a person can use to relieve painful symptoms and tackle infection; but feels that the medical profession does not sufficiently understand the psychological and social factors seen as very important in causing and exacerbating illness.

5.3.8   The account identified by Factor 8

This account expresses similar 'political' values to Account 6 :
improved health depends on resolving social injustice (Item 19 =
+6), good health is a fundamental human right (Item 21 = +5) and
doctors have a moral duty to support nuclear disarmament (Item
32 = +5). It also expresses similar (though less strong)
approval of modern medicine (Item 6 = +2, Item 13 = -2, Item 22 =
+2). However, unlike the mechanistic perception of the body
within Account 6, within Account 8 psychological aspects are more
important, endorsing 'therapy of the mind' (Item 24 = +5) and
rejecting the idea that technical expertise is more important in
a doctor than personal qualities (Item 79 = -5).

However, possibly the most interesting grouping of allocations
for this account are those which have to do with personal
responsibility. Unlike the others, Account 8 consistently gives
positive allocations to these items :

	Factors	
	8	the rest
33. If people are unpleasant to me it can have the effect of making me ill	+6	+1 to -6
37. I can't help seeing illness as a "weakness" in myself and in others	+4	-1 to -5
40. When I'm ill I feel as though in some way I'm to blame	+4	0 to -6
51. When I'm ill I don't just feel pain and discomfort, I feel less of a person	+2	0 to -6

Account 8 asserts that emotion can lead to physical illness, as
indicated by Participant 37's comments :

"Stress caused by major emotional upheaval can cause real health problems." (about Item 31)

"Oh yes, makes me physically sick." (about Item 33).

The notion of illness being something that is learned is strongly rejected by Account 8 (Item 29 = -6) (Comment from Participant 37 : "no, crap"). This combination of emotional but unlearned causes of physical illness imply a psychodynamic model of aetiology. It is, however, very different from Account 2 which, while adopting psychodynamic terminology, stresses the ability of the individual to use their resources of 'mind' purposively. While therapies like relaxation (Item 24 = +5) and the 'will to live' (Item 30 = +3) can aid recovery from illness, Account 8 construes little benefit in treating illness as a 'challenge' (Item 36 = -3).

Account 8 combines the 'personal' and the 'political' as does Account 6, but contrasts markedly in its model of aetiology, and notions of 'blame'. These distinctions are examined in more detail in Section 5.5.

5.3.9 The account identified by Factor 9

Within this account, health is highly valued (Item 47 = +6, Item 57 = -4), and illness not inevitable (Item 2 = -6). People should take responsibility for their own health (Item 61 = +5) and preventive measures like inoculations (Item 65 = +5) and fluoridation of the water supply (Item 76 = +5) are important. Illness is a result of the stress and pollution of 'modern life' (Item 16 = +6). Like Account 2, Account 9 rejects the idea that health and illness are products of injustice (Item 19 = -3), or

that the worst off have little choice (Item 48 = -5). This account once more sites control in the individual, evidenced by strong rejection of the idea that doctors have a moral duty to support disarmament (Item 32 = -6). The comment made by Participant 38 was :

"No - freedom must be regarded as paramount to life, difficult as this choice may be."

Several of the comments stress this theme of personal autonomy, such as the response to Item 23 (that people should be allowed to 'die with dignity'). Explaining his 0 placement for this item in the Q sort, Participant 38 wrote :

"Agree, but the decision must always be the individual's right, not society's."

Although the Q sample provided few opportunities to express this view, the impression given is that for Account 9 accounting for health and illness is less salient than the principle of individual freedom. However, this is not extended to freedom to damage one's own health (Item 60 = -1), about which Participant 38 commented :

"Only if they feel free to pay the costs too ! It's my taxes that pay for their treatment, and I object."

Some of the other comments were particularly interesting in the perception they presented of medicine itself. In response to Item 14 (doctors only recommend surgery when it's really necessary = -3) Participant 38 wrote :

"Wish that this were true, but they have their own livelihoods to consider, and won't diagnose themselves out of a job."

And in response to Item 61 (people should take responsibility for their own health) he wrote :

"Which includes private health care and insurance. If people had to pay for their treatment, they would look after themselves a lot better."

The comments make it clear that within this account, health is an 'investment' which can (and should) be insured, and health care little more than a business in which medical professionals are engaged. Patients are consumers, as indicated by the comment made about Item 1 (patients should follow doctor's orders = +1) :

"Having consulted an expert, of course it makes sense to follow his(sic) advice. That's what he's paid for. But second opinions should be sought in cases of uncertainty."

5.4 NEGOTIATING ACCOUNT SUMMARIES

Once the accounts had been identified and initially interpreted, summaries were written for each one and these were printed and sent out to people who had provided exemplificatory Q sorts, together with a short questionnaire asking participants to comment a) to what extent they were reasonably accurate summaries of the accounts they had expressed, b) whether anything crucial had been left out, and c) their views about the other accounts. Subsequently six of these people were also interviewed.[1] Materials used for this stage are shown in Appendix 7, and a sample interview report in Appendix 8. The main motive for the interviews was to gain more accurate descriptions of the alternative accounts. These, agreed by negotiation, are listed in Figure 5.1.

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1 : Attempts were made to interview at least one person for each Factor (i.e. one of the people who had provided an exemplificatory Q sort), but for a number of reasons, it was only possible to interview these six .(e.g. Some people were on leave, others had family problems).

Figure 5.1   Summaries of the accounts identified from the Q sort
and negotiated with participants

Account la

Issues concerning health are fundamentally to do with politics
and economics; with the way the rich and powerful exploit and
oppress the weak. The most common cause of ill-health in our
society, but particularly in the Third World, is poverty, with
the poorest and weakest deprived of the resources needed to be
healthy, and forced to live and work in conditions which are
unhealthy. The medical profession is part of the self-serving
establishment, who generally push for their own   personal
advancement rather than meeting the real needs of their patients;
treating symptoms, not the underlying causes of illness, and
diverting funds to high-technology, high status areas (which
often, in fact, do more harm than good) rather than offering the
basic, good   health   care   that people really need. Health
professionals are increasingly trying to take over our lives and
tell us what to do. In fact modern medicine makes very little
contribution to good health - more has been achieved in the last
100   years - in the West - by drains, clean water and better
housing than by all the 'breakthroughs' and marvels of medical
science. Capitalism is inherently anti-health : drug companies
are primarily concerned with profits; industry geared to
cost-efective production at the cost of bad working conditions
and pollution; 'big business' continues to aggressively market
tobacco, alcohol and junk food irrespective of the damage they
are known to do to health. And the recent fad for 'health'
products is more a matter of persuading people to spend more on
expensive food and fashionable jogging suits than actually
promoting health itself.

Account lb

I see my health in terms of my position as a woman living in a
patriarchial society in which I am disadvantaged and oppressed by
a man-made world in which I, like all women, am bound to loose
out. The medical profession is one of the major institutions
of patriarchial power, which : trivialises the health problems
women face; imposes so-called 'treatment' (e.g. high technology
childbirth) to gain greater dominance over women's bodies; and
uses diagnosis (e.g. of lesbianism as a 'sickness') as a form of
social control. Anyway, in a partiarchial society dominated by
men, I must eat their food, breathe their air, walk their
streets, suffer their violence and put up with their conditions
of employment; in such a world I have far more important and
productive things to do than worry about my personal health.

Account 2

Health is to do with the 'whole person' - being ill or well involves mind as well as body, and treatment for illness depends a lot on the warmth, understanding and personal commitment of the doctor. Medicine is not a 'science' (though science has taught us a lot) but an 'art', based upon human qualities and human sympathy by a group of people dedicated to helping others. Medicine is a 'calling' - it's not about making money, gaining fame or having an easy life - quite the opposite ! Compared with other professions it's very hard work, and its rewards lie in contributing to the wellbeing of others, and the alleviation of illness and suffering. The body has tremendous powers to heal itself and function properly; often a doctor's main role is merely to promote this self-healing. However, individuals have a lot of control over their own health. Anybody can improve their health, given the will to do so. Health is outside of politics. While it may be true that in countries like Russia mental illness is used as a means of social control that's not true here. Indeed, it is within democratic and free societies like our own that new drugs and improved health care have been made available to all - capitalism promotes health by providing the incentive for new discoveries, the resources to fund our Health Service, and the high living standards upon which basic good health is built.

Account 3

Good health is a fundamental human right; being healthy is a lot more than simply not being ill - it has to do with a positive sense of wellbeing, emotionally and spiritually as well as physically. Good health is extremely important - only when you are healthy can you enjoy what life has to offer. What is more, we each have considerable control over our own health - people can make major improvements in their health by taking sufficient exercise, eating a sensible diet, avoiding too much alcohol, by giving up smoking, and seeking out less stressful lifestyles. Health education is crucial. The worst off in our society tend to be the least healthy, in part because they have fewer resources (e.g. for good food, adequate housing) in part because poverty is stressful, but primarily because they lack knowledge about healthy living and healthy child care. Our Health Service is essentially a good one, though it stresses modern hospital medicine to the detriment of preventive and community care. We need to re-allocate NHS resources, putting less money into unnecessary drugs, high-tech equipment and expensive operations, and more into primary care, education and health promotion.

Account 4

Sensible people don't get obsessed about health. They take proper care of themselves by eating a proper balanced diet, taking sufficient exercise, not smoking and drinking only in moderation - but they don't take this to extremes, and remember that there are other more important things in life like good relationships with their families and satisfying and fulfilling work. Our bodies are pretty good at fighting off disease, particularly now that we can get ourselves innoculated against the real killers of the past, so it's just not worth worrying about the odd germ we are likely to meet sooner or later - there's not very much anybody can do about that. What matters most is approaching life with determination, and if you are unfortunate enough to get struck by illness, making the best of it and doing all you can to overcome it - not giving up and becoming morbid.

Account 5

We are fortunate to live in a world of medical excellence which provides an effective service to keep people healthy, and cure them when they are ill. The problem, unfortunately, is that all too often people don't benefit from what modern medical science has to offer because of their subborness, laziness or sheer unwillingness to participate fully in their treatment. Consequently an individual's state of health is essentially a product of their willingness to look after themselves, take advice, stick to healthy habits and take responsibility for themselves. It's true that some people are born with a robust constitution whereas others may have certain weaknesses, and the worst off may not have the opportunities or the education that others have. But basically, everyone has a duty to accept responsibility for their own health, and will only be healthy if they do so.

Account 6

Everybody has a right to good health. Unfortunately, our society is one which denies it to many, failing to provide them with the income or the resources to live in a healthy way, and, by a system of private medicine and privilege, offering one standard of health care to the rich, and another to the poor. The worst off must live in housing and work in environments which are unhealthy, and drug companies and the like put profits before the needs of sick people. Illness is the result, more often than not, of disadvantage. Modern medicine is something of which we should be proud - it offers the opportunities for people in our society to recieve a high standard of care and treatment when they are ill. The trouble is, particularly now that the NHS is being starved of funds, only a few can benefit from what is available. A far greater proportion of our national resources should go into the NHS, and its system of distribution should be made much more equitable. A good start could be made by spending less on nuclear weapons, and getting rid of private medicine.

Account 7

To understand what constitutes 'health' and what causes 'illness' we need to take account of the psychological and social factors involved. Health has as much to do with the mind and the spirit as with the body, and often the reassurance of talking about your troubles with a sympathetic and compassionate doctor will do more good than anything else. Doctors should have much more training in psychology and psychotherapy, and more contact with the communities in which their patients live. So much illness is the result of distress - ill-treatement, depression and worry so often lead to illness that although modern medicine can provide a great deal that is useful and effective, to work optimally it needs to be combined with an understanding of the psychological aspects of illness, and techniques which muster our psychological resources for recovery and wellbeing.

Account 8

Illness occurs in two ways; it can be the simple process of infection or bodily dysfunction, or it can be a response to emotional distress, the physical manifestation of inner feelings and conflicts. Feelings of contentment and happiness promote health and wellbeing. Feelings of powerlessness and unhappiness drain the body of its energy and capacity to resist disease, and feelings of anger show themselves as physical pain and sickness. Conflicts and unpleasantness make people ill. When you feel good about yourself, loved and cared for, then you are able to fight off infection, your body functions smoothly and you experience wellbeing. When you feel bad about yourself, unloved, uncared for, aggressed against, then you are dis-eased, your body showing as illness the turmoil inside. Illness can be a manifestation of anger. your body telling you what you want and need, in ways you may be unwilling to admit, not just to yourself but to others.

Account 9

Each individual has the absolute right to decide for themselves about matters that affect them. Hence we should encourage things like private medicine, and where health services are offered, people should be free to chose what they want, and indeed, refuse them if that's what they prefer. People are entitled to take risks with their own health they want to, as long as they don't expect other people to bear the costs. In Britain we have a very healthy society - much healthier than Communist countries where people have very little choice, and must accept the treatment the State offers. Here we have the ability to select medical care much like any other professional service - to chose our doctor, obtain second opinions, to buy whatever expertise we want. I reject ideas about inequality in health, and deprived people having little choice. We all have a lot of choice about the lives we lead, and many of the worst off in our society could be a lot healthier if they chose to spend their money more wisely, and organise their lives more sensibly.

5.4.1 Support for account sympatricity

However, the interviews also provided valuable information about the accounting process as perceived by the participants. Each of the interviewees (representatives providing exemplificatory Q sorts for all factors except 4, 7 and 9) all confirmed that the account defined by their Q sort did provide an account which broadly expressed their viewpoint (with minor changes negotiated for some of them). Indeed, several of the interviewees expressed surprise about how well they did reflect their overall views. Participant 20, for example, said :

"I was rather distrusting and a bit irritated by the Q sort - it took me an awful long time to do, and I did wonder about its purpose. But I'm pleasantly surprised, I have to admit, about the result - you have been surprisingly good at encapsulating. "

Like most of the rest, he also said :

" ... and I was fascinated by the other viewpoints ... it has really made me take stock and realise just how differently people see things, ... just how many different ways there are of looking at the same topic ... but even (more) ... interestingly, I can see descriptions that feel familiar. Account 9 for example, describes very well the way I feel sometimes, and I know I have used this argument..."

And, as Participant 53 put it :

"I can read each of these and think 'Yes, such and such a person I know thinks like that' or recognise the description. Like viewpoint three, it reads like a manifesto from something like the Health Education Council."

What was very clear indeed was that each of the interviewees had very definite views about each of the accounts. Some they felt sympathy with, in part at least. Some they rejected, often as 'simplistic' or 'naive' or because they saw them as stressing aspects that were to them unimportant or too extreme; some in

very antagonistic terms, as plain wrongminded. But perhaps most interestingly, several said that the summary of their own Q factor lacked ´depth´ without reference to one or more of the others. For example, Participant 48 wrote about hers :

"I agree with all of it, but on its own it lacks a definite political and economic dimension."

And in her interview said :

"I suppose what I´m saying is that while number three does sum up my views very well, I am also very much in sympathy with a lot of number one, and need to bring that in to give a balanced picture ... both are true for me, though I find number one a little bit extreme, and if pushed would have to say that number three is not so much a matter of being more accurate as being more optimistic and practicable ... I agree with most of number one, but on its own find it depressing... it´s what I focus on when I´m feeling depressed, whereas number three is how I feel whan I´m optimistic and feel something could be done, and should be done to ... improve (matters) ... but if you´d got me on a bad day, I suspect ... I would have been a number one. That´s me when I´m fed up and angry."

Later in the interview she commented :

"I am also very aware that that´s (Account 5) the way I used to think ... at school we were brought up on stories about the wonders of medical science, and when I started my training I was, like, full of a white hot enthusiasm ... that I would become a nurse and would make people well because of all the wonderful things medicine could do ..."

The account descriptions came over to many people as very clear and definite, yet rather too ´neat´ to be ´true to life´. They commented that they were "very self-contained", "more single-minded than I think most people actually think" and "a bit too articulate". The impression given was of people having a commitment to a dominant account which represents ´the way I usually think´ but is, on its own, overly simple and coherent compared with the experience of thinking, which is much more

muddled and contrary; to reflect this complexity, people were aware of often dipping into and out of several other accounts, often in somewhat contradictory ways. As Participant 53 put it :

"I think it demonstrates that I've got a sort of rag-bag of ideas that are sometimes in conflict with each other."

5.4.2 Identification of accounts, not classification of people

These impressions, together with the whole ethos of Q methodology, reiterate that the results of this study must not be seen as parallel to either a psychometric or ethnographic investigation. As Brown (1980) stressed :

"... we are not generally interested in what particular persons rendered a viewpoint - the same factors could probably have been gotten from other subjects - but in the ways in which the various viewpoints themselves differ." (P 238).

The study did not seek to describe what participant X or Y or Z 'thought', what their 'attitudes' or 'beliefs' were - and these data do not describe participants' accounting in those terms. Rather, the aim was to identify and define some of the many accounts to which people have access. In this it appears to have been very successful, certainly in terms of the participants' responses; for them at least the data obtained offered clarification and a means to achieve a better understanding of the accounts available <u>for</u> thinking, expressing opinions, arguing with and listening to others. Participant 53 said :

"It has really made me think, and re-examine my own opinions and ideas, first when I did the Q sort and was put on the line, that was very hard indeed, and it forced me to, well really make very difficult choices between my own inconsistencies. Though reading the viewpoints was more illuminating, as it ... gave me something to grasp onto ... I think I have a lot clearer picture now of my

own thinking and of the way other people think ... what really surprised me was that <u>all</u> of them were recognisable, <u>all</u> of them made sense, even though some of them I disagreed with a lot."

5.5 DISCUSSION AND CONCLUSIONS

In this Section I will first examine the accounts that have been identified - as accounts - and explore the implications they have for our understanding about the way people account for health and illness in our society. Subsequently, I will review these data in terms of what they have to offer to a theory of accounting.

The first point to be made is that unlike other studies (notably those described in Chapter 2) which have tended to identify just two or three alternative themes or images or viewpoints, this one has identified nine which differed not just in their endorsement or rejection of particular propositions, but in the salience they attribute to different aspects of the topic of health and illness. It reflects a principle from Kellian theory that what may be salient to one account is unimportant to another. Q method, in its focus on account sympatricity and in offering people the opportunity to specify salience, is able to abduce a taxonomy of accounts about a particular topic that is much more wideranging than with approaches that assume salience <u>a priori</u> and assume greater consensus.

This is both its appeal and its drawback, for while it gives access to account diversity that is informative and fascinating, it also places heavy cognitive loads on the researcher and the reader. Reports of studies like those described in Chapter 2 are

made easier to write and to read because they limit account descriptions to just two or three. With nine accounts identified, it is much more difficult to 'get a handle on' the data from Study 2. The discussions and analyses that follow are intended to make this task easier, while not 'doing violence' to the accounts themselves by imposing too much further analysis and classification. Within Q methodology it is the analyses and classification that people impose upon a particular concourse of propositions that are the focus for study, and it is not the job of the researcher to re-analyse these further, but to seek to understand them better.

5.5.1 Alternative explanations for health and illness

All of the accounts do offer explanations for health and illness - explanations of why people are healthy or well, what makes them ill, and, when they are ill, what makes them recover. This is, however, nowhere as simple as some theorists have assumed it to be. The consensual rejection of Item 50, that illness can be a punishment for misdeeds, places all nine of the accounts outside of a 'personalistic' framework (See Chapter 1). However, even within each account there is no straightforward distinction between, say, endogenous and exogenous ascriptions of cause. Probably the best known and most frequently used classification is the version of this proposed by Wallston and Wallston (1981) who, working from the notion of general locus of control developed by Rotter (1966), argue that people differ in their attributions of the site of control over health and illness, dividing between those who see the site as one of 'internal control' (primarily an individual's own actions) and those for whom control is sited externally (i.e. determined by the effects

of chance or fate), more recently extended to include a second form of 'external control', that of 'powerful others'.

Figure 5.2 shows a general analysis of the reasons ascribed for health, illness and recovery for each of the nine accounts, derived from Q sort placements, comments and interview data. For not one single one of these could an internal/external health locus of control classification be applied - all combine both aspects. However, more detailed analysis does show that some accounts at least, for some aspect of health/illness/recovery, tend to favour one or the other.

Beginning with an analysis of the ascribed reasons for health, shown in Figure 5.3, it can be seen that a wide range of reasons are attributed by the accounts overall: some, like behaviour, mind, heredity and the body's own defences, arising from within the individual; others like chance, social policy and medical advances, arising from outside of the individual. Account 1, as shown in Figure 5.4 can be seen to focus on reasons outside of the individual - external control - with the major emphasis placed upon social forces that exploit and oppress the weak, the poor and marginal or minority groups. Thus although there is recognition, within this account, that health is affected, for example, by an individual's lifestyle, this 'internal' element is seen as largely determined by social forces which enable some the freedom to adopt a healthy lifestyle, but deny this option to many.

In contrast, Account 2, as shown in Figure 5.5, can be seen to

Figure 5.2. Attributions for health, illness and recovery

Account	Reasons for Good health	Reasons for illness and bad health	Things that affect or bring about recovery
1	Reasonable living conditions, adequate food, clean water and proper drains	Pollution, stress, poverty and exploitation within a capitalist & partriarchial system; unnecessary and often harmful medical treatment & its use for social control	Fundamental changes in the way society is organised
2	Positive state of mind, the high living standards capitalism makes possible, looking after yourself.	Stress from things like life pressures; illness becoming 'a way of life'	The will to live Modern drugs
3	Reasonable living cond- itions, adequate food, clean water and drains; positive state of mind adopting a healthy life- style; prevention	Pollution, poverty Government policies & aggressive marketing of tobacco, alcohol and unhealthy food	The body's own defences good medical care, both conventional and from alternative medicine
4	Preventive measures like fluoridation & innoculation, taking responsibility for yourself, not worrying too much about illness	Disease organisms, not following a course of treatment properly, bad luck	The body's own defences boosted by inoculations the reassurance of the doctor,the will to live and seeing illness as a challenge
5	Genetic predisposition Taking care of yourself	Bad habits	Modern drugs Medical treat- ment, alternative therapies
6	Taking responsibility for yourself, adopting a healthy lifestyle & looking after yourself	Poverty and neglect and aggressive marketing of things like tobacco alcohol,and trendy health products	Access to good medical care
7	Positive state of mind Preventive measures like inoculations, adopting a healthy lifestyle	Bad habits	Modern drugs Medical treat- ment, body's own defences
8	State of mind, taking proper exercise and leisure, a vegetarian diet, medical advances	Labelling of mental illness as a form of social control	Therapies of the 'mind', medical treatment
9	Preventive measures like fluoridation and inoc- ulations; taking respons- ibility for yourself; the the high living standards capitalism makes possible	Stress and pollution of modern life	Freedom to buy and choose good medical care

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Figure 5.3   Explanations for what promotes good health

what makes for good health ?

reasons that
arise from
within the
individual

reasons that
arise from
outside of the
individual

behaviour

looking
after
yourself

adopting
a healthy
lifestyle

using
preventive
services
like
innoculations

Taking
responsibility
for
yourself

mind

Positive
attitudes

Not
worrying

heredity

healthy
constitution

body's
defences

fighting
off
disease

chance

social
policy

Public
Health
measures

Good living
standards

medical
advances

inoculations

contraception

Figure 5.4   Explanations for what promotes good health: Factor 1
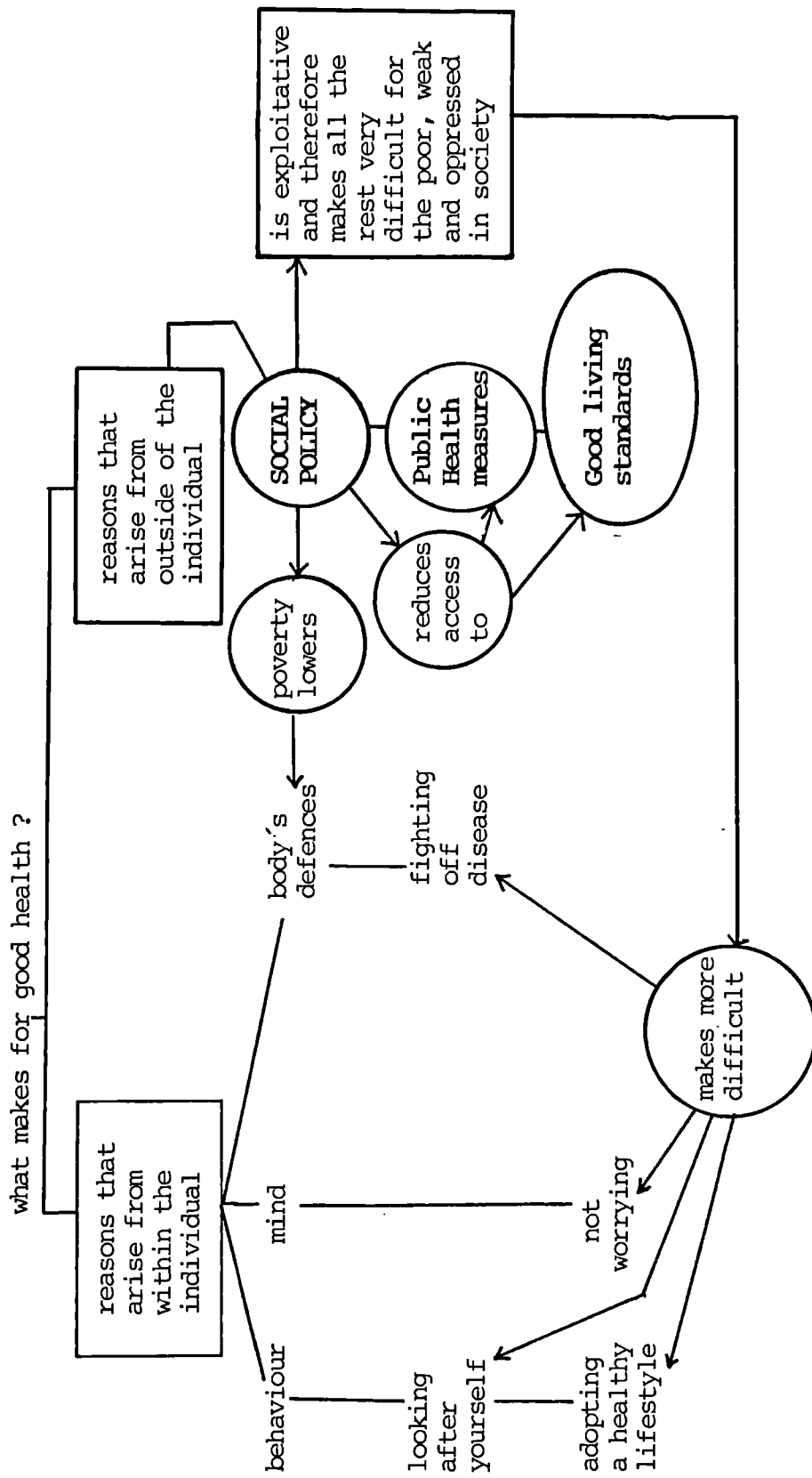
Figure 5.5   Explanations for what promotes good health : Factor 2

what makes for good health ?

reasons that arise from outside of the individual

medical advances

inoculations
contraception

social policy

Public Health measures

Good living standards

Made possible by capitalism

BODY'S DEFENCES

fighting off disease

boost

REASONS THAT ARISE FROM WITHIN THE INDIVIDUAL

MIND

BEHAVIOUR

Positive attitudes

Not worrying

Taking responsibility for yourself

looking after yourself

adopting a healthy lifestyle

using preventive services like inoculations

focus upon influences arising from <u>within</u> the individual - internal control. Here the emphasis is upon individuals' own behaviour - looking after themselves, and taking opportunities to boost their body's defences by being immunised, by positive attitudes, and as a product of the natural defences of their own bodies. While external influences like good living conditions are seen to be salient (in this analysis, made possible within the wealth provided by capitalism) the stress is firmly laid upon internal control - health comes primarily from within.

However, not all the accounts by any means ascribe influences primarily in one domain or the other. Explanations for why people became ill are particularly widely spread, those arising from within the individual including behaviour (e.g. bad habits, not following courses of treatment properly), mind (e.g. negative attitudes, worry and stress) and heredity; those from outside including chance, other people, disease organisms, products of social forces (e.g. pollution from industrial waste, the aggressive marketing of tobacco and alcohol) and medical intervention (e.g. iatrogenic illness). These are shown in Figure 5.6

As an example of how both external and internal influences are seen to play important roles, Figure 5.7 shows how Account 3 combines the two. It identifies behaviour as crucial - illness is seen to be a product of such things as smoking, a poor diet, drinking alcohol to excess, taking insufficient exercise etc. However, it also identifies a range of external influences arising as the product of social forces, which encourage such bad

Figure 5.6   Explanations of what causes illness
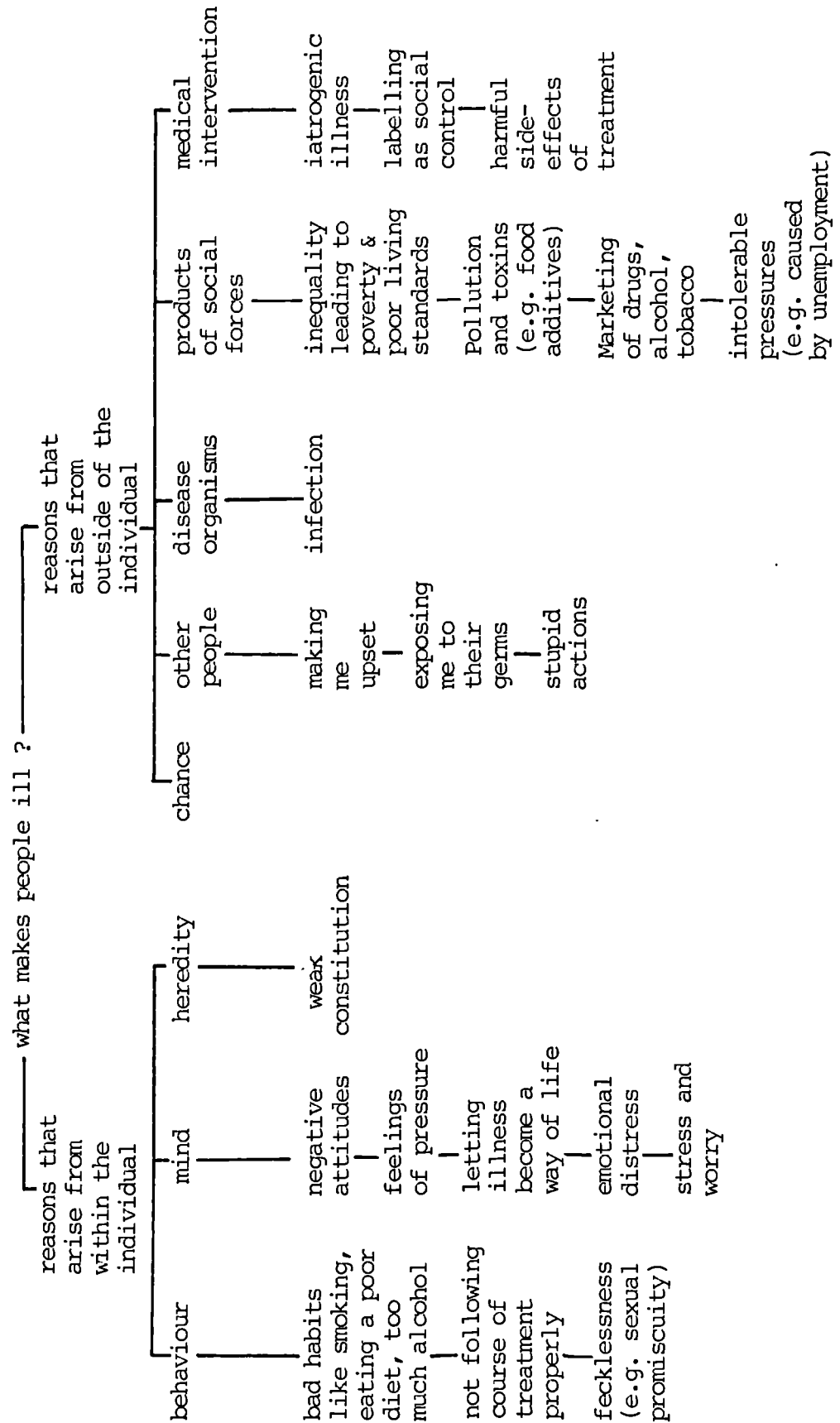
Figure 5.7 Explanations of what causes illness : Factor 3
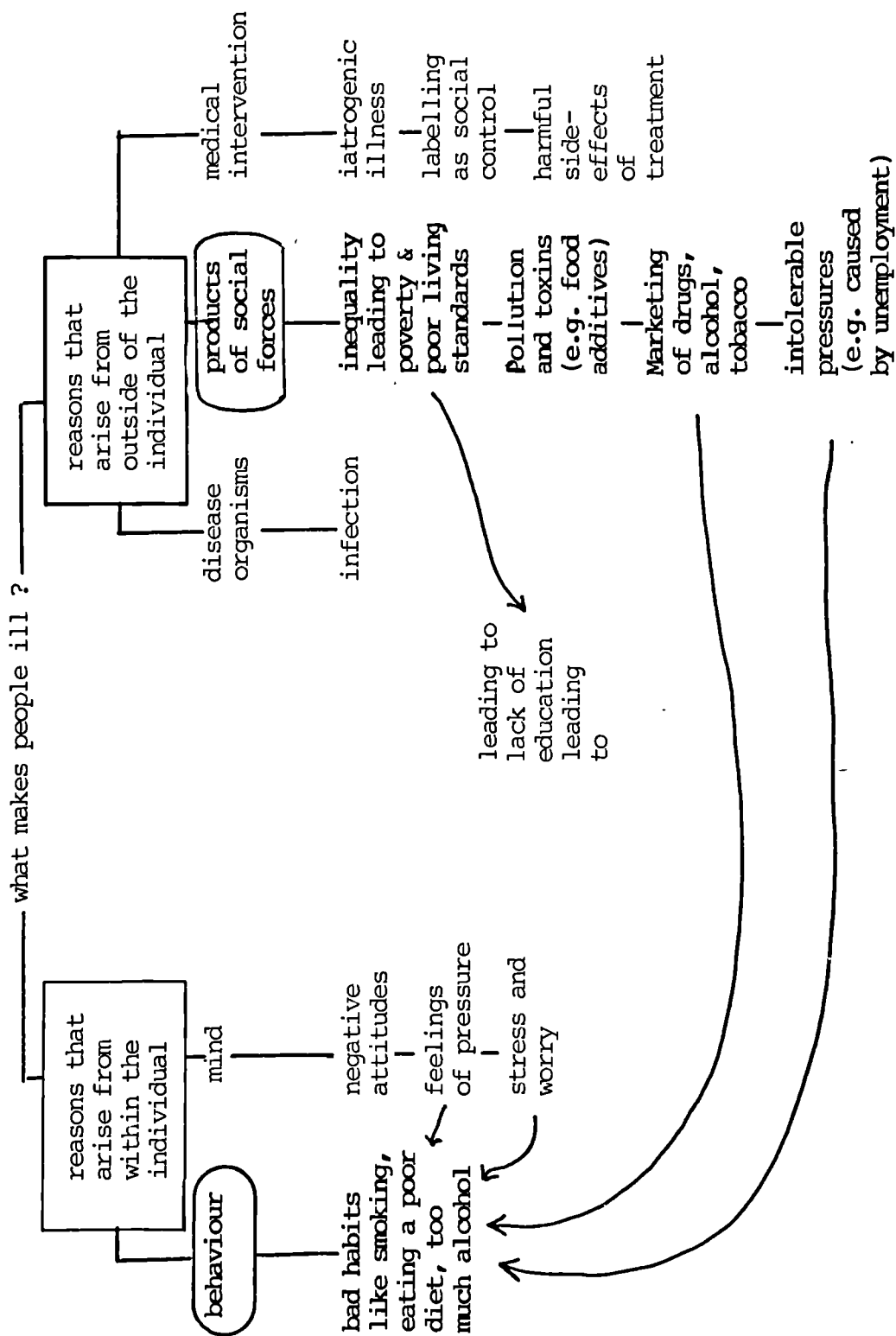
habits; for instance, the aggressive marketing of tobacco clearly has an impact upon smoking, as too do pressures from such socially determined life circumstances as unemployment, and the stress caused by overcrowded and damp housing. And it ascribes to poverty and inequality considerable responsibility for a lack of health education (also Government policies about resources) which, for example, exacerbate poor eating habits. Added to all of these are the impact of pollution and illness-engendering substances (e.g. food additives) which are seen to have a direct role in making people ill.

With explanations of recovery, once more some accounts stress one aspect more than the other. Figure 5.8 illustrates the range of factors, including those arising from within the individual such as the body's own mechanisms of defence, and those operating from outside such as medical treatments. Figure 5.9 shows that Account 4 stresses the role of internal factors in recovery; both matters of mind like the 'will to live' and 'seeing illness as a challenge' and the body's natural immunity boosted by inoculations. While there is some credence given to external influences, particularly the reassurance of the doctor, this presumably is regarded as something which facilitates the positive attitudes from within that are seen as important.

Account 5, as shown in Figure 5.10, concentrates upon external factors, with the role of medical therapy (predominantly orthodox, but also alternative medicine) paramount. While behaviour is seen as important too, this is largely a matter of willingness to make use of the curative facilities that medical

Figure 5.8 Explanations of what affects recovery

what affects recovery ?

reasons that arise from within the individual

reasons that arise from outside of the individual

behaviour

mind

body's own mechanisms

orthodox medical therapy

alternative therapies

social factors

The will to live

Seeing illness as a challenge

natural immunity

boosted by inoculations

modern drugs

medical technology

reassurance from a doctor

therapies of the mind

access to

medical care

sympathetic treatment by medical staff

Figure 5.9 Explanations of what affects recovery: Factor 4
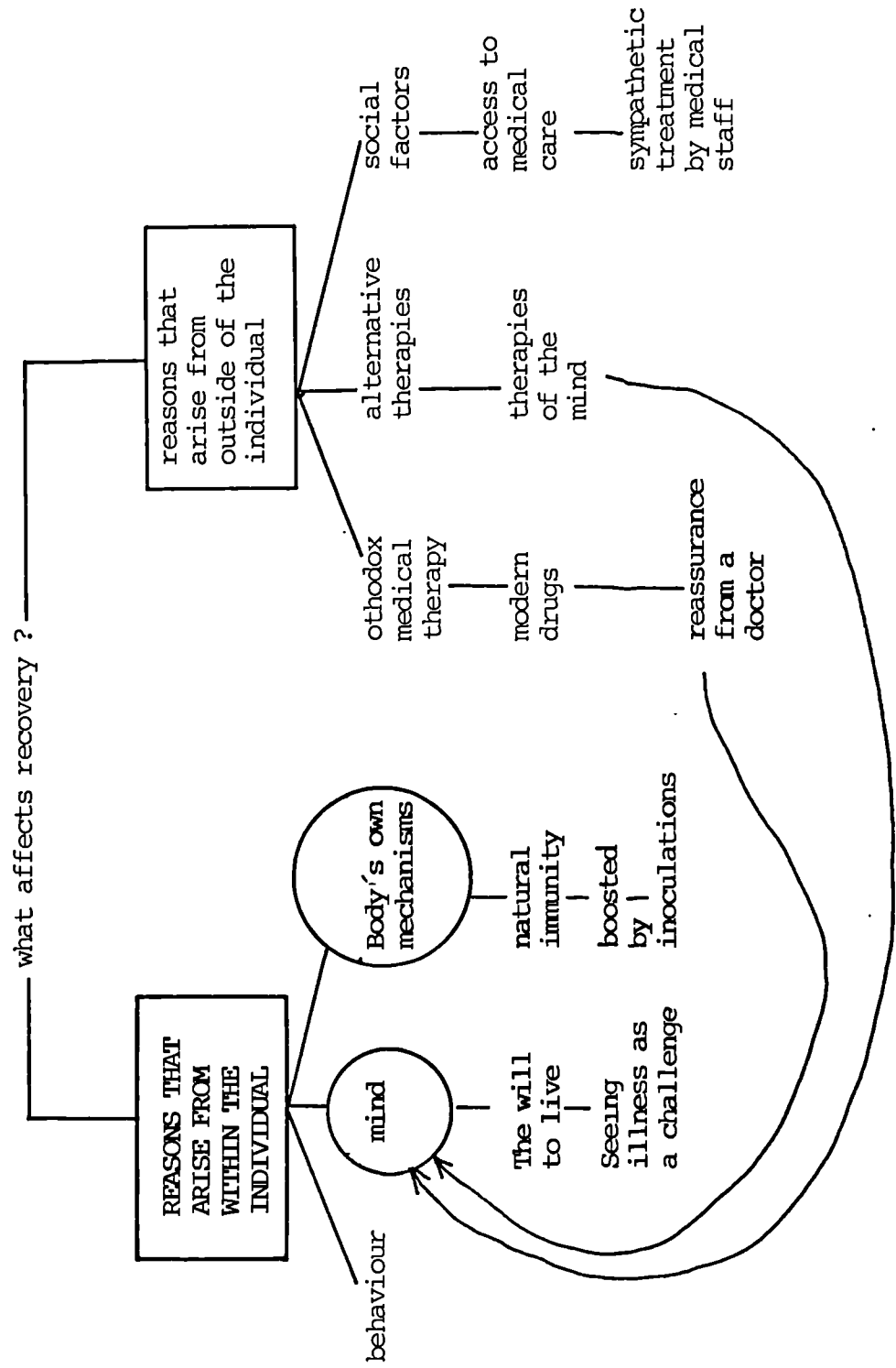
Figure 5.10 Explanations of what affects recovery : Factor 5
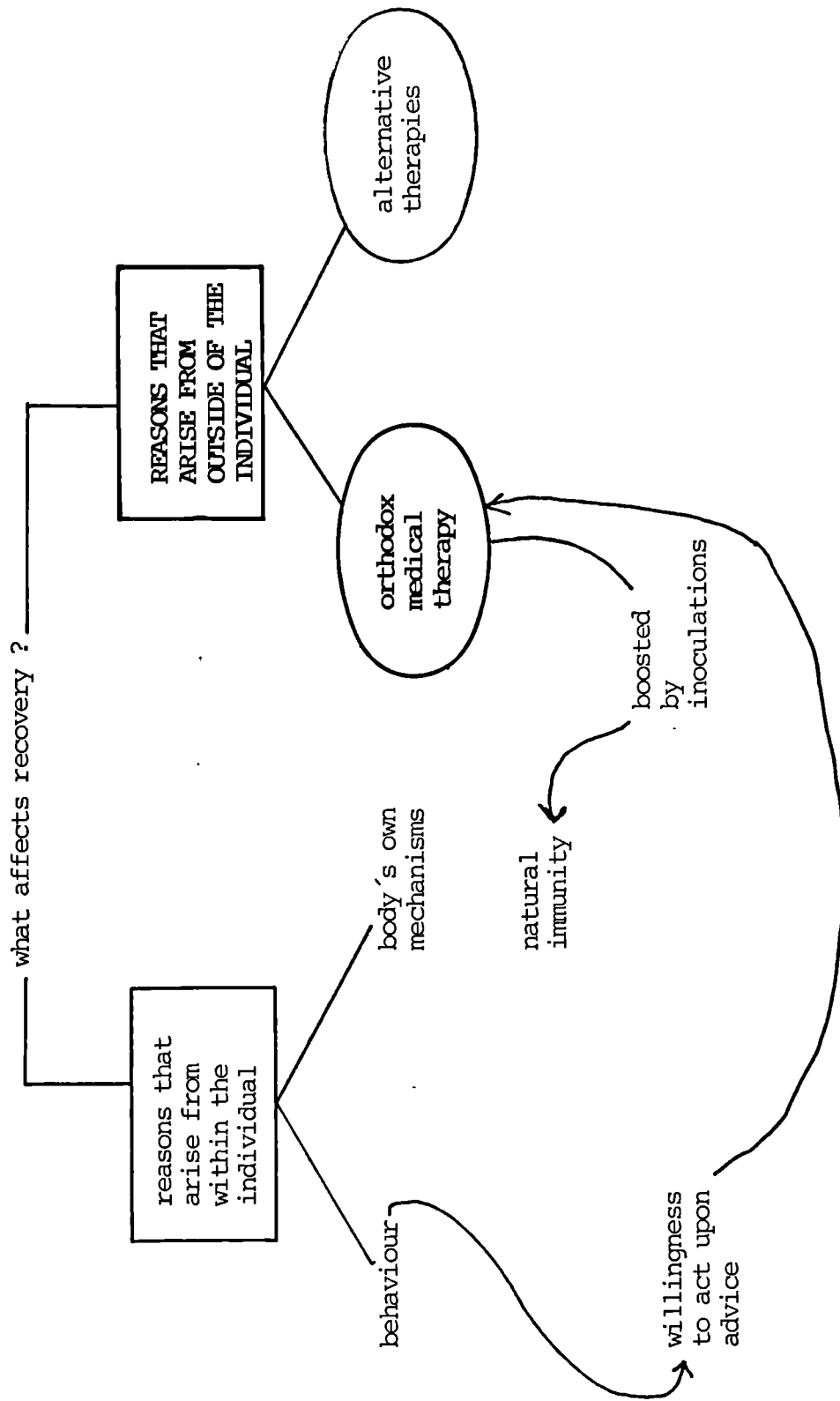
treatment has to offer. Getting better when you are ill, from this analysis, is mostly a matter of the medical care you receive.

5.5.2 Alternative models of society

Accounts 1 & 6 and 2 & 9 adopt contrasting stances about the position of the individual in society, as illustrated by their responses to these items :

	Accounts			
	1	6	2	9
19. We will only improve health overall when we have overcome injustices between rich and poor.	+6	+5	-5	-3
48. The worst off have little choice about the unhealthy lives they lead.	+5	+5	-2	-5

While several accounts (e.g. Account 4) take issue with these statements in written comments, and others (e.g. Account 3) incorporate a level of socio-political analysis, it was only Accounts 1, 2, 6 and 9 for whom individual/society was the central theme of their agreement or disagreement in the Q sort. Figure 5.11 illustrates how these four accounts line up along this aspect.

All four of these accounts predicate their understanding of health and illness upon the assumption that lifestyle and environment have a considerable degree of influence upon health status. They are all concerned with explanations of how the interplay between the individual and society affect lifestyles

Figure 5.11. Accounts concerned with models of social functioning

concern with socio-political analyses

conflict view of society

pluralist view of society

social constructionist view of medical hegemony and health and illness as social epistemology

Account 1

traditional socialist focus on inequitable distribution of resources

Account 6

traditionalist conservative perception of medicine as a 'profession'

Account 2

'New Right' view of medicine as trade and health as a commodity

Account 9

and the environment, and therefore affect health. Accounts 2 and 9 site their analyses within a 'social functionalist' or 'pluralistic' view of society - one which assumes that the various social or cultural groups who live together in Britain (i.e. social classes, different genders, different ethnic groups) co-exist in a functional manner, outside of the scope of the power relations attributed within the 'dominance' or 'conflict' worldview of Accounts 1 and 6. Whereas these latter focus on the reality-constructs-person view that individuals' choices and life chances - and consequently health status - are largely constrained and defined by their social position, the 'structural functionalists' focus more upon a person-constructs-reality view that sees individuals as ultimately able to strive for and choose their life-styles, living conditions and consequently, therefore, see health status as a matter of individual decision making and circumstances. Indeed, individual freedom to choose is at the very heart of Account 9's view of the world, and the uniqueness of the individual central to Account 2, while the lack of choice for the most vulnerable and oppressed groups is focal for Accounts 1 and 6.

But even within these two competing analyses, the data show there to be strong internal divisions. Between Accounts 2 and 9 the distinction centres around perceptions of the relationship between the medical profession and the rest of society, and the means of distribution of resources. Within Account 9 medical professionals are regarded as 'body mechanics' not different in principle from motor mechanics; traders whose services are paid for by the consumer, who perform particular tasks of monitoring,

maintenance and repair. Health care, in this analysis, is a commodity to be bought and sold, and health an investment to be protected by sensible after-care and insurance. The limits to personal freedom are only those that impose damage or unfair costs on others - where their investment may be threatened. Within Account 2, however, the task of health care is seen as much more that of a traditional 'profession', with its code of practice, obligations of service, and gentlemanly disdain of profit - the image of 'Dr Cameron' who knows each patient as an individual, and has the wisdom to respond to each of their individual needs. The contrast has resonances to that between the 'New Right' and traditional conservatism. This aspect is also expressed by Account 3, Study 1.

Subsumed under the 'dominance' analysis, as has been noted already, are two contrasting critiques, dependent upon assumptions about the role of the technological efficacy of biomedicine, themselves dependent upon a distinction between essentialist and social constructionist worldviews. For the essentialist Account 2, the 'science' of medicine, like all science, is ultimately a neutral analysis of a naturally occurring reality, within which the practice of medicine is essentially a neutral response. Diseases, for instance, are things-out-there that can be observed, diagnosed and treated. Within this analysis, whatever may be superimposed by, for example, the impact of professional paternalism, the actual techniques of medical practice and treatment are seen themselves to be functional - their purposes are, as they purport to be, to cure disease, save lives, reduce distress, ameliorate human anguish. The problem is not in the techniques themselves, or even

mainly in the way medicine is practiced, but in the way that resources are allocated. Against a principle that medical care should be available as a product of need, it is seen by Account 2 to be inequitably distributed, with those who have money, influence or social skills able to grab a larger slice of the cake.

Within the social constructionist Account 1, the so-called 'science' of medicine is a chimera, a cleverly constructed mask of benign neutrality drawn over the face of medicine as a social institution, whether that of the medicine-for-profit of the 'New Right', or the patronising humbug of the traditionally conservative 'profession' of medicine. Diseases are reifications of the doctor's 'medical gaze' (cf Foucault, 1963) and deeply socially sedimented ascriptions of 'disorder' (cf Dingwall, 1976; Taussig, 1986; Young, 1980). The problem from this standpoint is not one of the 'haves' snatching all the goodies, leaving the pickings for the 'have-nots', but the questionable nature of the 'goodies' themselves - good for whom ?

5.5.3. Alternative assumptions about responsibility and blame

The tendency to attribute blame to others rather than to events is, of course, the classic formulation in psychology which arose from Heider's (1958) work on social perception : the 'fundamental attribution error' (Jones and Nisbett, 1971; Ross, 1977; Nisbett and Ross, 1980) which connects outcomes with deservedness; misfortune that occurs to others perceived as a sign of their blameworthiness (Farr and Anderson, 1983 provide a

review of this area). However, the acceptance or denial of self-blame is a much more complex area. Post-misfortune self-blame (e.g. following accidents, serious illness or the birth of a sickly or 'handicapped' baby) has been noted in a number of studies (Tennen, Affleck and Gershman, 1986 provide an extensive review). The explanation usually offered is that accepting behavioural blame (rather than characterological) provides reassurance that similar misfortunes are avoidable in the future.

Tennen et al. note that people differ in their willingness to blame themselves for illness, and the accounts discovered in this study demonstrate that not only is 'self-blame' differentially endorsed, it is understood differently by different people and varies in its salience. Accounts 4, 6 and 7 in particular used extreme allocations in the Q sort to stress their lack of personal culpability for illness, whereas Account 8 was alone in accepting it :

	Factors			
	4	6	7	8
37. I can't help seeing illness as a 'weakness' in myself and in others.	-5	-4	-2	+4
40. When I'm ill I feel as though in some way I'm to blame.	-6	-4	-5	+4
51. When I'm ill I don't just feel pain and discomfort, I feel less of a person.	-3	-2	-6	+2

However, as before, while Accounts 4, 6 and 7 attribute strong salience to denying blame, their rationales are quite different. Account 4 focusses upon the biological aspects of health, and

therefore agrees that illness can be probabilistically determined. Comments by Participant 4 (who loaded 0.55 onto Factor 4) helps to show how the blame/responsibility distinction operates in this context:

"It's not a matter of kismet or karma, but that given we live side by side in the world with all manner of bugs, and given the world is an unpredictable place ... and given that say, genetics is a probabilistic game, an awful lot of what happens to us, including disease is just that, happenstance ... nobody and nothing is to blame ... and so it is as wrong to blame it on 'my bad luck' as it is to blame it on the weather or the Russians or the atom bomb."

Within Account 4, the unpredictability about whether or not disease will strike, and indeed the undesirability of worrying too much, or allowing oneself to become obsessed with illness, are not in conflict with taking responsibility. There are strong parallels with the account to which Cornwell (1984) clearly gained access in her 'public accounts' obtained via interviews with East Enders :

"The moral prescription for a healthy life is in fact a cheerful stoicism, evident in the refusal to worry or complain or to be morbid. Taking an interest in health is itself regarded as morbid..." (Cornwell, 1984 p188).

However, interestingly she also notes that once illness is mentioned :

"... the onus on the person giving the account was that of proving that the illness was 'real' and that it was therefore legitimate for them - or whoever was involved - to be a patient. The basic requirement was that they should be able to prove the 'otherness' of the illness, i.e. prove that it was a recognisable and separate entity which had 'happened' to the patient and not something for which they were personally responsible." (p 189).

This too was extremely close to what is to be found in Account 4,

particularly about mental illness which was stressed by Participant 27 as "real" (her emphasis). Within both versions of the account there is also a strong commitment to the idea that disease having struck, the individual has a lot of choice about how they respond - by seeing it as an excuse, or a tragedy or in fatalistic terms as their 'bad luck', or by treating it as a challenge, something to be overcome or made the best of. Cornwell notes that several of her interviewees speaking proudly of relatives who managed to 'keep going' in a happy and cheerful manner, and disparaging accounts of others who 'made a meal' of their illness and just gave up.

Cornwell argues that this moral proscriptive aspect of the 'public accounts' she observed was a product of a more general worldview linked to the employment patterns of her working class respondents in the East End, who had little choice about their working conditions and could only reject the self-deprecating label of 'victim' by seeing themselves as stoic hard-workers who made the best of life. But its very evident parallels to Account 4, expressed here by a professional dietitian suggest that it is not a prerogative of the working class to have 'hard earned lives' or operate within a moral system that defends self-esteem against blame for the misfortunes the person experiences - by seeing life as a challenge, and illness, within this context, as something to be borne with fortitude.

Smith, Bruner and White (1964) have specifically linked the 'opinions' an individual expresses to their 'personality' and suggested that one of the major functions of the holding and

expressing of particular opinions is their adjustive functions for the person's self-perception. They rejected the psychodynamic notion of 'ego defence', which they saw as overly negative, and adopted the term 'adjustive strategies' to stress the purposive and positive functions, a product of continual monitoring against 'reality' on the one side, and 'inner requirements' on the other. From this analysis, the kind of moral focus that is central to both Account 4, and the 'public accounts' observed by Cornwell, albeit in rather different socio-economic contexts, can be interpreted as a rational and highly functional 'blueprint for the world' (Smith et al's term) which empowers the individual to cope with adversity and maintain self-esteem in troubled circumstances.

Thus there is no paradox in accepting responsibility but rejecting blame, indeed they are highly consistent within this framework, both plausibly motivated by an image of the self as robust and in control. Indeed, more recent theorisation about the concepts of 'causality', 'blame' and 'responsibility' (cf Shaver and Drown, 1986) asserts that they are subjectively distinct; while people generally do accept responsibility for a misfortune, they deny blame.

Account 6 rejects blame in a different personal context. The woman who provided the exemplificatory Q sort summed her reasoning up succinctly :

"I don't get ill very much, only the usual things nobody can avoid like the odd cold. And I don't feel to blame for that sort of thing, that would be stupid. It just happens to everybody ... so when I put those ones there (i.e. placed Items 37 and 40 in the -4 positions) I think the reason why was that I was objecting

to the whole idea of illness being something that people should feel guilty about. I think I was reacting against that kind of claptrap (Account 8) about people 'wanting' to be ill. It makes me sick ! It's an insult... It's just used as another way of knocking people." (Participant 69).

As Litton and Potter (1985) have argued, people do not merely account in a vacuum, ignorant of the other discourses expressed within popular culture. They construct their own accounts, and in particular, argue their own views in relation to others and frequently by way of denying or refuting others.

Account 7 's denial of blame seems to have similar 'countering another account' qualities, although this is more dificult to interpret given only limited written comments from the one participant whose Q sort exemplified the Factor, and her unavailability to be interviewed (because of a family problem at the time). We did speak briefly by telephone and she gave some indications of her moral stance. She was a residential social worker, running a hostel for homeless young women and was contacted via Participant 66, a man serving a prison sentence for serious violent crime, whom she had befriended and visited regularly.

She commented that she was a devout Christian, and this together with her work and life experience with many people who would be regarded as society's 'misfits', many of them convicted of criminal offences, had resulted in a worldview which stressed the sanctity of life - alone among all the accounts, hers rejected strongly (-5) the notion that people who are incurably ill should be allowed to die with dignity (Item 23), and the need for compassion to all, regardless of their supposed moral failings :

"My faith stresses love, compassion and respect for the individual, no matter what they have done. Who are we to make judgements about others - that is for God, and God alone ... ours is to support with kindness, irrespective of sin ... to cherish each of God's people." (Participant 37)

She expressed considerable anger about the way she felt that doctors in particular acted coldly and judgmentally towards those who have often experienced severe deprivation and harrowing childhoods. From this perspective, to place personal blame on individuals, given the inordinate pressures of their lives, is morally wrong; it is also wrong in that, from this account, nobody has the right to judge but God.

Participant 53, whose Q sort exemplified Factor 8, herself gave a noticeably psychodynamic explanation of the centrality of 'guilt' in her view of the world (See Appendix 8). She spoke at some length about the way illness was paradoxically treated in her childhood, particularly by her mother. Her statements read like a classic 'double bind' in which illness was treated both as weakness and as a reason for being indulged. But at the base of her 'guilt' she suggested was the instillation, in her childhood, of the principle of service - that the way you show that you love and care for somebody is to do things for them.

Such a basis for human relationships sows the seeds for a dilemma that if love = service, then not performing service = retraction of love. Within this, in classical Parsonian terms, illness becomes very powerful, for it offers perhaps the only legitimate reason for withholding service while not being seen to withold

love. To fail to provide 'service' because you don't feel like it or have something else you would rather do instead reeks of 'not caring'; but if you have a 'terrible headache', or a 'stomach bug' then you can continue to be seen to care, but avoid the chore. There can be few people who have not at some time explicitly and guilelessly used illness as an excuse because it will be accepted as valid in a way that most other excuses will not, and of course there are strong resonances here with Herzlich's (1973) 'illness-as-release'.

What this account does is to shift the focus of the traditional analysis of 'sick role' away from its facility to discount social obligation, and place it into the context of personal relationships and the _emotional_ meaning attributed to actions. Where service = obligation, then undoubtedly feelings of guilt may be engendered when illness, say, prevents the fulfilling of, say, the obligations of being the breadwinner; but they are all the more likely to ensue when service = love. This analysis also makes clear the extent to which psychodynamic ideas have in Britain, as in France (cf Moscovici, 1961) entered popular discourse. Participant 53's reported dialogue with herself when she was ill shows this well :

"I do ask myself 'What are you trying to avoid with this headache?' and wonder just how much I am unconsciously providing myself with a convenient way out of an embarrassing situation, or something I don't want to do."

To her, illness can be "... my real and more selfish me, standing up for myself and saying 'no'.". She explicitly made the point that she thought that she was perhaps being "... more

honest than most" in accepting that she felt blame for her illness. Most people, she thought, not only sometimes consciously use illness as an excuse, but often do so unconsciously, and are just not prepared to admit it, or are insufficiently self-aware to recognise they are doing it. They reject blame because it is more comfortable not to face their own more selfish side. In part accepting blame is a means, within this account, of good self-presentation - of "...being honest with myself, even though it's painful". It is also, of course, very functional - for although one can express 'guilt' about the workings of one's unconscious, it isn't something one can control (by definition) and therefore there is no reason to change !

Thus, like Account 4, Account 8 can be interpreted as concerned, at least in part, with self-concept, but in this case in a much more reflexive manner; the introduction of psychodynamic notions enable the expression of moral issues in a account which is centrally concerned with the role and power of personal feelings and emotions. It is this which makes possible, and indeed makes necessary the acceptance of feelings of 'blame' for illness in a way that Account 4's ascription of illness as 'real' does not. Account 4, in Smith et al's (op cit) terms adopts an adjustive strategy in which you present yourself as a stoic who does not 'give in' to anything but 'real', unavoidable illness; Account 8's adaptive strategy is to present yourself as having insight into your deeper motives and feelings and admit that illness may be serving an emotional function. In the two accounts concepts like 'weakness' and 'guilt' convey quite different meanings - in one they are self-depreciating

descriptions that need to be rejected to maintain self-esteem; in the other they become almost matters of pride that you have reached sufficiently far along a path of self-discovery to have acknowledged them.

But in popular discourse, particularly within certain sectors of our society, psychodynamic concepts offer something more. The key may lie in Participant 53's use of the term "my <u>real</u> ... me". An idea that is current within popular versions of psychodynamic theory, particularly as has been promoted by humanistic developments, is that manifestations of the unconscious are routes to understanding aspects of oneself that are more 'true' and 'real' than the role performances learned and acted out in everyday social life. For instance, when she spoke of her 'real me' saying 'no' she linked this to an account of her changing role as a woman :

"Like most women of my age, I was brought up to believe that my role as a wife and mother is to look after others, and to put my needs and wishes in the background ... but more and more I am beginning to ... believe that I have needs and wants too that I have a right to look after."

Within this context, an episode of minor illness (like a headache) can <u>both</u> be interpreted as a 'healthy' and desirable unconscious signal which legitimises the indulgence of a day in bed reading ('my body is telling me what I really want and need') and yet, as something which raises guilt, stemming from the conscience instilled by 'Mother' that illness should <u>not</u> be used to avoid obligations of service to those we love ('my body is telling me I don't really love my children'). Thus Account 8 is more than just an account of health and illness

in terms of emotion, but is an 'intuitive psychology' (cf Wegner
and Vallacher, 1981; Heelas, 1981) incorporating the
principles of psychodynamics into everyday understanding of the
self.

5.5.4. Implications for a theory of accounting

Overall, then, the alternative accounts can be seen to differ in
terms of at least three aspects of accounting : different
assumptions about what is salient and what is irrelevant;
different explanations of causes, reasons and agents; and
different prescriptions about what should be done, how people
ought to behave, about the allocation of responsibilities and
obligations in terms of assumptions about people's duties and
rights. One of Stephenson's most recent studies (1987), which
examined alternative interpretations of the Iran hostage crisis,
similarly discovered factors which identified accounts that were
primarily moral or primarily explanatory.

The results of Study 2 demonstrated that accounts differ not just
in their content (i.e. what propositions are assumed to be true
and false), but in the emphasis they place upon the
alternative forms of 'understanding' that they offer. For some
explanation is central - meaning is taken-for-granted, and
prescription of minor importance. Account 4 is much like this,
for instance in its explanation of ill-health as the product of
dysfunctional behaviour (lack of education) but its avoidance of
blaming individuals who behave in this way. But while Account 5
shares similar explanatory convictions, it adds on a strong moral
prescription that people should act in the interests of their

health, and are to blame for illness resulting from their own
stupidity or rigidity. And for Account 1, 'meaning' is central,
concerned to de-construct preconceived assumptions and
reifications rather than seeking to explain what it is,
precisely, that makes a person ill or enables them to recover
from illness.

This variability of focus and salience provide evidence for
Stephenson's assertion (1986c) that accounts are
complementary. They cannot be melded one upon the other because
they are 'about' quite different things. Further evidence for
account complementarity is the indexicality (cf Barnes and Law,
1976) of the propositions, where meaning alters according to the
context of use. Each alternative account is formulated around
opposing 'truths' regarded as 'self-evident', preventing the
premises of one to be used to argue against the other.

In a recent review of 'ordinary explanations' (Antaki and
Fielding, 1981) three types of explanations of social actions
were identified : 'meaning' explanations of what an action
denotates, 'reason' explanations of why an action was performed
and 'morality' explanations of their rightness or wrongness.
These three correspond broadly to the three aspects of
accounting discovered in Study 2. However, while the Antaki and
Fielding approach considers them as separate 'explanations',
an account is assumed to articulate them in conjunction with each
other. To make sense of the world, an individual needs more than
just access to a motley set of independent explanations about
various aspects of an observation or set of events or ideas;

these need to be articulated together.

In proposing that accounts are complementary, Q theory is making a stronger claim than just that people differ in their understandings of a topic, or in whether they direct their concern to explaining, to defining meanings, or to moral analyses. It is asserting that the variability is sympatric - it portrays accounting as a process of drawing upon a number of discrete, non-comparable and non-subsumable 'storylines' or 'scripts' (Shank and Abelson, 1977). However, along with discourse analysts like Potter and Wetherell (1987), what is being argued is not an image of the 'person as cognitive miser' (Taylor, 1981), operating in a 'mindless' manner (as, say, attribution theorists like Langer, 1978 suggest), but as an active and thoughtful selector. Whereas Langer and Taylor assume that there is usually only a single 'script' available to match a particular situation, this portrayal is of the person as having a repertoire of 'scripts' at their disposal, into which they are able to dip in and out, both to express and to refute particular ideas. This 'accounting theory' will be developed further in Chapter 8.

5.5.5 Review and prospect

In this chapter I have described my second, more comprehensive attempt to identify and describe some of the accounts that operate in our society concerning health and illness. They have been found to be diverse and wide-ranging, differing in what they assume to be salient, both in terms of content and in the kinds of explanation they stress. Detailed analysis of the accounts

themselves, and how they relate to each other has shown that what may be an appropriate domain to understand one, is far less relevant for another. Some, for example Accounts 4 and 8, were amenable to psychological interpretation - they offered opportunities to examine the functions that accounting can play in terms of self-presentation and self-concept. Others such as Accounts 1, 2 and 6 were much more amenable to sociological interpretation. While an attempt could, in theory, be made to seek to explain the psychodynamic functions of focussing on power-relations in Account 1, say, or of the perception of medicine-as-a-calling of Account 2, within an approach in which the account itself sets the agenda for interpretation, this is less appropriate than taking the analytic domains at face-value, exploring the different perceptions of societal functioning within a socio-hermeneutic framework. Account 1 is proffered as a sociological discourse; it must be interpreted in those terms.

However, this does pose problems if the aim of enquiry is to explore the 'reason' explanation aspects of an account. Having established that with reference to a broad concourse 'about' health and illness, accounts differ in the extent to which they are explanatory, it was decided to shift the research question into the more specific explanatory domain. The study which will be described in Chapter 7 does just this. It constrains the concourse to accounts for health and illness in four situations - reasons people ascribe for their current state of health; assumptions about what would influence their capacity to improve their health in the future; their views about what makes them ill; and, when they become ill, what enables them to recover.

CHAPTER 6 : THE DEVELOPMENT OF, RESEARCH INTO, AND
DECONSTRUCTION OF, THE HEALTH LOCUS OF CONTROL CONSTRUCT

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6.0 INTRODUCTION

The data analysis in the last Chapter demonstrated that the external/internal distinction between assumed reasons for, influences upon and causes of good health, illness and recovery offered a useful conceptual framework for making sense of those accounts which were primarily concerned with explanation. Account 1 construed influences on overall health as predominantly external to the individual - sited within society and determined by economic and political forces. Account 2 construed internal influences as crucial, arising from characteristics of individuals themselves, such as their attitudes, actions and lifestyle. Similarly accounts differed in terms of their attributions about recovery from illness. Account 4, for example, stressed internal factors, particularly those to do with the individual´s willingness to treat illness as a challenge to be fought off rather than ´given in to´; whereas Account 5 emphasised the role of medical care. Other accounts, however, (e.g. Account 3) combined aspects of both external and internal attributions.

This internal/external framework (as was noted in Chapter 1) has been frequently used in anthropological analyses of cultural diversity (particularly in the form of the exogenous/endogenous distinction, cf Stoetzel, 1960; Valebrega, 1962; Young, 1976) and weaves more broadly through sociological and psychological theorisation (evident, for instance, in the social control/theoreticity distinction (cf Dingwall, 1976) in sociology, and the difference between person-constructs-reality/ reality-constructs-person theorisation (cf Buss, 1978) in psychology). It has also been a central element within

attribution theory (Kruglanski, 1975 and Lalljee and Abelson, 1983 provide reviews), and is the basis for Rotter's (1966) 'Locus of Control' construct, which was itself the basis for the development of the 'Health Locus of Control' scale (Wallston and Wallston, 1978), which has been used in numerous studies to provide measures of accounting as both an independent and dependent variable.

Because of the empirical support from Studies 1 and 2, and the theoretical ubiquity of the external/internal distinction within explanatory accounting, it was decided to make it a major focus for the final study of this thesis. This Chapter briefly reviews the development and use of the 'Health Locus of Control' scale, to place that study into context.

6.1 THE LOCUS OF CONTROL CONSTRUCT

6.1.1 Locus of Control

Rotter and his associates (notably Phares (1955, see 1976 for his review of the early work)) formulated the concept of Locus of Control (Rotter, Seeman and Liverant, 1962; Rotter 1966) from social learning theory. The locus of control construct is, as has been noted already (Section 1.4.1 in Chapter 1) a reality-constructs-person approach to understanding accounting. It construes individuals' worldviews as predicated upon one of two general rationales : they either see the events in their lives, their roles and status, and the rewards and punishments they gain from life as internally controlled (i.e. consequences of their own actions, strivings and personal characteristics), or as externally controlled (i.e. consequences outside of the individual's control such as chance and fate). According to

social learning theory, the one adopted depends upon   whether rewards or punishments have, in the past, been perceived as arbitary events unconnected with their own actions, or have been construed as consequent upon how they, themselves, have acted.

6.1.2 Questions about multidimensionality

A great deal of theorisation and research have been devoted to exploration of this concept, both within a social learning framework and beyond it (i.e. both within reality-constructs -person and person-constructs-reality approaches). One of the most important developments was Levenson´s extension of the scale to include ´Powerful Others´ as a third site for perceived control (her Chapter in Lefcourt, 1981, provides a summary and review), a consequence, she reports, of her own experiences of frustration when made to extend her studies by an adminitrative ruling :

"Lack of my personal control did not result in my becoming a frustrated fatalist. Instead I believed that events were predictable, and that there were powerful others who were in control of these events." [p 16].

Levenson was not the first to question the over-simplicity of the external/internal dichotomy. Hersch and Scheibe (1967) had also noted that whereas scores on the Rotter E-I scale were relatively homogenous for identified ´internals´, those who scored as ´externals´ displayed far more variability, suggesting that different meanings were being attributed to the ´external control´ construct, and a number of traditional factor analytic studies indicated that the E-I concept is experienced as a multidimensional construct (e.g. Collins, 1974; Gurin, Gurin Lao and Beattie, 1969; Mirels, 1970). Collins´ study,

for example, identified independent factors which suggested that the E-I scale breaks down into four components : belief in a difficult world, a just world, a predictable world and a politically responsive world.

6.1.3 Culturally implicit values

Multidimensionality has increasingly become seen as salient when considering links between perception of control and social-political action (see Klandermans, 1983, for a review). This is because early work with the E-I scale tended to favour ´internality´ as the more socially desirable worldview within North American culture, with its stress on the individual´s commitment to self-determination, carrying with it the implication of personal rather than collective responsibility. Lefcourt (1981) has commented, for example :

"An internal locus of control may be one prerequisite for competent behaviour and an external control orientation seems common for many people who do not function in a competently healthy manner." (p 191).

Roberts and Reid (1978) have claimed that the assumed unidimensionality of the construct is a product of its development with exclusively middle-class (and predominantly student) samples, and that people from different social class and/or ethnic backgrounds make recourse to aspects of accounting which do not fit within this framework. McClelland ·(1971) has described the pervasive valuation of personal control in North American white, male, middle class culture as ´need-power´ and argued that far from being functional and desirable, it is divisive and can be positively fatal (he suggested that it may lead to suicide, when people fail because of what they see are

their own inadequacies). Partington (1976) provided a well-argued case for the cultural salience of 'internality' to North American 'fat cat' psychologists, and its consequent overemphasis and implicit endorsement within North American theorisation. To be fair, Rotter himself specifically recognised the cultural limitations of the E-I construct :

"Theoretically, one would expect some relationship between internality and good adjustment in our culture ... In regard to the other end of the distribution ... very high scores toward the external end may suggest, at least in our culture, a defensiveness related to significant maladjustment." (Rotter, 1966, p16, my emphases).

6.1.4 The introduction of the 'powerful others' construct

By confounding within externality both 'chance' and the actions of others, the unidimensional E-I scale denies expression to worldviews which stress, for example, the agency of power-relations (as central to Account 1 in the previous study), labelling this kind of accounting as 'fatalism'. Whereas Rotter and his associates · assumed (and had provided data to support the contention, e.g. Gore and Rotter, 1963) that it would be 'internals' who would participate more readily in socio-political action, a number of other studies have refuted this. Although, as Klandermans notes, the empirical results of studies of E-I and political action considered overall were inconclusive, some studies at least (e.g. Ghaffaradli-Doty and Carlson, 1979; Nassi and Abramowitz, 1980; Silvern and Nakamura, 1971; Vleeming, 1976) have shown that it was individuals who scored more highly as 'externals' who were the most likely to actively participate in civil rights, womens' rights and other protest activities. This externality cannot plausibly be interpreted as mere 'fatalism', and indeed a series of studies by

Levenson and Miller (1976) showed that given the opportunity, more politically active individuals with radical or left-wing views were more likely to regard control as sited in the agency of ʹpowerful othersʹ.

While the expression of ʹexternalityʹ in such cases reflected a denial of personal control, it is highly unlikely to have derived from attributions of luck. It is more likely to reflect a construal of the individualʹs role in society, the events that occur in their lives, and especially any disadvantage they have experienced as the result of manipulation, oppression and exploitation by those in society who had the means to control the lives of others. Particularly salient to this formulation is the finding in one of the Levenson and Miller studies that within the feminist movement, radical lesbian feminists were more likely to endorse control by ʹpowerful othersʹ than other feminists, and more likely to see themselves as lacking internal control. It is surely more plausible that this kind of accounting arose out of the explicit ideology of lesbian feminism (that women are exploited and oppressed by the patriarchy) than that lesbian feminists were more ʹfatalisticʹ in their accounting than other feminists.

There are clear resonances between the ʹpowerful othersʹ measures of Levensonʹs Multidimensional Locus of Control MLC scale and the strongly politico-economic accounts in Studies 1 and 2 in this thesis, where lesbian feminists were observed to be the most vocal exponents (in their comments) and providers of the most strongly loading exemplificatory Q sorts which expressed the view that health is predominantly a product of social

inequality and the power-control of, in their case, the patriarchy.

6.1.5 The development of a multidimensional health locus of control scale

The original version of the 'health locus of control scale' (HLC) followed Rotter's E-I dimension, tapping whether people construed their health as controlled from within, or by chance. However, Wallston and Wallston, impressed by Levenson's introduction of the 'powerful others' construct, and depressed by lack of success with their HLC scale, decided to reformulate it as a multidimensional scale.

Given the political context for the emergence of 'powerful others' as an additional variable within the E-I construct, it is surprising that Wallston and Wallston formulated 'powerful others' not to reflect socio-political control (i.e. the role of medicine as an hegemony, or more broadly the links between health and social disadvantage) but instead focussed upon the benign influence of medical professionals, family and friends. This can be observed by examination of the items in the POMHLC (Powerful Others MHLC) sub-scale, for example :

If I see an excellent doctor regularly, I am less likely to have health problems.

I can only maintain my health by consulting health professionals.

Other people play a big part in whether I stay healthy or become sick.

Health professionals control my health.

Following doctor's orders to the letter is the best way for me to stay healthy.

My family has a lot to do with my becoming sick or staying healthy.

Thus the operational definition of 'powerful others' built into the POMHLC scale was at odds with the rationale from which this dimension was introduced. Furthermore, it included items which can be interpreted in different ways. For example, the item 'Health professionals control my health' can be read either as an endorsement of the idea that doctors, nurses and the like provide effective services to improve health and offer effective treatments against disease; or as supporting the notion that medicine is an hegemony, with doctors, nurses and the like exerting powers which may be detrimental to health, deny services to the disadvantaged, and construct certain forms of counter-normativity (e.g. lesbianism) as 'illness' to be 'treated'. Even within the domain of R methodology, where construct-validity and reliability are assumed to be crucial for correct scale construction, the POMHLC scale fails to meet the requirements of 'good' psychometric method.

This development therefore lacked conceptual and methodological rigour, given its theoretical origins, a distortion compounded by the sample on which it was first tested - persons recruited at an Airport. While air travel is more common in North America, and not as much restricted to the wealthy as in Britain, it is unlikely that the sample included many respondents, say, on 'welfare' or belonging to the radical protest groups with which the political 'powerful others' attributions had proved most salient. This point, also raised by Nash (1987), is an example of Harré's (1979) observation that questionnaires seldom discover more than :

" ... the representation of the shadow cast upon the social
world by the prior conceptual apparatus deployed by the person
who constructed the questionnaire." (p 115)

Wallston and Wallston appear to have had a fixed image of what

people's perceptions of 'powerful others control' in relation to

health would be, an image so blinkered that they did not even try

to introduce a PO construct analogous to that devised by

Levenson. It neither seems to have occurred to them that medical

care might be anything other than benign, nor that there may be

people whose accounting focussed on the 'powerful others' of the

State, capitalism, or the patriarchy. (In this respect it is

perhaps salient to note that Stephenson was prevented from

publishing his 1962/3 studies of 'Public Health Image' because of

the assumed 'communist' overtones of his results).

Another source of potential distortion is that the MHLC scale

(as does the E-I construct) makes the assumption that people are

consistent in their attributions of control across situations -

that, for example, somebody who sees doctors as crucial for

curing illness also sees them as crucial to preventing illness.

While the consistency of scores found by Wallston and Wallston

within each of the three dimensions implies that this assumption

was well-founded, the homogenisation engendered by R

methodological analysis is insensitive to the possibility that

while some people may indeed construe control consistently across

situations, others may not. Certainly the accounts identified and

the interview data from Studies 1 and 2 led me to suppose that

people do differ in this regard, for while some people adopt

the same explanatory model consistently for current and future

health, in terms of reasons for illness and reasons for

recovery, others did not, varying their attribution of control

according to the different contexts. Nash (op cit) has also found

in interviews with people who had completed a version of the MHLC

scale that :

"Locus of control tended to vary considerably even within individuals according to each very specific aspect of behaviour being discussed." (p 210).

6.2 EMPIRICAL STUDIES WITH THE MHLC SCALE

6.2.1 The MHLC scale

These considerations apart, Wallston and Wallston's multivariate

(MHLC) scale undoubtedly did represent an improvement over their

earlier version, the unidimensional (HLC) scale (in which only the

internal/external dimension was tapped), and in its use of · a

Likert format, in contrast to the original E-I scale. They

summarised (1981) studies which made use of the MHLC scale to

show that it did seem sensitive to some of the demographic and

other individual difference variables which might be expected to

relate to it (although only mean scores are reported, with no

indication of significant differences) :

Sample	N	Mean scores obtained		
		Internal (IMHLC)	Chance (CMHLC)	Powerful Others (POMHLC)
Healthy Adults	1287	25.55	16.21	19.16
Students	749	26.68	16.72	17.87
Persons engaged in preventive health programmes	720	27.38	15.52	18.44
Chronic patients	609	25.78	17.64	22.54

People engaged in preventive health programmes gained the highest mean IMHLC[1] score, and patients suffering from chronic disease gained the highest mean CMHLC[2] and POMHLC scores.

Conventional (i.e. R methodological) factor analytic studies (e.g. Nagelberg, 1979; Stuart, 1979) confirmed the independence of the IHLC/EHLC/POHLC dimensions using large American national samples, though other studies (e.g. Bloom, 1979 on women who had experienced a mastectomy, and Nash, op cit, with a British sample) did not. The Bloom study, for example, identified only two factors - Fate and self-blame (the latter indicating a division within internality between control and culpability). While some studies confirmed a high alpha reliability of the MHLC scale (e.g. De Haas and van Reken, 1979), others (e.g. Lewis, Morisky and Flynn, 1978; Albino, 1980) found it to be low, although Wallston and Wallston (1981) claimed that this may have been a product of methodological differences.

6.2.2 The MHLC scale used to measure accounting as an independent variable

Wallston, Maides and Wallston (1976) have argued that there is no reason to expect that the MHLC scale values will necessarily predict health related action, noting that social learning theory assumes that reinforcement expectation and valuation of health are also important determinants, and that other formulations (e.g. The Health Beliefs Model described in Chapter 1) incorporate additional variables such as perceptions of cost and instrumentality. (Kristiansen, 1985, has also argued that attempting to use MHLC as an independent variable without taking account of estimates of health value is likely to be

1 : IMHLC = 'Internal' MHLC   2 : CMHLC = 'external MHLC.

unproductive, since valuation of health varies so dramatically between people). Wallston and Wallston even express puzzlement and disbelief at studies in which MHLC values <u>were</u> found to be strongly and positively linked to health-linked action (e.g. Sproles, 1977), and indeed, these are few and far between.

Their own original study using the E-I based HLC scale had found that while a measure of health-value did predict willingness to read health educational literature in a role play, HLC scores did not, a negative result that held up in an attempted replication (DiVito, Reznikoff and Bogdanowitz, 1979) where HLC only predicted action when the measure they used for health value also scored high.

Nevertheless, Wallston and Wallston hoped that the development of the improved MHLC scale would gain them better results from a study of hypertension patients´ information seeking behaviour, but reported, somewhat forlornly :

"Now with three scales rather than one we felt we could not miss... We wish we could report the unqualified success of this strategy ... but we could find no combination of health-value and MHLC beliefs that explained the variance in number of hypertension-related pamphlets chosen."

A later study (reported in Wallston and Wallston 1981) did, however, reinstate their earlier finding of links with health-value, and this time with externality and powerful others scores too, though to their surprise only in terms of information about hypertension (i.e. where attempts had previously failed) and not about herpes (a disease they assumed would be highly salient to their student sample).

Similarly patchy and not very encouraging results were obtained when attempts were made to link MHLC with health preventive and treatment compliance behaviours. Olbrisch (1975) found no significant differences between the plans for future prevention of gonorrhea patients with high internal compared with high external scorers; McCusker and Morrow (1979) found no significant correlations between MHLC scores and cancer-preventive actions; and even with very large samples (participants in the 'Weight Watchers' programme) Stuart (1979) found no significant correlations at all between HLC measures and a wide variety of health behaviours. Carnahan (1979) found no links with dental behaviour; Wallston and McLeod (1979) and Lewis, Morisky and Flynn (1978) found none with compliance with a hypertension reduction regime. Baughman (1978) studied female clerical and secretarial employees with results that even Wallston and Wallston described as "... mixed but generally unimpressive.". Better results were obtained by Wildman et al (1979) for correlations with smoking reduction, but in another study by Kaplan and Cowles (1978) the better results for internals were found to be short-lived. The only area where the MHLC scale did seem to offer some predictive validity was with renal dialysis patients, with Sproles (op cit), Binik and Devins (1979) and Levin and Schulz (1980) all finding significant correlations between either internality or externality and compliance with dietary regimes.

6.2.3 The MHLC scale used to measure accounting as a dependent variable

Wallston and Wallston have argued that MHLC is most appropriate as a dependent variable. They cite a number of studies which gained, in their own words, "modest" support for their scale in

explaining antecedents of health beliefs, including one of their own (De Vellis, De Vellis Wallston and Wallston 1980b) which showed that for patients who had experiences of epileptic seizures, externality was more salient than the norm, another by Nicholson (1980)which showed that after hospitalisation on the birth of their child, first-time mothers gained higher external and lower internal scores than the norm; and another by Tolor (1978) which linked frequency of childhood illness to scores on externality, a result found only with women.

As a dependent variable to provide evidence about changes in health beliefs following some form of intervention. Wallston and Wallston cited four studies, all of which offered very disappointing results. Nagelberg (1979) studied the impact of a health risk reduction programme, in which no significant differences in HLC scores were found between participants and controls. Bloom (op cit) fared a little better, with counselled mastectomy patients proffering less fatalistic responses two months after their operation than a control group, although, as has been noted already, Bloom's data were inconsistent with the dimensions of the MHLC scale. Similar differences were found by Diller et al (1979) with cancer patients given psychosocial counselling, with the counselled group scoring lower on externality three months post-operatively, but these differences disappeared by six months after the operation, suggesting that Bloom's data may have reflected only a short-term effect. Schiller, Steckler, Dawson and Heyman (1979) used the MHLC to observe the impact of a health education programme, and again found no significant results, though Wallston and Wallston suggested that this may well have been a ceiling effect,

occurring because people who attended the programme began with higher internality scores than the norms Wallston and Wallston had established for persons engaged in health promotion activities.

Thus the only area in which the MHLC scale has been found to be   encouraging on its own was in studies that compared scores between different groups of people. Blacks scored higher on CMHLC than whites (Sproles, 1977); contraceptive users and women who had had an abortion scored higher on IMHLC than unmarried mothers (Harkey and King, 1976); persons having lower levels of education, and of lower socio-economic class scored higher on CMHLC than those with more education and from higher socio-economic groups (Harkey and King, op cit; Rosenblum, 1979; Sproles, op cit); attenders at a health fair scored higher on IMHLC and lower on CMHLC compared with a sample of nonselected adults (Wallston and Wallston, 1976); patients attending a weight reduction programme gained higher IMHLC scores than those being treated for cancer by chemotherapy (Saltzer, 1979). Women having just given birth to their first baby scored lowest on POMHLC (Lowenstein, 1979), and diabetics scored the highest (Nagy, 1979).

Overall, Wallston and Wallston concluded that while in a few studies IMHLC scores did provide some positive indications of ´healthy´ actions, CMHLC scores were (albeit still infrequently) better predictors, though paradoxically sometimes of ´desired´ behaviour (eg. compliance with drug regimes) sometimes with ´undesired´ behaviour, and that in general "... health locus of control research is still in its adolescence(sic), full of

pimples and promises, quivering on the brink of adulthood."
(Wallston and Wallston,1981). At the time of writing they felt
that while the reliability of the scale had been reasonably
established, its construct validity was still very much an open
question.

6.2.4 Theorisation about variability within the Locus of Control Scale

Nash´s (op cit) more recent research using a modified MLC scale
found similar paradoxical results, her highest ´internal´ scorers
being those who, when interviewed, described what she saw as
´unhealthy habits´ (i.e. smoking, taking little exercise and
eating ´junk food´). Nash herself was very critical of the MHLC
scale, and saw it as unsuited to British samples, which is why
she devised a new scale. In an attempt to explain these data she
cited a number of formulations (Janoff et al, 1980; Nowicki and
Duke, 1983; O´Brien, 1984; Wong and Sproule, 1982) that have
argued that extreme scores of particularly high ´externality´ or
´internality´ on the Rotter ´Locus of Control Scale´ are
dysfunctional. Janoff et al., for instance, have suggested
that they represent different patterns of ´pathological´
accounting, the ´pathology of low expectation´ (where people are
too easily discouraged) and the ´pathology of high expectation´
(where people stubbornly persist with insoluble tasks). Wong and
Spoule coined the term ´bi-locals´ to describe what Nash calls
"... sensible people who operate within their external
constraints to achieve realistic goals" i.e. middle-range E-I
scorers, who are more ´healthy´ than either extreme external or
extreme internal attributors.

Nash argues, therefore, that some of the reason why the MHLC scale had proved so ineffective at predicting health-related actions is that contrary to Wallston and Wallston's expectations, high 'internal control' attributions are not necessarily functional, nor linked to the kind of 'sensible' accounting system likely to be expressed by the kinds of people who do 'sensible' things like seek out health education information and preventive services, and who have adopted 'healthy' lifestyles.

6.2.5 Studies using MHLC with British samples

All of the studies reviewed by Wallston and Wallston (1981) were conducted with American Samples. The best known and most extensive work with the MHLC scale with British samples is that of Pill and Stott (1981, 1982, 1985a, 1985b, 1987, already described in Chapter 2, Section 2.2.2) who, in an investigation of the accounting of Welsh working class mothers, examined its links to reports of health-related actions, knowledge, lifestyle and a range of demographic variables.

In their initial pilot study (1981) they found no significant correlations between a salience of lifestyle index (SLI), developed to tap a mixture of attitudes to health, knowledge about such things as a 'healthy diet' and reports of health preventive actions, and MHLC scores, other than a small but significant negative relationship between 'powerful others' and SLI scores. They commented in relation to the internality dimension :

"The scale does not distinguish between a locus of control for health maintenance and a locus of control for illness behaviour. Moreover, it allows those who place emphasis on modification of

personal behaviour for prevention and self-treatment of illness to score as highly as those who stress the use of screening procedures and professionals for both prevention and illness. This must account for some of the contradictory findings and the sometimes disappointing predictive value of the tool." (p98).

And with regard to the 'powerful others' :

"There is, of course, no logical reason why an orientation to prevention that recognises the importance of day-to-day decisions in personal behaviour could not coexist with frequent recourse to the physician. The relationship between physician and patient could be very different, with the professionals being used as sources of advice to be evaluated and queried at the consultation." (p 98).

Later work bore out this supposition. A subsequent, more comprehensive study with a much larger sample (Pill and Stott, 1985a) indicated that while POMHLC score overall did not correlate with SLI, two items from the POMHLC scale did show significant negative correlations : "Whenever I don't feel well, I should consult a doctor" (r = 0.14, p = 0.05) and "Regarding my health, I can do only what my doctor tells me to do" (r = 0.165, p = <0.05).

As has already been noted in Chapter 2, Pill and Stott also made the point that what is often interpreted as 'fatalism' from a high score on the CMHLC can otherwise be interpreted as "... a realistic appraisal of the complex variables involved in the aetiology of illness ... The forces of the market place are very powerful influences which are essentially external and beyond the individual's control.". In other words, as they stress in their later paper that year (Pill and Stott, 1985b) belief about locus of control is just one among a large number of variables which determine overall worldview and action. Nevertheless, their most recently reported study (1987) did find a significant negative relationship (r = 0.263, p = <0.001) between score on an

improved SLI index and the CMHLC scale. Women who scored highly on their measure of 'healthy lifestyle', scored significantly lower on the CMHLC scale than those with a lower SLI score.

6.2.6. Modifications of the MHLC scale

Recently Blaxter (1987, forthcoming) has used an amended version of the MHLC scale, developed on the first 1000 respondents in a very large-scale survey of health beliefs, which showed that younger people, men, and in particular people who have had more education and those who define health in terms of 'fitness', tend to score more positively, seeing themselves as more 'in control' of their own health - even though, paradoxically (as was found by Nash, op cit), high scorers are more likely to engage in some forms of unhealthy behaviour such as smoking and drinking. Blaxter echoes Wallston and Wallston saying "Specific behaviour cannot necessarily be predicted from attitudes.",

Nash's (op cit) attempts to reformulate the MHLC were, as has been already mentioned, not very successful. Indeed, her typology (idenfified by R methodological factor analysis of scores) appears to be even more construct-invalid than the MHLC. She identified a clear 'Chance' factor, and a 'Powerful Others' factor exclusively concerned with compliance with medical care and advice, but her 'Internal' factor seems to have more in common with Pill and Stott's 'medium SLI' image of 'taking care of yourself' (See Section 2.2.2) than what they would regard as genuine 'internality', based as it is on the responses to just these two items :

Good health depends largely on my taking good care of myself.

If I was unwell it would probably be because I hadn't been looking after myself properly.

Nash called the other two factors she had identified 'realism' and 'idealism', though such terminology is strangely at odds with the items which loaded onto and defined them. 'Idealism' was defined by items about making money being easy, and having friends because 'it's easy to be popular', and "In life you can have anything if you want it enough" (which Nash regards as unrealistic over-optimism). 'Realism' comes over as much more to do with an account in which one's own behaviour is seen to be the controlling agency, with these items providing definitive loadings :

Good teeth are mostly a matter of sensible eating and brushing.

If I were financially successful, it would probably be because I proved I was capable.

Good teeth are mostly a matter of regular dental checkups.

If I had a lot of friends it would be because I do things for other people.

Nash seems to have fallen into the R-methodological essentialist trap of assuming that her theory-guided classificatory framework offers an adequate explanation for accounting, when it is quite clear that equally plausible alternatives are not only possible, but probably more tenable.

6.2.7 Deconstructing Health Locus of Control

An alternative explanation for the generally inconclusive construct validity of the MHLC scale is that its theoretical assumptions are fundamentally at fault. The poor results have encouraged researchers to surmise that the MHLC scale confounds a

number of potentially contradictory beliefs. It assumes just three loci of control - a person's own actions, chance, or the benign influence of others - but gives these more global labels - internal, chance and powerful others. Bloom (op cit), for instance, suggested that although self-blame and self-determination are both subsumed within the 'internal' dimension, they do not necessarily go together, a finding consistent with the results from Study 2, particularly in the separation between responsibility and blame made in Accounts 4 and 6. Pill and Stott commented upon the possible divisions between beliefs about who or what controls the ability to prevent illness, and who or what controls recovery from illness; that 'chance' attributions may be realistic appraisals of situational influences (e.g. poverty, working conditions) rather than fatalism; and that the POMHLC scale omits the more general political aspects of the Levenson MLC scale, found to be central to Account 1 in Study 1 and in Accounts 1 and 6 in Study 2.

Part of the motivation for the final study in this thesis, therefore, was to use Q methodology to deconstruct the locus of control construct as applied to health, and to seek, in this way, to do what Q methodology does best - identify alternative accounts by way of people's operancy rather than to define, a priori, what their accounts are likely to be and then to try to mould the data to fit. The Locus of Control, and its derivatives, the HLC and MHLC scales, are classic R methodological instruments. If Q method is as successful as its proponents claim it to be, then it should offer a useful technique for teasing out from the dimensions of the MHLC construct some of the alternative accounts which get submerged

within its three rather crude divisions between 'internal',
'chance' and 'powerful others'.

CHAPTER 7 : STUDY 3
A INVESTIGATION OF ACCOUNTING FOR HEALTH AND ILLNESS, LINKING
REPORTS ON THE MHLC SCALE, INFLUENCES ON HEALTH AND ILLNESS
QUESTIONNAIRE, AND Q SORT

7.00 INTRODUCTION

The research described in this Chapter examined the ways that, in British society, people explain what affects :

* their current state of health;

* whether or not they will achieve better health in the future;

* whether or not they become ill;

* the speed and likelihood of their recovery when they do become ill.

This task was approached by gaining responses on three different kinds of instrument. The first was the MHLC scale itself, modified by replacing the words 'sick' and 'sickness' with 'ill' and 'illness'; and 'physician' with 'doctor', because of the different meanings these words have Britain compared with America. The second was a health-control Q sort, structured in part by way of an analysis of potential influences suggested by Studies 1 and 2, and devised in part via careful piloting of items. The third instrument was an <u>Influences on Health and Illness Questionnaire</u> (IHIQ). This used a Likert format and was divided up into the four situations listed above, systematically and more comprehensively covering the different influences identified for the Q sort. The IHIQ was intended to provide a link between the MHLC scale and the Q sort, in that its format was similar to the MHLC (although, with 124 items a lot longer, and with a 0 = 'no influence' to 7 = 'strong influence', scaled slightly differently) but its analysis (factor analysis by persons) more similar to the Q sort. It also offered an opportunity to explore the potential for Q analysis of Likert format data. To aid comparability, all three instruments were

expressed, as is the MHLC, in the first person (i.e. what influences 'my' health, illness, etc.).

7.1 METHOD

7.1.1 Derivation of Q sample and the IHIQ

For the derivation of the Q sample an initial pool of 48 statements was selected, twelve drawn from the MHLC (sometimes rewritten to read more like everyday language), others from the accounts identified in Studies 1 and 2, and others from comments made by participants in those studies, and from some of the suggestions made by Pill and Stott (particularly their distinction between 'lifestyle' and 'taking care of yourself'). These were listed on a questionnaire (Shown in Appendix 9) completed by 8 associates (other researchers and theorists in the area, other Q methodologists and several colleagues), following which some items were changed (in response to comments about wording), some omitted (in response to comments about balance and duplication) and a number of suggested new items were added. From an analysis of these responses a framework was constructed to provide basis for a structured Q sample. This is shown in Figure 7.1. The new items, 60 in total, together with the framework (Shown in Appendix 10) were sent to 12 associates who once more provided information about balance, wording and this time also about comprehensiveness, including suggestions for additional items.

7.1.2 Materials

A final Q sample of 80 items and the IHIQ of 124 items were generated from this pilot testing. The IHIQ was not subjected to

Figure 7.1
Matrix used to aid structuring of Q sort for study 3

SITUATIONS/HEALTH STATUS

POSSIBLE FACTORS AFFECTING :-		State of Health	Health Promotion	Becoming ill	Recovery from illness
Self	Body				
	Mind				
	Action				
Chance	Fate				
	Probability				
Agents	Persons				
	God				
	Organisms				
	Environment				
	Circumstances				
	Events				
	Substances				

any psychometric validation, since the intention was not to provide a scale but to merely explore the kinds of accounts which would emerge from by-person factor analysis of Likert format data. Within this context such issues as objectively defined construct validity are inappropriate - constructs are regarded as the products of the alternative configurations of responses, created by participants' operancy, not in any sense 'in' the questionnaire itself. The materials used in the study are provided in Appendix 11 (except for the Q intructions, which were identical to those used in Study 2, except for the different format of the Q matrix). The instructions for the IHIQ contained detailed information about the interpretation of some of the terms used (e.g. distinctions between circumstances, relationship and environment, and between 'chance' and 'probability').

7.1.3 Participants

Seven participants from Studies 1 and 2 also took part in this one. Two associates placed advertisments on college noticeboards, recruiting 13 participants, and a further four were recruited by a relative and eight via a local group of 'Samaritans' (the incentives contributing to fund-raising). Other participants were recruited from my workplace, pubs, shops, a Spiritualist Church, a private 'alternative medicine' practice and a local homeopathic association. 'Snowballing' introduced a Hindu student, a psychotherapist and several people who were 'handicapped' or had suffered severe illness (e.g. pituitary tumour). Of a total of 100 sets of materials sent out, 83 were returned in a usable form.

Of the 83 participants, 36 were male and 47 were female. Ages

ranged from early teens to late sixties, and occupations included students, secretarial and administrative staff, lecturers and teachers, 'blue collar workers' (e.g. a motor mechanic, cook and bricklayer), and 'white collar workers' (e.g. engineers, computing staff, a company director and accountants). Nine participants were unwaged, including pensioners, unemployed people and mothers. Four participants were orthodox medical professionals, and six were practitioners in 'alternative' medicine. Religious affiliation included Church of England, Catholic, Christian spiritualists, and members of the Hindu and Bahai faiths. About a half of the participants lived in the South of England, the remaining half divided between the North of England, Wales and Scotland, both including rural, inner city and suburb locations. Once more about half of the sample were strategically selected, and about half to cover as broad a range of 'ordinary people' as possible.

7.1.4 Procedure

The materials as shown in Appendix 11 were given or mailed out to participants who were provided with a stamped addressed envelope for the return of completed scales and response forms. All participants worked from written instructions. Participants were paid £5 for completing the three scales, which was reported to have usually taken between one and two hours.

7.2 RESULTS

The Q sort responses were coded in the usual way, and together with the MHLC and IHIQ data were keyed into the computer. The Q sort and the IHIQ data were subjected, via SPSS, to principal components by-person factor analyses, factors extracted

by varimax rotation. The MHLC data were partitioned to give separate IMHLC, CMHLC and POMHLC scores for each participant, but were also by-person factor analysed for exploration of the factors which would emerge.

7.3 MHLC RESPONSES

The separate scores on the IMHLC (internal control), CMHLC (chance control) and POMHLC (powerful others control) sub-scales for each participant are shown in Table 7.1. The scores were from a six-point Likert scale, with 12 items in each sub-scale, combining the 6 items from each of the A&B versions. Thus the maximum score an individual can gain on any sub-scale would have been 72, with 42 representing the median. The mean for the IMHLC data is somewhat lower than means typically obtained in other (mostly American) studies, but means for CMHLC and POMHLC are within the usual ranges. However, for all three sub-scales, the data from this present study contain much more variance, with the standard deviations approximately double those typically found. This is to be expected, given that half of the participants were deliberately selected for diversity, and indeed provides some endorsement that diversity had indeed been achieved.

The results of the by-person factor analysis of MHLC data sets are shown in Appendix 4 (factor loadings). Perhaps surprisingly, sixteen independent factors with eigenvalues greater than unity were derived, of which seven contained at least one exemplificatory loading (in this case the criteria used were loadings > 0.70, with no other loading > 0.35). Table 7.2 summarises the exemplificatory Q sorts, together with the

Table 7.1 Internal/Chance/Powerful others Scores obtained on the MHLC scale in Study 3

Participant no.	IMHLC score	CMHLC score	POMHLC score	Participant no.	IMHLC score	CMHLC score	POMHLC score
1	55	41	38	43	42	36	24
2	45	64	30	44	40	35	30
3	36	45	24	45	43	55	39
4	45	42	30	46	58	23	30
5	35	34	23	47	45	49	41
6	49	36	43	48	62	24	16
7	53	50	25	49	55	20	23
8	56	39	35	50	33	57	27
9	29	36	27	51	25	44	36
10	49	26	31	52	43	25	34
11	40	44	30	53	33	29	31
12	57	15	17	54	54	47	60
13	59	44	41	55	42	32	37
14	61	25	17	56	57	49	27
15	48	26	23	57	39	54	46
16	45	35	35	58	41	40	40
17	51	37	36	59	38	44	26
18	29	68	33	60	42	49	57
19	57	46	39	61	64	16	31
20	45	20	31	62	49	21	27
21	52	34	26	63	53	15	30
22	50	16	32	64	56	30	31
23	47	29	40	65	51	34	26
24	28	45	41	66	38	31	17
25	25	29	27	67	21	49	25
26	41	47	40	68	31	51	15
27	30	36	26	69	48	34	40
28	66	25	21	70	41	24	39
29	46	35	28	71	53	30	25
30	42	43	32	72	56	18	29
31	65	31	19	73	41	43	37
32	48	42	32	74	40	44	26
33	45	25	25	75	53	30	25
34	45	40	20	76	61	18	37
35	54	18	28	77	57	31	32
36	55	29	23	78	42	22	19
37	43	31	32	79	40	33	22
38	37	24	37	80	48	31	31
39	53	22	23	81	38	29	22
40	26	51	18	82	26	40	23
41	52	34	32	83	39	44	40
42	50	28	20				

Averages   IMHLC = 45.53   CMHLC = 35.07   POMHLC = 30.22

Standard Deviation   = 10.29   = 11.60   = 8.69

Table 7. 2 Exemplars identified in inverted factor analysis of MHLC scores in Study 3

Factor	Loading	Participant	MHLC Score		
			I	C	PO
1	.87	12	57	15	17
	.87	14	61	25	17
	.77	15	48	26	23
	.80	22	50	16	22
	.87	28	66	25	21
	.90	31	65	31	19
	.81	35	54	18	28
	.82	36	55	29	23
	.83	39	53	22	23
	.72	46	58	23	30
	.93	48	62	24	16
	.91	49	55	20	23
	.88	61	64	16	31
	.75	62	49	21	27
	.82	63	53	15	30
	.76	64	56	30	31
	.70	65	51	34	26
	.82	71	53	30	25
	.71	72	56	18	29
	.89	76	61	18	37
	.76	77	57	31	32
	.81	78	42	22	19
2	.76	2	45	64	30
	.90	18	29	68	33
	.73	40	26	51	18
	.80	50	33	57	27
	.75	67	21	49	25
	.80	68	31	51	15
3	.82	51	25	44	36
4	.75	60	42	49	57
5	.81	25	25	29	27
6	.86	13	59	44	41
7	.81	37			

associated MHLC sub-scale scores.

7.3.1 MHLC Factor 1

Examination of Table 7.2 shows that Factor 1, with 22 of the participants' MHLC data sets providing exemplificatory loadings, clusters together response patterns in which the 'internal' scores are relatively much higher than 'chance' or 'powerful others', with the highest IMHLC score 66, and only one participant (78) with a IMHLC score lower than the overall mean of 45.53. This factor therefore clearly identifies an 'internal' viewpoint, contributing 39.7% of the variance in the participant sample.

7.3.2 MHLC Factor 2

Factor 2, with six MHLC data sets providing exemplificatory loadings, clusters together response patterns in which 'chance' scores are relatively much higher than either 'internal' or 'powerful others', with the highest CMHLC score 68, and even the lowest at 49 considerably higher than the overall mean of 35.07. This factor therefore clearly identifies a 'chance' viewpoint, contributing 14.7% of variance in the participant sample.

Thus 54.4% of the variance overall can be attributed to either 'internal' or 'chance' viewpoints, with 28 participants in the sample being identified as one or other by way of the by-person factor analysis. The internal/chance distinction seems to emerge from by-person factor analysis as it does from the more traditional by-item factor analysis. However, for the remaining five factors, the simple internal/chance/powerful others division does not emerge as clearly. Even with the limited MHLC scores

data, by-person factor analysis begins to deconstruct the MHLC construct in some interesting ways.

7.3.3 MHLC Factor 3

Factor 3 has just one participant providing an exemplificatory loading (participant 51). Her raw scores are not very informative, placing her IMHLC score lower than, but both CMHLC and POMHLC scores higher than the relevant overall means. This factor does not identify either a clear ´chance´ or ´powerful others´ viewpoint, but something more complex. Examination of her individual responses shows that she marked no items in the strongest agreement (6) category, and only two were marked 5, both ´powerful others´ items :

10. The type of care I receive from other people is what is responsible for how I recover from illness.

17. Health Professionals help keep me healthy.

However, she disagreed stongly with the following ´powerful others´ items (placement = 1) :

14. I can only maintain my health by consulting health professionals.

27. Health professionals control my health.

35. Regarding my health, I can only do what my doctor tells me to do.

The viewpoint identified by this factor therefore looks very much like the one Pill and Stott (1980) found among those of their Welsh working class mothers who had a high SLI index score. They rejected powerful others as controlling their health but recognised that health professionals can play a role in health promotion and maintenance. Pill and Stott arrived at this

interpretation by observing that scores on items about 'powerful others' controlling health correlated significantly negatively with scores on the SLI index.

However, unlike Pill and Stott's high SLI scorers, Participant 51 has a below average score on the IMHLC sub-scale. Her score is depressed by rejection of Item 12 (When I feel ill, I know it is because I have not been taking care of myself properly = 2), 22 (Whatever goes wrong with my health is my own fault = 1) and 25 (When I get ill I'm to blame = 2). Yet items such as 23 (I am in control of my health = 4), 29 (The main thing which affects my health is what I do myself = 4) and 36 (If I become ill, I have the power to make myself well again = 4) all receive agreement. Since Participant 51 also provided an exemplificatory Q sort, her account can be explored in more detail later. However, at this stage, MHLC Factor 3 appears to identify an account for health and illness which, like Account 4 in Study 2, accepts responsibility for health, denies blame for illness, and sees chance as salient for becoming ill.

7.3.4 MHLC Factor 4

Factor 4 is also exemplified by just one participant's loading (participant 60). In this case the 'powerful others' score of 57 is much higher in relation to the IMHLC and CMHLC scores, and it would seem that it is Factor 4 which provides the clearest identification of the 'powerful others' viewpoint, although 'chance' is also quite strongly attributed. Examination of this participant's responses shows that getting ill and being well are both seen as matters of 'what will be will be' (Items 18 and 28

both = 6), but both family and friends and medical professionals are seen to have a lot of influence, particularly over recovery from illness (items 5 and 10 both = 6). While overall the 'internality' score is low, it is the strong rejection of self-blame items (12,22 and 25 = 2) and of items which suggest the individual can prevent illness (e.g. Item 13 = 1) which depress it. Recovery is seen as a matter over which he had control - item 1 (If I get ill, it is my own behaviour which determines how soon I get well again = 6).

7.3.5 MHLC Factor 5

Factor 5, exemplified by participant 25, is notable because of its low scores in all the three categories - all are below the overall means. No items were marked 6, and only two were marked 5 - item 18 (No matter what I do, if I'm going to get ill, I will get ill) and item 34 (Often I feel that no matter what I do, if I'm going to get ill, I will be ill). The overall low endorsement, a viewpoint that nothing makes a lot of difference, and the selection of these two for strongest agreement, suggest that this factor is one which identifies a genuinely 'fatalistic' viewpoint.

7.3.6 MHLC Factor 6

Factor 6, exemplified by participant 13,is in contrast,one where all scores are higher than the overall means, indicating a viewpoint which regards health and illness as multiply determined by all three kinds of influence - 'internal', 'chance' and 'powerful others'. Some insight into this pattern is provided by a letter sent with the responses by Participant 13, a woman who was physically challenged by having been born with spina bifida,

who had always walked with crutches and had experienced surgery many times in childhood. She wrote :

"... having filled in all the questionnaires, I realised that I was taking a different attitude to different ones ... my spina bifida was just bad luck, I can't really blame anyone or anything ... but that does not mean I can ignore advice about diet, or the need to keep active even within the limits of my handicap if I want to be healthy. I <u>have</u> to keep my weight down and do my exercises regularly if I'm to keep mobile ... People like me can't help but value what modern surgery has done for us. If I had been born 100 years ago I simply would not have survived, I would have died soon after birth ... and without the help of many doctors .. and people like physiotherapists ... and the tremendous support I have always got from my family, and from my friends too, I could not have got where I am now, holding down a job and owning and running my own home."

She clearly had good reason to endorse all three. These two latter factors could have been simply interpreted as 'nay-saying' and 'yea-saying', but as closer examination of the patterns of response indicate, they do both in fact reflect more complex and meaningful viewpoints.

7.3.7 MHLC Factor 7

Factor 7 was identified by Participant 37's exemplificatory loading. This man's IHIQ data set exemplified a factor, which, as will be described later, identifies an account which reflects very much his Hindu background. He distinguishes between fate (Item 6 = 4) and good fortune (Item 11 = 1), accident (Item 21 = 1) and luck (Item 32 = 1); between the importance of family and friends (Item 6 = 4, Item 10 = 5) and medical professionals (Items 8, 14, and 17 = 2, Item 27 = 1). It is relatively easy to make sense of these with hindsight, knowing about his cultural and religious backgound, but without this information, his MHLC responses would give little or no indication of his viewpoint.

7.4 INFLUENCES ON HEALTH AND ILLNESS QUESTIONNAIRE RESPONSES

The by-person factor analysis of the the IHIQ data yielded eleven factors with eigenvalues greater than unity, of which seven had one or more exemplificatory loadings (loading >0.6, where no other loading on another factor was greater than 0.35). The factor loadings are shown in Appendix 4, and a summary of exemplars (including MHLC scores and, where relevant, the factor exemplified by the MHLC scale) are provided in Table 7.3 From this it can be seen that the IHIQ factors deconstruct the MHLC construct further. Table 7.4 shows the factor scores (calculated by a weighted averaging procedure similar to that used for estimating Q factor scores) for each of the 124 items.

Whereas with the MHLC data a single factor drew together those people expressing ´internal control´, here they are divided up between Factors 1 and 2. IHIQ Factor 1 is exemplified by 19 people´s response patterns, five of whom had exemplified HMLC Factor 1. IHIQ Factor 2 is exemplified by four people´s response patterns, all participants who had also exemplified MHLC Factor 1. Thus the IHIQ data sets yield two Factors which show evidence of ´internality´, but since they are independent, different versions of ´internality´. Similarly, IHIQ Factor 3 and IHIQ Factor 4 deconstruct ´externality´. Each one is exemplified by two people who were exemplars for MHLC Factor 2. IHIQ Factor 5 is exemplified by two participants, one of whom was the exemplar for MHLC Factor 7. IHIQ Factor 6 is exemplified by participant 58, whose MHLC data set did not load onto any of the MHLC Factors; but IHIQ Factor 7 was exemplified by participant 60, who was the exemplar for MHLC Factor 4.

Table 7.3   Exemplars identified from by-person factor
analysis of IHIQ   data in Study 3

Factor	Loading	Participant	MHLC Scores			Factors from MHLC data
			I	C	PO	
1	.68	1	55	41	38	
	.70	3	36	45	24	
	.60	4	45	42	30	
	.68	8	56	39	35	
	.73	15	48	26	23	1
	.76	17	51	37	36	
	.64	23	47	29	40	
	.63	25	25	29	27	
	.69	29	46	35	28	
	.73	35	54	18	28	1
	.68	38	37	24	37	
	.79	42	50	28	20	
	.72	44	40	35	30	
	.78	46	58	23	30	1
	.77	52	43	25	34	
	.60	54	54	47	60	
	.72	57	39	54	46	
	.70	61	64	16	31	1
	.79	78	42	22	19	1
2	.64	14	61	25	17	1
	.69	36	55	29	23	1
	.67	48	62	24	16	1
	.60	49	55	20	23	1
3	.73	2	45	64	30	2
	.64	67	21	49	25	2
4	.70	18	29	68	23	2
	.77	68	31	51	15	2
5	.63	6	49	36	43	
	.66	37	43	31	32	7
6	.61	58	41	40	40	
7	.61	60	42	49	57	4

Table 7.4 Factor Scores obtained from IHIQ data   in Study 3

Current State of Health

Q item no :	Factors						
	1	2	3	4	5	6	7
1	3.0	4.4	5.2	1.8	2.0	3	7
2	5.0	6.4	5.7	4.6	1.4	7	7
3	6.0	4.0	2.9	2.8	4.2	5	6
4	6.0	3.0	2.4	1.8	5.4	3	5
5	5.3	4.5	2.9	0.0	6.0	5	3
6	6.3	3.5	3.3	2.8	2.9	2	5
7	5.3	5.8	4.3	1.0	0.7	5	4
8	6.3	5.7	4.6	2.4	3.2	7	7
9	6.0	5.7	2.8	4.6	3.0	3	6
10	4.4	6.4	5.0	2.4	5.1	4	3
11	1.7	1.0	6.6	0.0	0.4	0	1
12	2.7	1.2	6.1	6.6	0.0	3	2
13	4.7	2.0	5.2	2.2	3.7	6	5
14	5.0	1.5	4.8	0.6	6.6	5	6
15	2.9	2.1	2.9	1.2	2.9	5	7
16	5.4	2.4	2.0	2.4	5.6	7	2
17	3.0	1.4	4.3	1.2	2.5	6	6
18	0.0	1.4	2.2	0.0	3.5	0	1
19	0.0	4.9	0.9	0.0	6.4	7	2
20	2.4	3.8	6.1	6.4	3.1	4	1
21	5.4	2.2	3.4	2.8	2.9	7	6
22	6.0	3.6	3.9	2.8	2.2	5	1
23	6.4	3.1	3.9	2.8	2.9	7	1
24	6.0	3.6	2.3	2.2	2.2	3	1
25	6.3	3.0	2.3	0.8	5.4	2	6
26	4.4	4.4	3.8	1.0	2.6	3	4
27	4.7	2.6	6.1	0.0	2.9	4	7

Capacity to become healthier in the future

Q item no :	Factors						
	1	2	3	4	5	6	7
28	3.4	3.0	5.7	0.0	2.0	3	6
29	4.7	3.1	5.0	1.2	4.1	5	4
30	5.3	5.7	3.4	0.6	3.4	4	4
31	6.0	5.0	4.0	1.8	4.7	4	4
32	6.6	3.3	5.4	1.8	2.0	5	6
33	6.0	4.6	4.4	0.0	5.4	2	4
34	6.3	5.1	3.4	0.4	3.1	7	4
35	6.0	5.7	5.6	1.0	2.6	1	1
36	5.3	6.1	6.4	1.6	4.5	5	5
37	6.0	6.4	6.4	0.0	4.5	1	0
38	4.0	1.5	1.0	0.0	0.0	4	6
39	0.4	1.6	6.6	0.0	0.0	0	2
40	1.4	1.1	6.1	7.0	0.0	3	2
41	5.4	3.5	2.4	1.6	6.0	4	2
42	2.0	1.5	3.0	1.2	3.7	7	5
43	3.7	2.6	2.6	1.2	4.4	5	0
44	2.3	3.2	3.6	6.0	1.6	2	1
45	3.0	1.1	4.1	2.6	1.4	5	6
46	3.0	4.9	2.3	1.6	1.7	5	0
47	3.3	0.7	5.7	1.6	1.4	7	6
48	5.0	1.0	7.0	0.0	1.6	7	7
49	0.0	5.2	1.8	0.0	7.0	7	3
50	0.0	2.8	1.8	0.0	7.0	0	0
51	2.6	3.0	7.0	5.8	4.2	5	0
52	2.9	0.8	4.3	0.4	3.2	6	0
53	5.7	2.5	4.3	4.8	2.9	7	0
54	5.7	2.4	3.9	4.8	2.7	7	6
55	6.4	4.4	3.8	3.2	2.1	2	0
56	5.1	3.9	7.0	5.2	4.6	6	4
57	5.4	4.8	6.0	3.9	4.7	3	4
58	2.4	2.3	2.3	2.2	0.4	6	0

Whether or not I become ill

Q item no :	Factors						
	1	2	3	4	5	6	7
59	2.7	4.5	5.7	4.1	2.4	4	6
60	6.0	7.0	7.0	7.0	5.4	5	6
61	6.3	4.8	4.3	1.2	5.4	2	6
62	5.3	4.4	3.9	1.8	2.5	3	6
63	4.3	3.8	3.4	0.0	5.1	1	0
64	5.4	6.4	5.9	1.0	3.9	5	0
65	3.6	7.0	6.0	4.4	3.2	7	0
66	1.3	1.7	6.4	0.0	0.4	0	0
67	2.4	1.4	5.6	7.0	0.4	2	2
68	3.6	2.7	2.4	3.2	5.1	3	0
69	4.3	2.2	2.4	3.2	3.8	0	0
70	3.9	1.4	4.9	3.6	3.9	7	0
71	5.3	5.2	5.9	6.6	5.4	7	0
72	5.0	2.1	4.3	4.0	5.4	1	0
73	0.0	5.5	1.8	0.0	7.0	7	4
74	0.0	3.1	1.8	0.0	7.0	0	3
75	0.0	1.6	1.8	0.0	6.4	0	0
76	3.3	0.7	2.3	0.0	3.5	7	1
77	3.6	3.1	7.0	7.0	4.1	7	1
78	5.4	4.2	5.0	4.4	3.5	7	0
79	6.0	4.7	6.0	4.8	5.4	6	0
80	5.7	4.3	3.9	3.2	5.8	5	3
81	6.7	3.8	4.3	4.2	3.2	2	0
82	6.4	3.7	4.3	4.8	3.2	2	2
83	2.6	4.5	3.9	2.8	3.1	4	0
84	5.3	4.8	6.0	5.8	3.2	3	3
85	3.9	1.7	6.4	5.4	3.2	0	6
86	6.0	4.5	4.8	4.2	2.7	3	7
87	4.6	3.9	6.6	7.0	2.4	7	5
88	2.3	1.3	1.0	0.0	0.6	3	6
.89	2.6	1.6	6.6	0.0	0.6	4	7

When I'm ill, how quickly and effectively I recover

Q item no :	Factors						
	1	2	3	4	5	6	7
90	3.6	3.2	1.3	4.6	4.5	7	2
91	4.6	2.7	2.3	3.2	3.9	5	4
92	5.2	2.5	2.3	0.0	3.9	1	4
93	5.6	6.8	3.3	2.8	4.0	7	6
94	5.3	6.0	4.3	2.4	4.5	5	7
95	5.0	6.4	4.3	2.8	4.5	7	2
96	4.6	6.2	3.1	2.2	5.1	6	5
97	5.6	6.7	2.3	0.4	5.1	0	0
98	0.0	1.1	3.2	0.4	0.0	3	1
99	0.6	1.4	3.7	7.0	0.4	5	1
100	4.0	2.4	3.4	2.8	6.4	7	6
101	3.2	2.4	6.0	2.6	4.5	7	7
102	2.6	2.5	1.0	2.1	3.5	7	6
103	4.7	3.9	5.6	3.6	3.5	6	4
104	0.0	1.1	0.4	0.0	3.5	0	0
105	0.3	3.6	1.8	0.4	6.4	1	0
106	0.0	2.4	2.7	1.2	6.4	7	4
107	0.0	5.2	0.4	2.3	7.0	7	4
108	0.0	2.4	0.4	0.0	7.0	0	0
109	4.0	5.9	6.1	7.0	1.9	1	6
110	5.6	5.2	4.0	4.4	2.2	7	4
111	5.6	6.7	3.9	4.4	2.5	7	4
112	5.6	3.2	3.3	3.4	2.6	4	1
113	2.6	3.9	6.1	5.8	3.6	7	4
114	2.3	6.0	6.1	2.1	4.7	3	1
115	2.9	5.5	6.1	5.8	4.0	7	7
116	3.0	4.5	4.6	1.2	3.9	3	7
117	4.6	6.5	5.0	4.1	2.9	6	7
118	4.9	4.4	1.9	2.3	2.9	4	7
119	2.9	2.4	3.4	2.4	3.5	7	7
120	2.3	4.4	2.0	5.0	3.6	3	3
121	2.3	3.4	6.0	4.8	4.5	7	5
122	3.2	1.4	1.0	2.6	3.5	1	1
123	2.2	1.2	0.6	2.4	0.0	2	7
124	2.6	1.6	6.6	0.0	0.6	7	7

7.4.1 IHIQ Factor 1

Table 7.5 lists the items which gained an average score of >6 from the response sets providing the exemplificatory loading. From this it can be observed that within IHIQ Factor 1, ´internality´ is by no means the only focus around which the account is built. In terms of health and <u>becoming</u> ill, such things as work and home circumstances and environmental influences are also seen as important determinants. However, ´internality´ is mostly to do with ´state of mind´, including both positive (e.g. feeling ´on top of life´ is important for current health, and ´positive attitude´ and ´seeking out things that make me happy´ are important for improving health in the future) and negative aspects (e.g. ´my state of mind becoming negative´ is cited as something very likely to engender illness). Within this context, stress is accorded a central role - particularly in the working environment, and in terms of the impact of stressful or upsetting events. These attributions, plus a specific endorsement of the idea that ´tackling unresolved inner conflicts´ would be salient to improving health in the future, imply a psychosomatic account of health and illness. This is supported by the observation that none of the influences suggested concerning recovery receive a mean endorsement higher than 6. Psychosomatic explanations are better accounts for illness than its cure.

However, this account is not just concerned with mind; action is salient too in terms of health, with ´taking care of myself´ and ´lifestyle´ important influences affecting current health, and capacity to be healthier in the future strongly determined by ´taking charge of my life´, ´changing day to day behaviour´ and

Table 7.5   Strongest influences as identified within IHIQ
Factor 1

Situation	Influences scored as +6 or more (Scale 0-7)
My current state of health	3. My state of mind 4. My emotions 6. Whether I feel 'on top' of life 8. My overall lifestyle 9. 'Taking good care of myself' 22. My working environment 23. The circumstances of my home-life 24. The current circumstances at work 25. Particular events in life at the time
My capacity to become healthier in the future	31. Promoting a positive attitude 32. Seeking out things that make me happy 33. Tackling unresolved inner conflicts 34. Taking charge of my own life 35. Changing my day to day behaviour 37. Giving up unhealthy habits 55. Improvements in work circumstances
Whether or not I become ill	60. My body's natural defences weakened 61. My state of mind becoming negative 79. Working in a poor environment 81. Stressful conditions at work 82. Stressful, nasty or unsettling events 86. Inbuilt weaknesses
When I am ill, how quickly I will recover	none

'giving up unhealthy habits'. Actions are less involved in engendering illness, but both 'taking responsibility' and 'giving up unhealthy habits' gain mean scores of 5.6 in the section about recovery from illness.

Overall then, this account is one of multiple influences which expresses a form of 'internal control' attribution in which both mind and actions are seen as crucial, but where external factors like events and circumstances (which, of course, will affect such things as state of mind, particularly when stressful) are also seen to play a role.

7.4.2 IHIQ Factor 2

IHIQ Factor 2 responses indicate an account much closer to the original intentions of Wallston and Wallston for 'internality', with the majority of items that gain a mean score of 6 or more being ones to do with the individual's own actions. However, in addition the body's defences are also seen as very important for current health and recovery from illness, and conducive circumstances and medical treatments regarded as salient to recovery. Unlike IHIQ Factor 1, internal aspects associated with 'mind' are regarded as relatively unimportant. Examination of Table 7.6 provides a very clear picture of 'internality' as a belief in the individual's pre-eminent capacity to control their health in all situations by what they do.

7.4.3 IHIQ Factor 3

IHIQ Factor 3, like IHIQ Factor 1, identifies an account in which multiple influences are seen to play a part, as shown in Table 7.7 The influence of luck is strongly endorsed except for

Table 7.6   Strongest influences as identified within IHIQ
Factor 2

Situation	Influences scored as +6 or more (Scale 0-7)
Current state of health	2. My Body's natural defences 10. Actively taking action to be healthy
My capacity to become healthier in the future	36. Changing to a more healthy lifestyle 37. Giving up unhealthy habits
Whether or not I become ill	64. Behaving in stupid ways 65. Adopting unhealthy life-style
When I am ill, how quickly I recover	93. Taking responsibility for myself 94. Looking after myself 95. Being careful about my behaviour 96. Making my life-style more healthy 97. Giving up unhealthy habits 111. Circumstances conducive to recovery 114. Treatments 117. My body's own natural defences

Table 7.7   Strongest influences as identified within IHIQ
Factor 3

Situation	Influences scored as +6 or more (Scale 0-7)
My current state of health	11. Good or bad luck 12. Simple probability 20. Exposure to infectious organisms 27. My age
Capacity to become healthier in the future	36. Changing to a more healthy lifestyle 37. Giving up unhealthy habits 39. Good or bad luck 40. Simple probability 48. My age 51. Exposure to infectious organisms 56. What happens in the future 57. Exposure to substances
Whether or not I become ill	60. My body's natur defences weakened 65. Adopting unhealthy life-style 66. Bad luck 77. Exposure to infectious organisms 79. Working in a poor environment 84. Exposure to harmful chemicals 85. Other people's stupid actions 87. Virulence of infective organism 89. My age
When I am ill, how quickly I will recover	101. Quality of medical treatement 109. Virulence of the disease 113. Taking drugs or medicines 114. Treatments 115. 'Alternative' therapies 121. Seeking medical advice soon enough 124. My age

recovery (Item 98 = 3.2), 'luck' and 'probability' are treated as synonymous, both possibly linked to the high overall salience attributed to infectious organisms and other uncontrollable agents like pollution, age and other people's stupid actions. The sense, then, is that it is not so much that some malevolent or benign 'fate' is operating, as the sheer unpredictability of factors that are outside of the individual's control.

Recovery is treated rather differently from the other situations in that medical intervention (Items 101, 113, 114, 115 and 121) is seen as very important (whereas none of the medical intervention or advice items score much above 4 in the other situations). While this would be interpreted as a 'powerful others' in the MHLC scale, it reads in the context of this scale much more like a perception of illness as amenable to the technological procedures of biomedicine in tackling disease organisms and dysfunction rather than the agency of 'people' per se. Thus this Factor is evidence of a further dimension to the three within the MHLC construct. It is not an 'externality' that sites the locus of control either in chance per se, or in people, but in the unpredictability of disease organisms and the physical environment, supported by strong endorsements for 'lifestyle' items (36 and 65) in relation to becoming healthier and what may result in illness.

7.4.4 IHIQ Factor 4

IHIQ Factor 4 is also 'external' in focus, though what is striking is the strong distinction made between 'luck' as having virtually no influence and 'probability' as being very

important indeed. From this perspective luck seems to be interpreted as a capricious determinant (as in 'I'm feeling lucky tonight') whereas probability is just a matter of statistical odds. Here too infectious organisms are scored as highly salient, with medicine seen as having little role other as a preventive measure (presumably such things as inoculations) and in its ability to bring about iatrogenic illness. Examination of Table 7.8 shows that other influences (e.g. pollution, the body's defences, medical treatments) are seen as salient, and the individual is seen as having some control (e.g. 'Taking care of myself' is scored 4.6 with regard to current health) so it would be wrong to see this account as out-and-out fatalism. But it provides the clearest picture of what Wallston and Wallston presumably intended by their CMHLC construct.

7.4.5 IHIQ Factor 5

This factor was exemplified by the Hindu student (participant 37) who exemplified MHLC Factor 7. With opportunities to accredit 'God' and other supernatural forces as influences over health provided, the account can be seen with much more clarity (See Table 7.9). The strong focus on religious, cultural and kinship aspects of life express a form of 'powerful others' control attribution that is very different from the one Wallston and Wallston assumed. The second exemplar, Participant 6, was a Christian Spiritualist, belonging to a church in which faith healing is practiced. Thus the account is not restricted to a particular religious or cultural background, but reflects a more wide-ranging explanatory system in which supernatural powers are regarded as pre-eminent.

Table 7..8 Strongest influences as identified within THIN
Factor 4

Situation	Influences scored as +6 or more (Scale 0-7)
My current state of health	12. Simple probability 20. Exposure to infective organisms
Capacity to become healthier in the future	40. Simple probability 44. Seeking out preventive services
Whether or not I become ill	60. My body's defences weakened 67. Simple probability 71. Effects of poor medical treatment 77. Exposure to infectious organisms 87. The virulence of infective organism
When I am ill, how quickly I recover	99. Simple probability 109. The virulence of the disease itself

Table 7.9   Strongest influences as identified within IHIQ —
Factor 5

Situation	Influences scored as +6 or more (Scale 0-7)
Current state of health	5. Inner forces of my 'psyche' 14. The culture within which I live 19. God or some other supernatural power
Capacity to become healthier in the future	41. Improvements in family relationships 49. God's power or influence 50. Some other supernatural influence
Whether or not I become ill	73. God's will 74. Other supernatural influences 75. A curse or ill-wishing
When I am ill, how quickly I recover	100. Care from my family and friends 105. Intervention of a spiritual healer 106. Prayers said for me 107. God's will 108. Some other supernatural power

7.4.6   IHIQ Factor 6

This Factor, like IHIQ Factor 7 (below), is more difficult to interpret as it is based upon the response set of just one individual. However, IHIQ Factor 6 is notable in that, like Factor 5, God is seen as an important influence (though not other supernatural powers or ill wishing), making the point that it is not just people from minority cultural or religious groups who see a religious dimension to control over health and illness.

7.4.7 IHIQ Factor 7

IHIQ Factor 7 differs from the rest in its consistent stress on constitution, age and the impact of the weather. The participant whose IHIQ response set exemplified this Factor also provided the MHLC 'powerful others' exemplification. The wider repertoire of available responses here shows that this is not as clear-cut an account as the MHLC factor suggested. Though friends and family are seen as important in recovery, the main 'others' control appears to be that of medical professionals, cited as a strong influence over health and recovery (but not becoming ill). 'Following doctors orders' is scored 7 for recovery. Clearly, medical expertise and competence are highly respected.

7.5 DISCUSSION OF THE MHLC AND IHIQ DATA

Overall, then, the MHLC and IHIQ responses provide evidence about three aspects of accounting for health and illness. First, they demonstrate that although accounts vary considerably in their focus, all offer complex explanations for health and illness which are never entirely 'external', 'internal' or 'powerful others' attributions. Of course, Wallston and Wallston and others

who have used their scale never claim that this is so, but their use of these labels (often following quite crude statistical techniques, such as dividing a sample at the mean), as in any research methodology which labels individuals by averaged responses, tends to reify accounting, so that a higher-than-average CMHLC response score is used to translate an individual into a 'fatalist', submerging the complexity of their responses (themselves highly constrained) and ignoring the possibility that the person may have expressed strong endorsement of, say, some 'internal' items.

The 'reliability' of the scale assessed over many individuals beguiles researchers into forgetting that any one individual's average score on a sub-scale can be obtained just as easily by endorsing some items strongly and rejecting others as it can be by marking all items with mild disagreement. And yet, as the fine-grained analysis made possible by the by-person factor analyis of the MHLC scale data showed, people do make very clear distinctions between ostensively (to the scale designers) small differences in wording (as IHIQ Factor 4 showed so clearly in its distinction between 'chance' and 'probability'). This is particularly true when culture becomes involved. Participant 37, whose data sets exemplified MHLC Factor 7 and IHIQ Factor 5, was socialised and lives within a culture in which the concept of 'fate' is very different from its meaning in the mainstream of British culture.

Second, these data have shown that the assumed homogeneity of the three constructs 'internal', 'chance' and 'powerful others', for all the reliability claimed by Wallston and Wallston for

sub-scale responses, hides clearly distinctive and different constructions. 'Internality' segments into a focus on 'my own actions and lifestyle' (IHIQ Factor 2) and a focus on 'my state of mind' (IHIQ Factor 1). Similarly, there are at least two constructions of externality, one which is predominantly 'fatalistic' (IHIQ Factor 4) and one in which the external attribution of control is towards the agency of infective organisms, and the role of biomedicine in fighting them (IHIQ Factor 3). 'Powerful others' splits up into at least three alternative constructions: one which stresses the role of medical professionals as 'in control', albeit within a context of multiple aetiology (IHIQ Factor 7, MHLC Factor 4); one which sees them as 'advisors' but not in control (HMLC Factor 3); and one which stresses the role of God, other supernatural influences, culture and family (IHIQ Factor 5, MHLC Factor 7).

Of course, this classification is unlikely to encompass all of the accounts that operate within the popular discourse of British culture, but even accepting that there may well be others, this range of what are clearly very diverse constructions gives some clues about why the MHLC scale has not been a resounding success either as a dependent or independent variable. Its reliability, which even Wallston and Wallston admit seems to fluctuate quite disturbingly study by study, is much more a reflection of the homogeneity of their participant samples and the culturally restricted coverage of their item sets than the homogeneity of the constructs as operating within popular discourse.

Finally, these results demonstrate another kind of diversity -

differences in the distinctions people make between different situations. The MHLC scale assumes that people attribute the same locus of control, irrespective of whether it is ´being healthy´, ´improving health´, ´getting ill´ or ´getting better from illness´ that is being considered. Some accounts do attribute similar levels of agreement to the same influences throughout - IHIQ Factor 4 is a good example, in its consistent endorsement of chance/probability throughout. But in other constructions strong distinctions are made between situations. IHIQ Factor 3, for example switches from ´organisms´ as major determinants of health and illness, to ´medical treatment´ as the major factor affecting recovery. These kinds of within-account attributional variability question the whole basis of the ´locus of control´ construct - that individuals construe the world according to some general, consistent causal explanation. These results suggest that construal is instead a flexible process in which attribution is differentially applied according to a variety of situational and other demands (a point also made by King, 1983, who argues that the "...static and global" features of the locus of control construct limit its usefulness).

The use of by-person factor analysis for R-data has demonstrated that even without Q sorting, pattern analysis has a lot to offer. There is currently a growing movement in social psychology in this direction, particularly among Europeans (Areni, Mannetti and Sabino´s investigation of the links between cultural schemas and contraceptive choice, 1985, and Vala-Salvador and Leite-Viegas´ study of the links between value patterns and political opinions in Portugal, 1987 are good examples). However, despite the finer-grained interpretation that by-person factor analysis of

these two Likert format instruments made possible, it has been argued in this thesis that Q method offers a highly sensitive technique for investigating and describing accounts in a way that 'mindless' and disjunctive scale responding can never do. Despite their relatively faster and easier completion, because Likert format instruments lack the intentional relational linkages that Q sorting demands, the most distinctive features of accounts remain untapped.

7.6 Q SORT RESPONSES

The 80 item Q pack was sorted from -5 (strongly disagree) to +5 (strongly agree), 11 categories in all. The Q sort data yielded fourteen factors with eigenvalues greater than unity, of which eight had one or more exemplificatory loadings (loadings >0.6 where no other loading on another factor was greater than 0.35). The factor loadings are provided in Appendix 4, and a summary of exemplars (including MHLC scores and, where relevant the factors exemplified by the MHLC and IHIQ scales) is provided in Table 7..10 Factor scores are shown in Table 7..11.[1]

7.6.1 The account identified by Q Factor 1

Of the eight participants whose Q sorts exemplified this factor, the MHLC data sets of seven exemplified MHLC Factor 1, the IHIQ data sets of three also exemplified IHIQ Factor 2, and of another exemplified IHIQ Factor 1. These cross-linkages suggest that Q Account 1 is basically one of 'internal control' attribution, with both a 'behavioural' and a 'mind' aspect. The exemplificatory Q sorts were provided by : a psychologist, the owner of a health food shop, an osteopath/acupuncturist, a herbalist, somebody who described himself as "a student of the

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1: The items are included in the experimental materials (appendix 11) which provides a convenient source for checking factor scores.

Table 7.10 Exemplificatory Q sorts for Study 3

Factor	Loading	Participant number	MHLC scores			Exemplification via other data	
			I	C	PO	MHLC	LIKERT
1	0.81	12	57	15	17	1	
	0.61	21	52	34	26		
	0.65	28	66	25	21	1	
	0.83	36	55	29	23	1	2
	0.83	48	62	24	16	1	2
	0.66	49	55	20	23	1	2
	0.65	61	64	16	31	1	1
	0.83	76	61	18	37	1	
2	0.68	10	49	26	31		
	0.79	16	45	35	35		
	0.71	19	57	46	39		
	0.78	34	45	40	20		
	0.70	45	43	55	39		
3	0.69	17	51	37	36		1
	0.73	51	25	44	36	3	
	0.64	73	41	43	37		1
4	0.78	43	42	36	24		
	0.79	82	26	40	23		
5	0.66	77	57	31	32	1	
6	0.85	47	45	49	41		
7	0.66	33	45	25	25		
8	0.77	18	29	68	3	2	4

Table 7.11   Factor Scores obtained in Study 3

Q item no :	Factors							
	1	2	3	4	5	6	7	8
1	+1	-2	+3	+3	0	-2	+5	-4
2	-1	+5	+2	-2	+2	+5	-5	-2
3	-1	0	-1	-5	-4	+3	0	+3
4	-4	-1	-1	+3	+1	-2	0	-2
5	-2	+1	-3	+2	-1	+1	-1	+2
6	0	+2	+1	+2	+2	-3	-1	0
7	-2	-3	-1	+2	-2	+2	+4	+3
8	-4	+3	-2	-2	+2	+2	-2	-2
9	0	-4	-3	+5	-1	-5	+3	+1
10	+3	+2	-3	-3	-5	-1	+3	-3
11	-3	+5	0	-4	+2	+5	-4	+3
12	-2	+3	+2	+1	0	-1	+5	+2
13	-2	-4	-5	-4	-4	-5	-5	-4
14	+4	+1	+2	-1	-2	+1	-1	0
15	-5	-3	-2	0	-5	+1	-2	-1
16	-1	0	-2	-5	-4	+4	+5	+1
17	-3	+1	+1	+4	-5	+2	0	+4
18	0	-1	+5	0	+3	-2	-2	-3
19	+2	-5	-4	-4	+5	+3	-4	-5
20	-1	+4	-1	+2	+1	-1	+1	+3
21	+4	+4	+1	+2	-1	-1	+1	+1
22	0	0	+3	0	0	0	-2	+1
23	+2	-1	+4	0	-1	-4	-3	-1
24	-1	-2	0	+3	0	-1	-2	-2
25	+3	0	+1	0	+3	+2	0	-1
26	+1	-2	-2	-3	-4	-2	0	-3
27	-4	-4	+1	-1	+1	-2	-2	-1
28	-4	0	-1	0	-3	+2	0	+1
29	0	+3	+1	+5	-2	+1	+4	+2
30	0	-2	+2	+4	-3	-4	-4	-3
31	-3	+4	+1	+1	+5	+4	+4	+3
32	-5	-3	-2	0	-2	+2	-4	0
33	-1	+1	-3	+1	-3	-2	0	+3
34	-2	-1	-3	-2	0	-5	0	+5
35	+1	-5	-5	-3	+4	+3	-3	-5
36	+4	-2	+3	+2	+1	-3	0	0
37	+2	+2	0	+2	+2	+4	0	+2
38	+1	-2	+4	+1	+1	-2	0	+2
39	+3	+1	0	-1	+2	+5	-2	-1
40	-5	-2	-2	0	-2	-4	-3	-1

Table 7.11   Factor Scores obtained in Study 3 /cont.

Q item no :	Factors							
	1	2	3	4	5	6	7	8
41	+1	-1	+5	+3	+4	-3	0	+3
42	+1	+1	0	-3	0	-3	+1	-2
43	-1	0	-1	-4	-1	+1	-3	+2
44	-3	-2	-2	-1	-1	+2	0	0
45	-4	+2	0	+1	+1	+4	+4	+4
46	+3	0	+2	+1	-1	0	0	-2
47	0	+2	+4	0	+4	-1	+3	+1
48	0	0	+4	-1	0	-3	+1	+1
49	-1	+1	-1	+5	-2	-3	-1	-3
50	+1	+1	-3	0	-1	+3	+3	0
51	+2	+3	0	-1	0	-3	+3	-1
52	-1	+5	+3	+1	+1	-1	-2	+2
53	+3	-2	+5	+2	-2	0	0	+1
54	-2	+1	-4	-2	0	-1	-1	0
55	0	-5	-5	-4	-3	+3	-3	-5
56	0	-1	+1	0	+3	+2	0	+2
57	-3	-1	-1	-5	-3	0	0	+4
58	+5	+2	0	-1	+5	0	0	-2
59	-2	0	-2	+2	+2	0	-1	-1
60	+3	-3	0	-1	0	0	+1	-1
61	0	+3	+2	-1	+3	0	+1	+1
62	+2	+2	0	+3	0	+1	-1	-2
63	+1	-1	+3	-3	+1	-4	-1	-3
64	+1	-4	-4	-3	+1	0	-5	0
65	+4	+2	+1	+5	+3	+3	+3	+4
66	+5	+4	+2	+1	0	+2	+3	0
67	-1	-3	-2	-2	-1	-4	-3	-1
68	0	+2	+1	+3	-1	0	+4	+5
69	+2	0	+3	+4	-2	+1	-1	+1
70	+5	-1	-2	+1	+2	+1	+1	0
71	-2	-1	+4	0	-3	-2	0	-4
72	-3	0	-3	-2	-3	+1	0	+2
73	-3	+4	+3	+4	+3	-2	+1	0
74	+4	+3	+2	+1	+2	+4	+1	+4
75	+1	+1	0	-1	+1	+3	+1	+5
76	+2	0	-4	-2	+4	0	-4	0
77	+2	-3	-4	-3	+4	0	0	-4
78	+2	-1	-1	+3	+3	-1	-3	-2
79	-2	-3	-1	-2	-4	-1	-2	-4
80	+3	-4	+2	-2	-2	+1	-1	-3

arcane school", a. member of a 'charismatic' Christian church, an acupuncturist belonging to the Bahai faith, an osteopath/herbalist, and an Open University Course Manager who was at the time of responding engaged in a course of biogenic treatment.

Not surprisingly, the account favours alternative medicine (Item 70 = +5), is unconvinced about the efficacy of conventional medicine (Item 2 = -1, Item 9 = 0, Item 11 = -3, Item 52 = -1) and rejects the view that illness is cured by prescribed medicines (Item 8 = -4). Rather, this account stresses an individual's competence to decide for themselves on treatment, and the effectiveness of their body's self-healing mechanisms (Items 65 and 74 = +4). However, the strongest theme is a strong 'internal' conviction about personal control over, and responsibility for their own health. This shows up in a variety of statements which expressly endorse such a commitment :

21. How well or badly I look after myself generally
has an influence over my overall health.   +4

40. When I'm ill, there is very little that I can do
for myself that will help me get better faster.   -5

46. My overall state of health has a lot to do with
my own day to day actions - I can allow myself to   +3
get run down, or take steps to stay healthy.

58. My own actions are crucial to achieving better
health - it is something I have to work for.   +5

66. My health is my own responsibility.   +5

This commitment extends to a willingness to take the blame for illness (Item 10 = +3, Item 42 = +1, Item 51 = +2),[1] and is underlined by strong and consistent rejection of any effect of luck (Item 15 = -5, Item 28 = -4, Item 32 = -5) or probabilistic

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1 : Although endorsement is mild, it is relatively stronger than most of the other accounts.

influence (Item 7 = -2, Item 17 = -3, Item 44 = -3). More unusually, within this account disease organisms are not important reasons for illness (Item 12 = -2, Item 20 = -1, Item 31 = -3, Item 45 = -4), neither are environmental influences (Item 4 = -4, Item 33 = - , Item 73 = -3). The influence of other people is not salient,. including relationships (Item 18 = 0), people being unpleasant (Item 30 = 0), others' stupid actions (Item 59 = -2) as causes of illness, and the care of others as influences on overall health (Item 56 =). However, pollution and such things as food additives do have some influence (Item 57 = -3). Some flavour of the importance of personal control and responsibility is provided by the comments written by those whose Q sorts exemplified this factor :

"I feel there is always something you can do to help your health. The very fact of taking a positive action can help by improving your state of mind. You could feel very negative waiting for 'good luck' to turn up... We must be the person who knows our own body best; what exercise it needs, food it needs, rest it needs, etc. etc. No one else can take responsibility for these things, and since I believe that lifestyle has a major influence on health, we can to a great extent determine our own health." (Participant 36).

"Health will usually improve if we can help the body heal itself. Health is the natural state, so luck doesn't really play a part (except perhaps in one's circumstances)." (Participant 48).

"I am firmly convinced that I have considerable power to influence my own health... I believe that disease can often be held off - it is never purely physical... One should have sufficient control over oneself to prevent one from getting ill." (Participant 12).

"There's plenty I can do, from resting, taking medicine and advice and changing those habits etc. which made me get ill in the first place... It is my responsibility to eat well, exercise and have a positive state of mind and try to develop these skills... My own attitude and actions are crucial, not luck." (Participant 49).

To begin to unpack what is meant by the commitment to personal control, it is evident that the focus is upon what might be called the 'will'. This account stresses seeing yourself as 'in charge', by power of mind, of your body, and consequently both of your health, and your capacity to recover from illness. The impression given is that while agents capable of engendering illness - e.g. disease organisms, adverse environmental factors, pressures from other people - have the potential to affect you, you regard yourself as both capable of, and in some sense duty bound to resisting, and thereby maintaining/achieving health in spite of them.

"I take actions to mean psychological effort here, as that's the type of work I think achieves health ... If illness only emerges as a result of psychological factors 'letting disease in', then one must try to understand and hence control them." (Participant 12)

"The power of the mind is the strongest influence over my health." (Participant 21).

"My state of health is often determined by whether I take on board positive or negative thoughts and feelings. Promoting a positive outlook will make me much less susceptible to illness." (participant 61).

This emphasis on 'state of mind' is also evident in the Q sort allocations (Item 14 = +4, Items 39 and 53 = +3), with 'emotions' also mildly important (Items 23 and 62 = +2, Item 41 = +1), particularly life pressures (Item 36 = +4) and less saliently, sudden stressful life events (Item 38 = +1). What this suggests, is that as with Account 2 in Study 2, this construal of control sited in 'the mind' is not one of blind, uncontrollable psychodynamic forces, but of the mind as an active agent of the will, a means to control, not a means by which one is controlled :

"Our own inner state of health nearly always determines whether or not we get infected, ill or even have accidents !" (Participant 28).

"I do not believe disease attacks as a separate entity in itself - symptoms express some disturbance of body function - the body can be encouraged to right itself." (Participant 48).

The internal attribution is thus of the 'body' as well as the 'mind', reflected in a moderate acceptance for inbuilt weaknesses (Item 1 = +1) and the effects of constitution (Item 36 = -2) and of the body's self-healing properties (Item 37 = +2). Within the Q sorts exemplifying this account there is some diversity of opinion about the role of God, faith healing and prayer, with the comments of some people denying any divine intervention, but a majority asserting that the spiritual aspect of health as very important indeed, albeit in different forms and from different faiths :

"I believe in a sort of Karma. Illness acts as a reminder that I shouldn't take all the good things in life for granted. If I were a perfect 'Christian' person I might not be ill." (Participant 36).

"God has frequently answered prayers of faith for physical healing both for myself and for other people ... God desires that I should live in perfect health and never instigated my ill health. Our vulnerability to sickness is caused by living in a sinful world which has, to a large extent, rejected God ... My health is a reflection of my lifestyle - I need to be spiritually, mentally, emotionally and physically whole to be truly healthy. I believe complete wholeness is only attainable through reconciliation with God." (Participant 61)

"I believe in the healing power of one's personal prayer to God or inner spirit or whatever ... Attuning to the universal 'will' is the best way of shaking loose selfish tendencies which cause me to be dis-eased." (Participant 21).

This account derived from Q sorting provides a very clear and definite description of the role of the individual's control, which appeared in the IHIQ data as simply 'behavioural' with some

'mind' aspects (all the exemplars on this Q Factor load positively onto IHIQ Factor 1). It is an 'internal' account par excellence, with external factors such as the vicissitudes · of bacteria and environmental factors, the influence of other people seen as negligibly important compared with the individual's own self-control mechanisms, either in themselves or in conjunction with a godly or universal power. There is a strong sense both of 'mind over matter' and self-determination over fate, although bodily factors (i.e. constitution and biological mechanisms) are also regarded as important. Of the eight Q factors identified it is the one which most consistently attributes locus of control, responsibility and accountability within the self, and most consistently rejects the impact of external factors, or the influence of other people. Whether an individual is ill or well is not a matter of luck, but has a reason - and that reason is predominantly found deeply within the person themselves (Item 80 = +3).

This account has been expressed within popular discourse from at least as far back as the writings of John Barlow (1843), Daniel Noble (1853) and Daniel Hack Tuke (1872) who asserted : "The power of the will in resisting disease is unquestionable". More of our age, in a 'Wholistic Handbook' Miles (1978) wrote :

"... nature is an interactive friend, and disease is a feedback process whithin the choosing system of the individual, a process which informs the individual that some life-process is off course. The individual is the only person who can discover that feedback message and act upon it." (p 20).

In the same book Bauman (1978) counselled expressly against the "negativity" of blaming the environment for illness. Ardell, writing at much the same time (1977) specifically stressed

self-responsibility :

"All dimensions of high level wellness are equally important, but self-responsibility seems more equal than the rest. It is the philosopher's stone, the mariner's compass, and the ring of power to a high level wellness lifestyle. Without an active sense of accountability for your own well-being, you won't have the necessary motivation to lead to a health-enhancing lifestyle." (p 94).

Crawford (1980) regards concepts of individual responsibility and self-determination central to the forms of 'alternative' medicine that stress wholism. It is therefore not surprising that four of the six practitioners in 'alternative' medicine in the participant sample provided Q sorts exemplifying this factor. The account itself is evidence for the contemporary prominence in British currently of the kind of 'individualising' discourses discussed in Chapter 1 (See also Aakster, 1986; Graham, 1986, Chapter 4).

7.6.2 The account identified by Q Factor 2

The five participant's whose Q sorts exemplify this Factor described themselves as a secretary, a fire officer, a clerical officer, a housewife and a school student. None of their other data sets exemplified either a MHLC or IHIQ Factor. Whatever it is that the account identified by Q Factor 2 is expressing was not picked up by the other measures. Inspection of the factor scores for this account (See Table 7.11) shows that it expresses multiple aetiology and influence, including aspects of 'external', 'internal' and 'powerful others'.

So far as 'internality' is concerned, there is commitment to the idea that the individual is responsible for, and able to influence their health (Item 66 = +4), though in some instances

expressed less strongly than it was for Q Factor 1 (Item 40 = -2,

Item 58 = +2). Blame is similarly mildly accepted

(Item 10 = +2, Item 42 = +1, Item 51 = +3). However, the

attribution of internal control is by no means unequivocal,

given the distinction shown between a mild rejection of

'lifestyle' (Item 78 = -1) but the strong endorsement of 'looking

after myself' (Item 21 = +4) as influences over health. This more

attenuated attribution of internal control is matched by

distinctions drawn between different aspects of chance and

probability. Items that place heavy emphasis on luck and

probability over health and recovery are rejected (Items 7, 15

and 32 = -3, Item 44 = -2), getting ill as a matter of luck is

neither rejected or accepted (Item 28 = 0), and items that

suggest some degree of chance are mildly endorsed:

17. Try as I may, there is nothing I can do that I
can be certain will improve my health. The best I can   +1
do is change the odds to give myself a greater chance
of becoming healthy.

29. Illness is a fact of life - I cannot expect to go
through life without ever becoming ill, or without   +3
risk of disability.

Clearly within this account, with chance/probability allocations

ranging from +3 to -3, quite subtle distinctions are being made

between the alternative wordings of items. These begin to make

more sense when allocations with regard to infectious organisms

are examined. Unlike Q Factor 1's account, where they were

regarded as having only marginal influence, within this account

they are accorded consistent, sometimes strong influence (Item 12

= +3, Items 20 and 31 = +4, Item 45 = +2). There is also

endorsement of the kinds of environmental factors which may

increase one´s susceptibility to infection, such as being exposed

to cold or damp (Item 73 = +4). However, within this account the

´strongest agree´ allocations were used to endorse the

effectiveness of orthodox medical care :

2. When I´m ill enough to consult a doctor, my
recovery will be faster if I comply properly with   +5
the treatment I get.

9. I have little faith that the advice I get from
the medical profession can help very much in   -4
improving my health.

8. I usually expect to take medicine to help me
recover from illness.   +3

11. If I were ever seriously ill, I would have a lot
of faith in the ability of doctors to find a cure.   +5

52. When I´m ill, my recovery depends a lot on the
quality of medical treatment I receive.   +5

Thus looked at simply in terms of the three MHLC constructs, this

account regards all three as influencing health and illness :

´internal control´ in terms of a degree of personal

responsibility and culpability; ´external control´ in terms,

particularly, of infectious organisms; and ´powerful others´ with

regard to the efficacy of the care and advice provided by medical

professionals. Together all three may well explain the

distinctions attributed to chance in different situations - being

attacked by disease organisms as an inevitable and probabilistic

´fact of life´, but you do not have to be a passive victim - you

can take steps to avoid infection, and to have the infection

treated when it occurs. This multiple attribution of aetiology of

illness, its prevention, and response to it is supported by

observing that participant 13, whose MHLC scores indicated such

an account in exemplifying MHLC Factor 6, loads 0.53 on this Q

Factor; and participants 2 and 67, who exemplified such an

account via their IHIQ responses, load 0.39 and 0.54 on it respectively.

However, the Q sort data enables this particular account to be interpreted in more detail. While all three of the MHLC constructs are engaged within it, in terms of 'powerful others' at least, a distinction is made between the assumed control of medical professionals (endorsed) and that of friends and family, which is either mildly rejected, or simply seen as unimportant :

18. The state of my relationships with others -
how well or badly I 'm getting on with those   -1
close to me at a particular point in time - has
a significant impact on my state of health.

30. When others are unpleasant to me, or I get into   -2
conflicts, it can have the effect of making me ill.

59. Sometimes the stupid or thoughtless actions of
others can lead to me becoming unwell.   0

56. The care and support I get from others has an
influence on my overall health.   -1

The ministrations of others are, however, important for recovery. Although the item does not distinguish between lay and expert care, its wording does imply something rather different from specifically medical treatment :

61. The 'tender loving care' I get from others
when I am ill can make all the difference to   +3
whether I make a full recovery or not.

Some clues about the division made between lay and expert 'others' is provided by a neutral allocation for Item 43 (and in some cases a rejection, as participants 19 and 45 marked their Q

matrix with these as disagree) that 'sometimes just the chance to talk to the doctor will make me feel better' and mild agreement (+1) with Item 5 that the body is 'rather like a machine'. This perception (albeit only mildly endorsed - no factor allocates it higher than +2) of the body as machine-like suggests that the account construes the mechanisms involved in health and illness as predominantly physical and biochemical. Within this context, as was the case in IHIQ Factor 3, medical professionals are not so much 'powerful others' per se as the agents who operate a technological system of prevention and treatment, and it is that system which has control over health and illness. This is shown in one of the comments made by Participant 45, concerning items about the power of God :

"I do not think God or religion has anything to do with your health. No one but you and the mechanics of your body are responsible... nothing can cure you but medicine and rest. No man(sic) can perform a miracle and make you walk."

This mechanistic perspective assumes the body has self-healing properties (Item 37 = +2) and that for minor illnesses, it is better to let 'nature take its course' than seek out medical treatment (Item 65 = +2). This stress on the physical aspects of illness is coupled with mild rejection of the influence of 'state of mind' over health (Item 53 = -2) and only mild acceptance that 'thinking positively' aids recovery (Items 14 and 39 = +1). In particular, psychological factors such as stress, emotions and unresolved worries are mildly but consistently rejected as explanations for illness (Items 23, 41 and 63 = -1, Items 36 and 38 = -2). Item 80, about seeking deep within oneself for the reasons for illness, the most psychodynamic, is rejected the most strongly (= -4). The mechanistic emphasis shows up particularly in strong refutation of any influence attributable

to God, other supernatural forces, or indeed any ´mumbo jumbo´ (as one participant expressed it) about curses or faith healing (Items 19, 35 and 55 = -5, Items 13 and 64 = -4, Item 77 = -3).

Overall the internal/external/powerful others dimensions are simply not all that salient to this account. Rather it is a mechanistic explanatory model of health and illness - the ´medical model´ which provides the basis for biomedicine. This is supported by observing that Participant 10, who provided one of the exemplificatory Q sorts, was an exemplar for Factor 6 in Study 2, which also identified a ´medical model´ account. It does include some recognition of psychosomatic processes (e.g. Participant 16 commented that in some cases ´smarties´ would work as well as ´active´ drugs). But fundamentally its perception is of illness as the simple breakdown in physical function, due to infection, pollution, injury, or degeneration, capable of being cured by the body´s own regenerative and defensive mechanisms, aided by medical care and treatment. Within this model, illness is often inevitable, but can also be held off some of the time by ´taking care´ of the body, and avoiding situations where it is exposed to infection or damage. Participant 45 summarises this well in her comments :

"I think health in general boils down to you yourself leading as healthy a life as you can. If you are fat and unfit you are more likely to have illness. Although health is your responsibility in some illnesses, not all - e.g. if you break a leg you could not stop that happening - no matter how much exercise ! Medicine alone will not make you completely better - your body´s defenses, etc, will start to work and help your recovery. For some minor illnesses e.g. a cold, you just ´ride it out´, no medicine needed. For more serious illness I would expect to take some form of medicine - if you go to the doctors, your illness was serious enough to merit you going, so you always expect something."

7.6.3 The account identified by Q Factor 3

Two of the three people whose Q sorts exemplify Q Factor 3 also provided exemplificatory data sets for IHIQ Factor 1 (i.e. the 'mind' construction of internal control). They are Participant 17, a course manager and participant 73, an unemployed man. The other person who provides an exemplificatory Q sort for this factor is Participant 51, a psychotherapist, who exemplified MHLC Factor 3. At first sight, then, the Q analysis seems faced with inconsistency, bringing these people together as exemplars. However, closer examination of their Q sort allocations demonstrates that they are much more easily reconciled than might be assumed.

Items that relate to emotions and state of mind are consistently and often strongly endorsed, including 'state of mind' as an important influence on overall health (Item 53 = +5) and health improvement (Item 14 = +2), that when unhappy one is more likely to be ill (Item 23 = +4), emotional distress can upset general health (Item 41 = +5), and that when ill, one should seek 'deep within' oneself for the reason (Item 80 = +2). Although health and happiness are not equivalent Item 62 = 0), emotions, state of mind and inner motivations and pressures are highly salient to health status, the process of becoming ill, and the process of recovery. This is consistent with the 'mind' version of 'internality' as identified by IHIQ Factor 1. However, unlike Q Factor 1's perception of 'mind' as an active, purposive agent of the self (i.e. the 'will'), within Q Factor 3, 'mind' is much more a passive object of psychodynamic forces. This is indicated by the allocations to those items which refer to the individual's ability to manage their health and illness by 'will-power' (Item

26 = -2, Item 39 = 0). Though 'mind' itself is an internal property of the person, within this account it is not 'in control' but 'controlled'.

Other Q sort allocations make clear the kinds of agents seen to do the controlling - all of them 'external'. First there is the agency of 'powerful others'. State of relationships (Item 18 = +5) is crucial; regarded as less important are 'others being un-pleasant', and 'tender loving care' in terms of recovery (Items 30 and 61 = +2). However, unlike Q Factor 2, it is not other people as a source of infection that matters (Item 33 = -3). Rather it is the influence of events and circumstances (Item 22 = +3, Item 47 = +4), long-term pressures (Item 36 = +3), stressful life events (Item 38 = +4), and what is going on in life (Item 48 = +4, Item 54 = -4) that affect health, can make you ill, and determine recovery. Furthermore stress and 'state of mind' interact :

69. Stress only makes me ill when I'm 'down'; when
I'm feeling full of energy, and/or content, I can   +3
ride it out with no ill effects.

This is explicitly expressed in written comments :

"I strongly believe that health or ill health is derived from factors such as environment, stress or upsets with others, and whether I'm feeling self-confident or not, all working interactively." (Participant 51).

"What is going on in your life affects how you feel - 'up' or 'down' and so, I think, your susceptibility to coping with illness ... one's day to day 'ups' and 'downs' do affect one's general health ... economic resources are one of the major sources of feelings of security and wellbeing, or insecurity and stress." (Participant 73).

All of these aspects of the account are consistent with a stress model,   in which there is a feeling that both health

and illness are determined predominantly by external influences out of the individual's control. i.e. a perception of oneself as the 'innocent victim' of illness-provoking circumstances, stresses, and the psychological responses to them. It also shows up as a denial of blame for illness (Items 10 and 50 = -3) and in only limited acceptance of the idea of personal responsibility for health (Item 66 = +2) or that an individual's own actions are all that important (Item 46 = +2, Items 21 and 25 = +1, Item 58 = 0, Item 40 = -2). Additional support for this as a psychosomatic account is provided by the observation that Participant 11 (Participant 53 in Study 2) who provided the exemplificatory Q sort for Account 8 in Study 2 (also interpreted as psychosomatic) loaded 0.56 on this Factor.

Her Q sort responses and open-ended comments in her Study 2 interview included a recognition of the role of biological factors. The same can be observed here, for while the idea of the body as machine-like is refuted (Item 5 = -3), disease organisms are seen to play a role in health and illness, although not a highly salient one (Item 12 = +2, Item 31 = +1, Item 45 = 0). Similarly, orthodox medicine makes some contribution, though allocations show that its importance is relatively low (Item 2 = +2, Item 9 = -3, Item 11 = 0, Item 52 = +3), and consistent with the psychosomatic overview, taking medicine is not seen as effective for recovery (Item 8 = -2).

Thus the picture that builds up is one in which control is sited predominantly externally, in events, circumstances and stresses that operate upon the individual's 'mind' psychosomatically, leading both directly to illness (e.g. thyroid

dysfunction) and indirectly (e.g. by lowering the body's defences to fight infection). It is not an 'externality' that sites the locus of control in chance or fate per se - chance and luck are rejected (Items 15, 32 and 44 = -2). Illness always has a cause, but that cause may be random life-events or life-circumstances, as Participant 17 wrote in her comments :

"I'm well aware that when personal relationships go badly (particularly at work) they affect my health - specifically severe insomnia. My state of mind all year has been depressed and dissatisfied and I rarely sleep more than 4-5 hours. I have had two episodes of illness that were likely to have resulted from long-term stresses e.g. a spate of boils during a tough 2 years, and thyroid troubles as a result of years of stress."

This account is about a chain of influences acting upon each other. Stresses affect emotions, feelings and psychological wellbeing, which in turn emerge as physical symptoms. There is certainly some recognition that the individual can play a part in the process (e.g. participant 51 described how she gives herself Mars bars when she is 'down' as a 'treat' to cheer her up and tackle her negative emotions), but there is an over-riding sense that if you happen to get caught up in a lifestyle that is distressing (e.g. unemployment) or inherently stressful (e.g. major reorganisation and upheavals at work), circumstances largely out of your control, illness is likely to follow through no fault of your own.

This account comes closest to a locus of control construed in terms of 'powerful others', but not God or supernatural others (all the relevant items are allocated Q sort placements at the 'strongly disagree' end); nor medical professionals as the controllers of medical technology; nor the 'political'

interpretation of hegemony which was so salient to Factor 1 accounts in the two previous studies (and which re-appears in the next Factor in this study). Within this account the other people who have control over health and illness are those within close proximity, at home and at work, who subject the individual to interpersonal conflicts and attack their self-esteem. While the account recognises the impact of life-circumstances and life-events, all of those specifically mentioned involve social relationships and emotions.

All three of the exemplars are graduates in psychology, so they are presumably more conversant with psychosomatics than most people in the general population (though note that other psychologists, such as Participants 12 and 82, do not provide Q-sorts which express this account). However, Participant 11 is not a psychologist, and inspection of the factor loadings (Appendix 4) shows that a variety of other people loaded fairly strongly onto this factor, indicating that a stress account for health and illness has been widely incorporated into popular discourse in Britain as it has in America (cf Young, 1980).

7.6 4 The account identified by Q Factor 4

Q Factor 4 was exemplified by two women, Participants 43 (a teacher), and 82 (a research psychologist) both of whom had exemplified the radical feminist version of Factor 1 accounts in the two previous studies. Two other women, Participants 3 (another researcher, also a qualified nurse) and 42 (a postgraduate student) also gained loadings >0.6 but were excluded as exemplars, because they loaded >0.35 on other factors. My own Q sort loaded most strongly onto this Factor (0.55). All of these

people describe themselves as feminists and politically
'radical'.

Given the purpose of this study was to elucidate explanatory
accounts in relation to the MHLC construct, the Q item sample
introduced few opportunities to provide a 'cultural critique' or
radical feminist analysis. These, it was felt, had been clearly
identified and articulated in previous studies. Thus this
account, expressed as it is by the Q sorts from the women who had
previously exemplified the hegemonic 'powerful others' account
for health and illness, brings out other features which in this
context provided additional clues about the ways in which
capitalism and particularly patriarchy are seen to endanger
health in three main ways. First, their domination of economic
resources. With the one item in the sample which specifically
mentions economics, this acount is the only one to give it a
clearly positive allocation :

24. My state of overall
health is in part a
product of my economic
resources - how "well
off" or "badly off" I
am.

Factors							
1	2	3	4	5	6	7	8
-1	-2	0	+3	0	-1	-2	-2

Second, the way that the physical environment is damaged by such
things as industrialisation, creating an unhealthy, polluted
world :

4. To improve my health
would require improve-
ments in the environ-
ment in which I live.

Factors							
1	2	3	4	5	6	7	8
-4	-1	-1	+3	+1	-2	0	-2

There is strong and consistent emphasis on physical external influences - such as housing and working conditions (Item 16 = -5), pollution (Item 3 = -5), and food additives (Item 57 = -5) and the stressful, exploitative society in which we live (Item 49 = +5) :

"I work in a clean, relatively unpolluted environment. I live in dry, uncrowded, high standard housing. All of these enable me to be healthier. If I were an industrial worker living in the North, or a third world peasant with no clean water and open sewers, or the inhabitant of a shanty town on the edge of a large city, I would not have anything like the chances of being well." (Participant 3).

"Looking out over my Fen in the summer sun, I realise that the farmer sprays herbicides regularly in the field next to my house, my tap water comes from surface water heavily polluted with nitrates and there's radioactive dust in my allotment. " (Participant 43).

The specifically feminist perspective, furthermore, attributes the major blame for the health-threatening violence done to the physical world specifically to its man-made features :

"I'd add ... patriarchial control of the noxious influences ... my overall state of health has a lot to do with being a woman in a man's world." (Participant 82).

Thirdly, hegemonic and particularly patriarchial power is seen as destructive to health in the way it constructs 'reality' in a form that seeks to shift the blame for health onto individuals. Such blame is denied (Items 10 and 42 = -3, Item 51 = -1) :

"Telling people that if they don't pull their socks up and take responsibility for their own health is a lovely way for the Government and the bosses of industry to pass the buck." (Participant 3)

"... the 'blame the victim' stance of 'if you're ill, it's because deep down you really want to be ill." (Participant 42)

Therefore this account - in marked contrast to Q Factor 1´s - is wary of the notion that people have some kind of deep seated mental power either to ´will themselves well´ (Items 14 and 39 = -1) or that may account for illness (Item 80 = -2), and plays down individual responsibility for health and illness (Item 66 = +1) and the importance of an individual´s actions (Item 21 = +2, Item 46 = +1, Item 40 = 0, Item 58 = -1). It is clearly a perception of external locus of control, distinguishing between chance and probability, with allocations of chance items neutral (Items 15, 28 and 32 all = 0) but probabilistic influences endorsed (Item 7 = +2, Item 17 = +4, Item 29 = +5). Illness as a ´fact of life´ engendered the comment :

"Of course. And important in terms of the rights of the physically challenged." (Participant 82).

This comment is critical, for it makes the point that an acceptance of illness and disability as probabilistic is certainly not ´fatalism´ in this context, but what is regarded as a more realistic appraisal of life than the assumption that the individual can somehow avoid illness and disability if they simply adopt a particular lifestyle. It is a denial of what is seen as a politically motivated ´individualism´ which subverts the rights and self-esteem of people who are physically challenged. The term ´physically challenged´ has been adopted within the feminist movement and elsewhere (particularly among groups such as the Disability Alliance, cf Finkelstein, 1980, working for the rights of disabled people to self-determination) to dispute the perception of disability as deviance or sub-normality, refuting the popular image of health and able-bodiedness as in some way morally superior to and more desirable than illness or handicap.

There is positive (albeit mildly so) acceptance of the effects of contagious disease organisms (Items 12, 31 and 45 = +1, Item 20 = +2) but, as before, some distrust of biomedicine, mildly rejecting compliance (Item 2 = -2), the capability of medicine (Item 8 = -2) and doctors (Item 11 = -4) to cure illness and in particular, rejecting the advice they give. (Item 9 = +5). Minor illness is best dealt with by the body's own defensive (Item 37 = +2) and curative (Item 65 = +5) capacities.

Overall, then, this account is like the one expressed by Factor 3 in focussing on 'external' causes of ill-health. However, the accounts are quite different in the way they construe external factors operating. First, they have a completely different perception of what kinds of external factors are involved. Q Factor 3 is concerned more with individual actions and circumstances (e.g. a particular person who is unpleasant, or a particular work setting or lifestyle that is distressing), whereas with Q Factor 4 the concern is with aspects of the power base within society as a whole - the effects of capitalism, patriarchy, social inequality etc. Also there is a strong political analysis of the notion of cause, blame and responsibility. Participants wrote :

"[My awareness of] ... the relationship between poverty and ill health, Third World women, private health care and of the London Food Commission report, etc. ... There are more important things to worry about than the state of my personal health, given that Man and Nature between them will eventually finish me off anyway" (Participant 43).

"I see the bugs and viruses as an important a part of nature as we are, and therefore find them easier to accept than the disease created by society." (Participant 42).

Secondly, this viewpoint rejects psychosomatic explanations of illness, not so much to deny the possibility that ·'stress' can affect health, but because it regards such explanations as a way of shifting blame from society onto the individual. The explicitly political stance taken here, then, is one which rejects notions of 'internal control' in a considered and deliberate way as a form of 'false consciousness', adopting instead a particular form of 'external control' attribution predominantly to do with the direct and indirect influences of 'powerful others', not as individuals, but as a collectivity. This construction is placed in a perspective in which illness, in a biological sense, is a fact-of-life - even in a 'perfect' society, there would be some disease and disability. What matters is not so much what causes it, but how we respond to it. Finally, there is an understanding that 'powerful others' engender ill-health via their assaults on physical environment - industrial pollution, food additives, poor housing conditions etc.

Basically this account can be viewed as a politicised, Westernised form of a 'personalistic' belief system, replacing a perception of illness as the result of the direct and motivated intervention of malicious ghosts, spirits or witchdoctors by the perception of illness as the result of the direct and motivated impact of exploitative capitalists, politicians, the medical hegemony and decision and policy makers, groups which are almost entirely male. For example, in response to item 59 (Sometimes the stupid or thoughtless actions of others can lead to me becoming ill) Participant 43 wrote, in the wake of the

Chernobyl   incident :

"e.g. the stupid idiots who let a radioactive cloud loose over my planet."

Accounting for health and illness is divided into two distinct domains. There is illness which is <u>inevitable</u> within a biological ecosystem, about which individuals can take some action (e.g. getting enough exercise and chosing a healthy diet) but in general, there is little anybody can do. However, much more importantly, there is illness which is potentially <u>preventable</u> or <u>avoidable</u> if society were organised differently. If the patriarchial power-base were replaced by a . more just society in which clean water, proper drains and adequate housing were available to all, where poverty was abolished, and where commerce, industry and the arms-race were forced to give way to principles of ecological protection and safe, nutritious food, then all the peoples of the world would have a good chance of a healthy life. In a world without poverty, anomie and exploitation, people would not need to resort to tobacco, alcohol and other 'unhealthy habits', and in a world freed from the commercial greed of the profit motive, they would not be submitted to the aggressive marketing of the 'naughty but nice'. But beyond this, a truly healthy society would be one where illness and particularly disability would be freed from their negative connotations, and where collective living would be organised to enable the sick and the physically challenged to participate fully and autonomously alongside the well and the able-bodied.

7.6.5 The account identified by Q Factor 5

This factor was exemplified by one individual, participant 77, a homeopathic pharmacist. A number of other people's Q sorts loaded, though less strongly, onto it, including participant 4, a lecturer in Neurophysiology; participant 6, who exemplifed IHIQ Factor 5, a Spiritualist healer; participant 54, a pensioner who describes herself as 'an active church member', and participant 55 a nurse in a managerial position. Its distinguishing feature is its strong focus on the power of spiritual and religious forces in controlling health and bringing about recovery. God is regarded as a major positive force for promoting and caring for health, this account allocating the highest endorsement of all for associated items :

	Factors							
	1	2	3	4	5	6	7	8
19. God has given me the means by which to improve my health.	+2	-5	-4	-4	+5	+3	-4	-5
35. I believe that God watches over my health.	+1	-5	-5	-3	+4	+3	-3	-5
77. By attuning myself to nature itself - to the 'power for good' in the Universe, I can improve my health.	+2	-3	-4	-3	+4	0	0	-4

"I believe that God has ultimate control over all of us." (Participant 6).

God does not send illness (Item 55= -3) nor can ill wishing or curses cause illness (Item 13 = -4), but faith healing (Item 64 = +1, Item 76 = +4) and the power of prayer (Item 71 = -3) can cure :

"I believe in a God who hears and answers prayer. Though an analytical scientist, I also believe as a commited Christian in

faith healing." (Participant 4).

Unlike the account identified by Q Factor 1, though, this account combines religious and spiritual faith with some acceptance of conventional medical care and treatment (Items 2, 8 and 11 = +2) as well as 'alternative medicine' (Item 70 = +2). The account is equivocal about individual action,/seen as fairly salient to recovery (Item 40 = -2) but strongly linked to health (Item 58 = +5), but not salient to overall health (Items 21 and 46 = -1). Personal responsibility (Item 66 = 0) is not important, and blame for illness is strongly denied (Item 10 = -5). This is likely to be due in part . to mild acceptance of the role of disease organisms in causing illness (Items 20 and 45 = +1) and particularly virulence as affecting recovery (Item 31 = +5).

However, although in other accounts such acceptance of the role of infection is linked to an acceptance of the role of chance, a characteristic of this account is its consistent

rejection of luck (Item 15 = -5, Item 28 = -3, Item 32 = -2) or probability (Items 7 and 29 = -2, Item 17 = -5) influencing health and illness Indeed, comments about these items show a strong antipathy to what is regarded as 'fatalism' :

"I do not believe in an irresponsible fatalistic attitude to illness." (Participant 77).

The account allots a definite role to external factors : physical conditions and pollution (Items 3 and 16 = -4, Items 57 and 72 = -3); circumstances and events (Item 47 = +4, Item 72 = -3) and other people (Items 18, 56 and 61 = +3), though not interpersonal conflicts (Item 30 = -3). Similarly, internal factors are also

seen as playing some role, e.g. , the body's own mechanisms and defenses (Item 37 = +2, items 25 and 65 = +3) and emotional distress (Item 41 = +4). However, it is God's intervention that is the ultimate controlling influence :

"It is through the Lord Jesus that we are given our health and wellbeing." (participant 77).

This is, then, an account which superimposes upon the ecological and biological model expressed by Q Factor 2 a strong belief in the direct and effective role to be played by God. However, it is not a 'personalistic' belief system which regards God as purposively bringing illness and health but rather concentrates on the ability of God to heal illness. Illness arises out of 'natural' (e.g. viruses and 'bugs') and person-made (e.g. pollution) attacks upon the body, which the body is able to fight by its own mechanisms and medicine is often able to cure. It does not deny self-determination - indeed, there is a sense of a moral responsibility on behalf of the individual to act in ways that promote their health, act 'responsibly' and avoid 'fatalism'. It sees the individual as somewhat in control, within a context of multiple aetiology, with the most important and benign resource to be drawn upon that of God's love, care and healing.

7.6.6 The account identified by Q Factor 6

Q Factor 6 was exemplified by the Q sort of participant 47, a village shopkeeper, with a telecommunications engineer loading 0.60 but also loading 0.39 on Q Factor 5. It is the only Q factor in which the influence of chance (Item 15 = +1, Items 28 and 32 = +2) and probability (Items 7, 17, and 44 = +2; Item 29

= +1) are consistently but mildly endorsed. Infectious organisms are also regarded as important (Items 31 and 45 = +4), and so too are heredity (Item 34 = -5), the body's own defences (Item 25 = +2) and, in particular, personal determination to mobilise these to aid recovery (Item 37 = +4, Item 39 = +5).

"I am a great believer in inner strength ... Determination is needed. One's spirit helps to try to overcome illness and not become depressed by illness." (Participant 47)

Emotions, feelings and worries are rejected as affecting health (Item 41 = -3) or engendering illness (Items 23 and 63 = -4); so too are environmental influences (Item 3 = +3, Item 16 =+4) and relationships with others (Item 18 = -2) and interpersonal conflicts (Item 30 = -4). However, medical care is seen as influential in effecting recovery (Item 8 = +2, Item 9 = -5, Item 11 = +5) and doctors' orders should be followed (Item 2).

"I have the greatest faith and trust...Because when I have found it necessary to seek medical help I feel they have given me the best of their ability and I have faith and trust in their judgement. You have to comply to give the treatment chance to work. Advice should also be followed as it might improve and prolong one's life." (Participant 57).

It is an account that attributes some 'internal' and some 'external' influences, though largely those over which the individual has little personal control. While the individual can affect recovery (Item 40 = -4) and is somewhat responsible (Item 66 = +2), this is not carried through to a belief in personal control over health by 'looking after myself' (Item 21 = -1), actions (Items 46 and 58 = 0), or lifestyle (Item 78 = -1). Rather, this account sees health reflecting overall fulfillment in life (Item 75 = +3). God (Items 19 and 35 = +3) and prayer

(Item 71 = -2) have some influence, God may even · send illness (Item 55 = +3) but curses cannot (Item 13 = -5).

Overall, then, this is the Q account that comes closest of all to the 'chance control' attribution. Essentially it is a fairly mechanistic viewpoint, seeing the major factors causing illness as infectious organisms, and the major protections a 'strong constitution', the body's own defences and medical care and treatment. There is basically a denial of one's own behaviour and actions playing any significant part in maintaining or improving health, although when illness does occur, individual action, a positive attitude, God, prayer and medical intervention can all aid recovery.

7.6.7 The account identified by Q Factor 7

Q Factor 7 was exemplified by the Q sort of participant 33, a secretary. The account denies virtually all external influences on health except the impact of infectious organisms and invasive disease, which are strongly endorsed (Item 12 = +5, items 31 and 45 = +4). Getting ill is a 'fact of life' (Items 7 and 29 = +4) but getting better (Item 15 = -2, Item 40 = -3) and improving health (Item 32 = -4) are not just luck. Personal responsibility (Item 66 = +3) and blame for illness (Items 10 and 51 = +3, Item 42 = +1) are accepted, but lifestyle does not affect health (Item 78 = -3). Neither God nor supernatural forces affect health (Items 64 and 13 = -5; Items 19 and 76 = -4; Items 35 and 55 = -3); neither medicine (Item 8 = -2) nor medical treatment are salient to recovery (Item 52 = -2); doctors cannot find cures (Item 11 = -4), and the advice given by the medical profession is not trustworthy (Item 9 = +3).

"I don't believe that anything the doctor gives you really works... I don't believe in doctor's treatment."

Possibly the key to understanding this account is the endorsement of the individual's right to act in unhealthy ways if they chose (Item 68 = +4) strongly refuting any need to comply with doctors' orders (Item 2 = -5). The issue of control over illness and health is, quite simply, not all that salient. The individual's right to behave as they chose is much more important **than** worrying about health, which includes doing things which are known to be harmful to health, reminiscent of Account 8 in Study 2.

"I believe the rights of the individual are what is important here, not whatever causes illness".

7.6.8 The account identified by Q Factor 8

Q Factor 8 was exemplified by the Q-sort of Participant 18, a woman who described herself as a mother. This participant's data sets provided exemplars MHLC Factor 2, and for IHIQ Factor 4, indicating a locus of control as 'probabilistic'. A Lecturer, participant 79, also loaded 0.53 (but had loadings of 0.33, 0.36 and 0.43 on other factors). As with IHIQ Factor 4, health is not a matter of luck (Items 15 and 60 = -1, item 32 = 0) but probability (Item 7 = +3, item 17 = +4 and item 29 = +2).

"Good or bad health is part of life and worrying too much is pointless." (Participant 18).

"(Agreement with these items is) ... fundamental to anybody who construes 'reality' as fundamentally stochastic ... basic probabalistic or actuarial 'truth'. If not, assurance companies would go bust." (Participant 79).

It is not surprising, therefore, to find rejection of the idea that the individual can do much to influence their own health (Items 46, 58 and 78 = -2) and hence the individual can hardly be held responsible (Item 66 = 0) let alone blameworthy for any illness (Item 10 = -3). Good health has more to do with living a satisfying life than being obsessive over things like exercise and diet (Item 75 = +5). Illness may be the result of infection Item 12 = +2, item 31 = +3, item 45 = +4), against which medical care is effective (Item 11 = +3, item 52 = +2). But 'mind' (Item 14 = 0), one's emotions (Items 23 = -1, 62 = -2); 'other people' (Items 18 = -3, 30 = -3); God (Items 19 = -5, 35 = -5); pollution (Item 3 = +3, Item 57 = +4), 'inbuilt weaknesses' (Item 1 = -4) and constitution (Item 34 = +5) are all rejected as influences or simply regarded as not salient.

"Susceptibility to bad health varies throughout the lifetime - sometimes I will be ill, sometimes I won't - accounting these variations as a constitution with which I was born is therefore irrelevant." (Participant 18).

This account regards the issue of the factors that control health and illness as itself questionable :

"The factors that determine, at any point in time, whether I am ill or well are complex and interactive. It doesn't make any sense to me to say that it's X or Y that makes me ill, or that by doing Z I can ensure good health. That's nonsense - I could eat all the right foods, take exercise, give up smoking, and then the nuclear power station close by could spring a leak, or some idiot could mow me down with his car, and all the 'good habits' in the world wouldn't save me from the consequences." (Participant 79).

Even more than Q Account 7, Q Account 8 stresses the rights of the individual for autonomy and self-determination (Item 68 = +5), much less concerned to allocate a locus of control than to express a moral discourse :

"To me this is a moral issue, and far more fundamental than any belief I may have about, say, whether exercise is good or bad for you. It's my body, my risk to die young, my lungs, and I reserve the absolute right to decide, and not be dictated to by a doctor or so-called expert from the Health Education Council." (Participant 18).

"I have the right to the ultimate decisions I make on matters affecting my health, whether harmful or not." (Participant 79).

7.7 DISCUSSION AND CONCLUSIONS

7.7.1 Discussion of the Q data

The eight Q Factors are illustrated in relation to one another in Figure 7.2.

The Q data and analyses demonstrate three things. First, it provides convincing evidence for the inadequacy of the MHLC construct; while broad internal/external/powerful others constructs have some relevance for five of the eight accounts identified, for three they are largely irrelevant. Even within an 'explanatory' framework, accounting cannot be properly understood by assuming that all accounts share common constructs that are equally salient. Perhaps most significantly, the 'medical model' of Q Factor 2 is only made operant by the Q sort, neither the MHLC or the IHIQ responses gave any clues about its existence. The multiplicity of attributed influences simply gets lost in the MHLC scale, appearing as so much 'muddy data' that in many studies would be rejected as 'too close to the mean' and not very interesting. Given the importance of the 'medical model', in biomedicine if nowhere else, this failure of the MHLC scale to tap it may provide some clues about why it is that the MHLC scale has been found to be so disappointing (as described in Chapter 6).

Figure 7.2   Accounts for health and illness as identified by the Q sort in Study 3
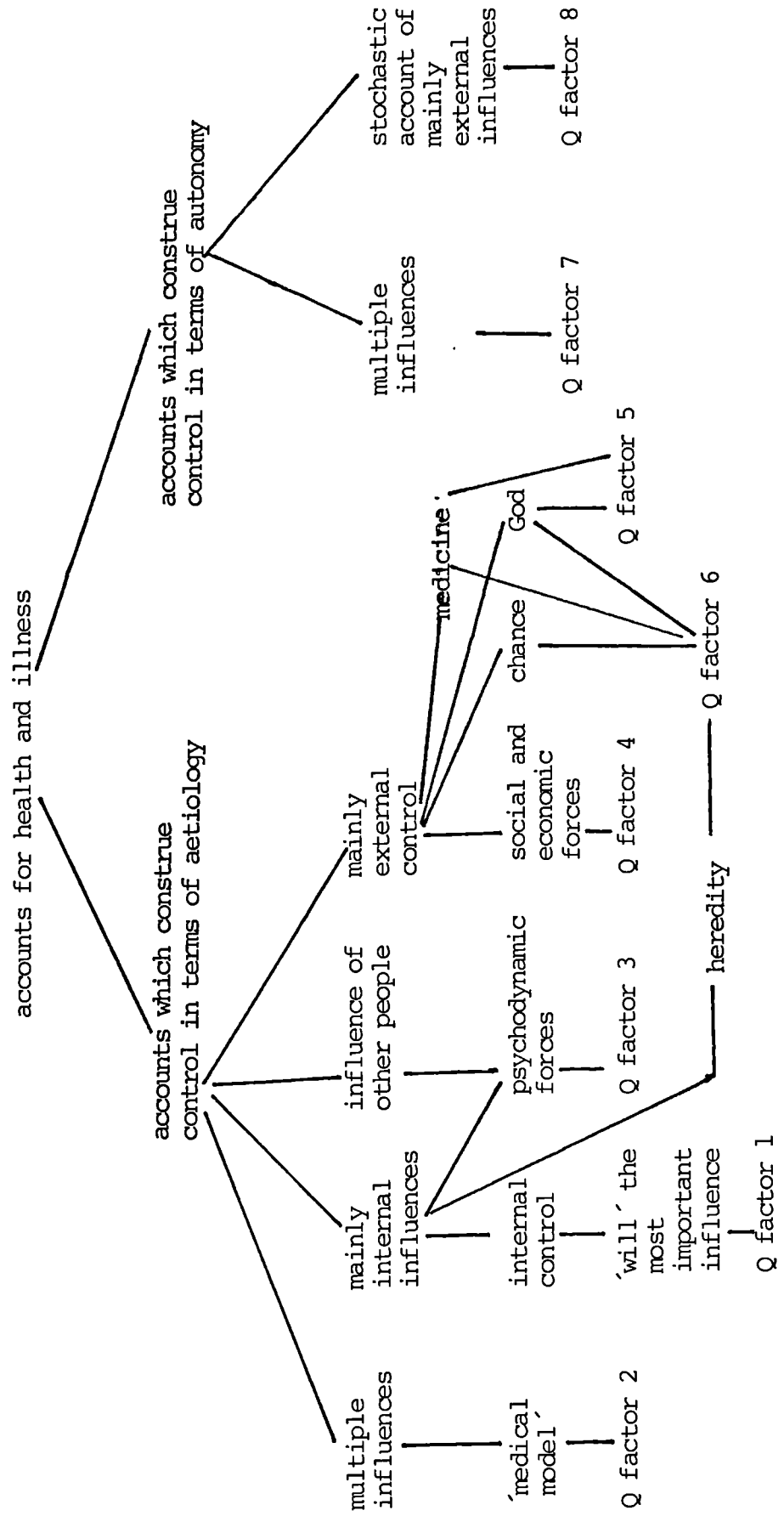
However, even in the five Q Accounts where the MHLC constructs are relevant, the crude division between the three constructs, which reifies individuals as one or another, is grossly inadequate to classify the alternative accounts expressed. While same Q Accounts (e.g. 1 and 4) do focus quite specifically on just one aspect, for others both internal and external loci of control are equally important. Furthermore, constructs which are excluded from the MHLC domain of applicability are highly salient in same cases (e.g. Q Account 2´s focus on the impact of stress). This latter account in particular raises questions about the basis of ´locus of control´. While the locus of agency - the mind - is clearly ´internal´, it is nonetheless not a ´locus of control´ in the sense either Rotter or Wallston & Wallston intended it. Control is attributed, ultimately, externally - primarily within the domain of social relationships and life-stresses which operate upon the ´mind´.

Secondly, the Q analysis does offer opportunities to gain more articulated descriptions of accounts than did the R data. While by-person factor analysis, acting as a form of pattern analysis, opened the MHLC and IHIQ data up to more detailed account interpretation than R analysis is conventionally able to do, the Q sorting, by its demands upon participants to rank items in relation to each other, and consider the items in more wholistic terms, enabled factor interpretation to be both more precise, and carried out in greater depth. However, it must also be noted that there were same accounts (notably the one identified by IHIQ Factor 5) which were not articulated by Q sorting, demonstrating that the Q sample does constrain the accounts that can be expressed.

Finally, the parallel completion of the three instruments demonstrated surprisingly high consistency across instrument responses. While there were a few occasions where at first it appeared that people were expressing different accounts in the different situations, once more detailed analysis was carried out, the performance of individuals on one scale was usually seen to be highly compatible with their performance on the others. Although some aspects were easier to express in different situations, by and large the same people often emerged as exemplars of factors with different data, and when they did so, while what they were 'saying' in their responses was not identical, it was plausibly linked. This provides independent evidence that Q sorting does not simply engender particular accounts from the item sample.

However, it also suggests that Q sorting is an activity which focuses attention, and creates a framework in which for some people at least, performance is a product of a single account rather than a process of dividing between several. This is not all that surprising given the demand characteristics. Potter and Wetherell (1987) argue that accounting within an interview is a process where people access different accounts in order to serve different discursive functions. It would appear that in Q sorting, the demand characteristics encourage some individuals at least to be more 'single minded', although others spread their responses over a number of factors (e.g. Participant 52).

7.7.2 The nature of accounts

It has been argued in Chapter 5 that this results in the accounts identified by Q sorting being almost 'too good to be true'. Certainly the eight Q accounts in Study 3 read in detail, convey 'storylines' that are usually both recognisable and distinctive. This was not just a matter of a number of themes running through all of them, that merely changed in their evaluative valency. For example, 'chance and probability' was a concept responded to within each account. In some cases people tended to deal similarly with all the relevant items - all were agreed were with, or all disagreed with. But in others the overall topic was deconstructed - chance might be seen differently from probability or both chance and proability seen as different in different situations; in some cases chance attribution was linked to attributions of disease organisms and in other cases not.

The image conveyed to me is somewhat analogous to chemical reactions, with different elements combining to produce different compounds having very different properties, and the compounds being highly distinctive according to the combinations. Part of the reason why Q sorting generates such nice, clear account descriptions, I believe, is that the process provides the response conditions under which compounds rather than motley jumbles of elements are articulated (as is more the case in R scale responding) but in which some people at least (i.e. those that act as exemplars) are persuaded to express a single 'compound' rather than a mixture. To take the analogy just a little further, at the end of the Q study I have a sense that I began with a muddy kind of mixture which I have been able -

albeit quite crudely - to fraction out into some 'purer' compounds.

7.7.3 Accounting is complex and multi-faceted

So what did the alchemy discover ? Well, certainly that the mixture contained a lot more than has often been assumed. Accounting for health and illness is, even within an explanatory domain, predicated upon sophisticated theories-about-the-world, which link 'meaning', 'explanation' and 'morality' as described in Chapter 5. The sense conveyed when reading Q Accounts is that of people making use of complex networks of inter-related assumptions, interpretations and proscriptions, not merely responding according to some simple linear model. The MHLC scale in particular can only extract from people very crude, faint and often very distorted n-order approximations of these rich constructs, rather like a photocopy-of-a-photocopy, from which it is almost impossible to decipher the form or content of a brightly coloured original, where many crucial elements have simply not been picked up, or so grossly distorted they loose all of their power to convey anything meaningful. If we want to discover how people construct and interpret their world, we must develop theories and methodologies that do justice to the subtlety and complexity of their thinking - that reflects their imagination, creativity and sheer competence as thinkers; and the abundance of images, ideas and arguments with which they are bombarded in contemporary life from the mass media. McGuire argued this case cogently some thirteen years ago :

"I stress here the basic point that our cognitive systems and social systems are complex and that currently conventional simple linear process models have outlived their heuristic usefulness as descriptions of these complex systems. In our actual cognitive and social systems, effects are the outcome of multiple causes

which are often in complex interactions; moreover, it is the rule rather than the exception that the effects back on the causal variables. Hence, students of cognitive and social processes must be encouraged to think big, or rather to think complexly." (pp 42-43).

Q method, I believe, offers one potential route to 'thinking complexly'. In the final Chapter to follow I will describe what I think it has been able to offer to our understanding of the way people account for health and illness, and in particular what the results of these studies have been able to contribute to a more satisfactory theory of accounting.

CHAPTER 8 : REVIEW AND PROSPECT
ACCOUNTS FOR HEALTH AND ILLNESS, AND OBSERVATIONS ABOUT
ACCOUNTING AS 'MAKING SENSE'

8.00 INTRODUCTION

The objectives set for the thesis in Chapter 1 were to identify
and describe some of the main accounts for health and illness
that are current in British culture, placing them within broader
contexts and wider explanatory frameworks; and, by way of an
analysis of these ecological aspects, illuminate our
understanding of such accounting. This Chapter summarises the
results obtained in terms of those objectives and examines the
theoretical and practical implications of the dissertation as a
whole.

8.1 IDENTIFICATION AND DESCRIPTION OF ACCOUNTS

Within the three studies, eight very diverse accounts for health
and illness were identified. There were, of course, others, but
these eight represent those of the identified accounts which
were most clear-cut and meaningfully ´common property´,
constituted by the responses of several people in each case, and
(except for the last), identified in more than one Q study. These
were, in summary :

1. The wonders of modern medicine account, operating within the
positivist worldview of science, within which illness is
naturally occurring and ´real´, and modern biomedicine is seen as
the only source of effective treatment for any kind of serious
illness.

2. The illness is the result of stress account, where the
causes of illness are sited within the immediate social world of
interpersonal conflicts and the ´stress´ of modern life, acting

upon the body through the agency of ´mind.

3. The <u>cultural critique of medicine</u> account, based upon a ´dominance´ sociological worldview of exploitation and oppression and a social constructionist analysis of knowledge as socially and politically mediated,

4. The <u>healthy lifestyle</u> account, which recognises both collective and personal responsibility for ill-health, but stresses the need for positively adopting a ´healthy lifestyle´ in order for good health to be achieved and maintained and illness to be prevented.

5. The <u>traditional</u> account, which sees illness as largely inevitable, so that although it can sometimes be avoided by ´looking after yourself´, people should not be blamed for being ill.

6. The <u>individual autonomy</u> account, which is more concerned with the individual´s right to a ´satisfying life´ and to elect their lifestyle for themself than with the aetiology of illness.

7. The <u>Theistic</u> account, within which health is a product of ´right living´, spiritual wellbeing and God´s care, and recovery from illness a matter of regaining spiritual wholeness, attained by intercession to some form of Deity or spiritual power.

8. The <u>Willpower</u> account, which sees the individual as pre-eminently in control, and stresses the moral responsibility of the individual to use their ´Will´ to maintain good health.

Figure 8.1 : Summary of alternative accounts identified in the thesis

Description	Accounts*	Identified/described elsewhere
The wonders of modern medicine account	S1 A4 S2 A5 S3 QA2 IHIQA3	Ehrenreich (1978)
The 'stress' account	S2 A8 S3 QA3 IHIQA1	Blumhagen (1980) Young (1980) Herzlich (1973)
The cultural critique of medicine account	S1 A1 S2 A1 S3 QA4	Ehrenreich (1978) Taussig (1980) Doyal (1981)
The healthy life-style account	S1 A5 S2 A3	Crawford (1986)
The traditional account	S2 A4 S3 QA6	Pill and Stott (1985) Helman (1978) Cornwell (1984) Blaxter (1984)
The individual autonomy account	S2 A9 S3 QA7&8	Crawford (1984)
The Theistic account	S2 Q7 MHLCA7 IHIQA5 QA5 & 6	Snow (1974) Williams (1986b)
The Willpower account	S3 QA1	Crawford (1980) Levin & Coreil (1986)

* S = Study; A = Account; QA = Q Account; MHLCA = Health Locus of Control Account; IHIQA = 'Influences on Health and Illness' Account.

The sources of these accounts as identified within the empirical work of this thesis, and in the literature are shown in Figure 8.1.

8.2 ACCOUNTS IN THEIR SOCIAL, CULTURAL AND PSYCHOLOGICAL CONTEXTS

The first three of these accounts reflect Moscovici's (1984) assertion that within Western culture, social representations are often popularised or 'commonsense' versions of scientific, academic or professional theories, operating within everyday discourse.

8.2.1 The 'wonders of modern medicine' account

This account is the most directly derivative, indicating that the tenets upon which biomedicine is based have been transmitted outside of the professional domain, modified (e.g. by processes of personification, figuration and ontologization, cf Moscovici and Hewstone, 1983) to form a popular theory which regards health as the smooth running of the body-as-machine, and illness as the invasion of disease organisms or the consequence of bodily decay or breakdown. The technological capabilities of modern biomedical treatments are regarded as almost miraculously effective, and medical professionals are seen as possessing high-level, rarefied skills, expertise and knowledge that enable them to treat illness effectively.

Kristiansen (1985) in a content-analysis study of the British press's reporting about health and illness, noted that the 'wonders of modern medicine' is the account most commonly

portrayed by the media, even in the 'quality' press, and particularly by television. This is an image and a story which sells newspapers and makes for exciting and entertaining television programmes, from 'That's Life' to 'Tomorrow's World' (Murrell, 1987, provides an excellent analysis of the construction of popular accounts of medicine and science by the latter). It is promoted by charities that seek funds for medical research and equipment, as the sponsorship for any 'Fun Run' and the advertisments in newspapers and on hoardings make evident.

However, as media analysts (e.g. Gardner and Young, 1981; Hall, 1980; Murrell, op cit; Rose and Rose, 1976) have been pointing out for some time, it is a distorted image, constrained by the ideologies of the media producers. Morrell, for instance, argues that programmes like 'Tomorrow's World' are not neutral 'windows' through which science can be viewed, but like all discourses : "... actively reconstructs the real world in specific ways to generate specific meanings." These meanings impose "... approving glosses on explanations" and thereby construct an image of "... an autonymous science which naturalizes the 'impartiality' and, in a material sense, the inevitability of the consequences of 'scientific progress.'.".

Moscovici and Hewstone (op cit) argue that this kind of compelling 'isn't-science-wonderful' message, popularised by the media and transmitted within the education system, has turned many people into 'amateur scientists'. This second-hand knowledge enables people to fulfil psychological needs. Biomedical theorisation, which turns illness into disease, and promises effective cure, gives people a sense of safety and

fulfills the desire to know, for certain, of the <u>cause</u> (and usually the treatment) of the worrisomeness of illness.

As Ehrenreich (1978) has noted, however, although its operation in lay accounting is functional for the medical professionals insofar as it facilitates patient compliance (although it also has its drawbacks for professionals, cf Doran, 1983), it is an account which generates dependency and an unwillingness to assume personal responsibility, since medicine is seen to be able to intervene after-the-event, making preventive actions unnecessary. Thus, as Ehrenreich and Ehrenreich stressed (1978), later in the book, this is an account which is becoming increasingly dysfunctional, since it engenders unrealistic expectations which have led to the :

"... inability of (North)American medicine to deal adequately with problems that require the patient's willed participation in the cure ... Patients expect to be cured ... they do not expect the doctor to impose new hardships." (p 69)

8.2.2. The 'stress' account

This account is a popularisation and selective modification of psychodynamic theory. Sometimes, as the accounts obtained here showed, the stress account is incorporated into a broader account within which a number of psychodynamic concepts (e.g. 'complex' and 'unconscious motives') are articulated. The transmission of such ideas into popular discourse was the first social representation investigation carried out by Moscovici (1961). But in its specific objectification of health-threatening external influence as 'stress', the stress account focusses attention upon an assumed process whereby troubling and distressing life events become somatised as disease, an image

which was central to Herzlich's identification of 'modern life' perceived as a major threat to health and cause of illness. This 'stress' account has been extensively studied by anthropologists such as Blumhagen (1980) and Young (1980). Also popularised in magazines, self-help books, television programmes, lectures and advertisments for vitamins and sleep preparations, it has developed into a very pervasive and powerful account of its own.

The stress account can be psychologically functional for people, since it allows them to attribute illness to a specific cause; stress acquires 'thinghood' and consequently offers a focus for explaining how distressing life events or life circumstances make people ill. However, Young argues that it also serves functions for the medical establishment, for it allows medicine to distance itself from its inability to cure and to thrust the responsibility back onto the patient to 'do something' about their stressful lifestyle. But, he argues, its entry into popular accounting and its growing salience do not merely reflect its function to doctor and patient, but a congruence between the ideological content of the stress discourse in medicine and the beliefs most middle class North Americans hold about people's social nature. These Young argues, combine concepts of empiricism, individualism and voluntarism.

The stress account enables people operating from these taken-for-granteds to objectify 'stress' as an immediate cause of illness, acting on the individual, and thus repress broader social determinants (e.g. capitalist production, structural disadvantage) from consideration. To Young the stress discourse is a means by which the cultural critique is denied. It is not

unemployment, or a lousy job, or the patriarchy that make you ill, it is 'stress', and thus the exploitation and oppression acted out upon people is sanitised into something stripped of any moral value, thus discouraging any questioning the social status quo.

8.2.3 The 'cultural critique of medicine' account

This account has been extensively described and discussed already. It is explicitly critical of both of the above 'popularisation of science' accounts, incommensurable with them, and indeed constructed (predominantly by academic theorists) and polemicised as a deliberate attempt to refute the principles upon which such 'science' is based. Its articulation as a cultural critique of medicine is couched within the more general social epistemological account which seeks to demystify essentialism, positivism and empiricism, and to deny that (in this case) scientific knowledge is, as it claims to be "... merely mirroring the real conditions of existence" (Young, op cit) but is rather the product of social relations which reflect the social divisions of power and labour in our culture, vulnerable to historical and ideological forces.

The articulation of the cultural critique of medicine account in the Q-studies was by the Q-sorting of people who described themselves as political radicals, although as noted in Chapters 4 and 5, the account melded together quite different radical formulations, including feminist and Marxist interpretations.

It is interesting as much in its refutal as its expression. Particularly in Study 2, the items provided for its expression (e.g. about Capitalism being inherently anti-health) drew forth, in some accounts, highly antagonistic comments such as "Must have come out of a Communist Manifesto". Indeed, one participant wrote to me accompanying his Q-sort, demanding that I remove "... all this political gobbledygook" from my questionnaire, as "...health has nothing to do with politics, and to include this rubbish does no service to you as a researcher."

It is interesting to speculate why this account seemed to make some people so angry. Certainly antagonism to what is portrayed in the tabloid newspapers as the ´Loony Left´ is an emerging cultural theme within the political arena in Britain today, with the label ´Marxist´ and even ´feminist´ acquiring the status of insult across a broad popular front. This analysis suggests that the people who control the media do not just sensationalise a ´good story´ to sell newsprint and increase viewing figures, but act from overt and explicit political motives, seeking not just to promote certain accounts conducive to their own perpetuation, but also to distort and villify other accounts that they regard as threatening.

To the extent that this is true, the cultural critique account is suppressed from popular discourse. It tends to be a marginal and somewhat elite discourse of a particular counter-cultural ´in-group´, restricted in in its availability to those who seek out radical, counter-orthodox ideas by, for instance, engaging in radical politics and reading the ´radical´ press; who have access to, the motivation and the intellectual skills

to, read and discuss the appropriate academic literature.

The basis of this acount is usually traced back to the writings of Gramsci (in English translation, 1971; Bennett et al, 1981, provide an excellent summary and review), smuggled out when he was imprisoned by Mussolini. Gramsci focussed on the term ´hegemony´ within his argument for a Marxist analysis which trancended what he saw as the ´vulgar maternalism´ of the notion of class domination. His thesis was that social control is acted out by powerful groups not just by their capacity to dominate in terms of their control over economic and other resources, but by their intellectual ´ethical-political´ power to construct culture.

Gramsci´s attacks on intellectualism were specifically antagonistic to the idea that expert knowledge is either politically neutral, or should be seen as a justification for assumed superiority :

"We need to free ourselves from the habit of seeing culture as encyclopaedic knowledge, and men(sic) as mere receptacles to be stuffed full of empirical data and a mass of unconnected raw facts... This form of culture is really dangerous, particularly for the proletariat. It serves only to create maladjusted people, people who believe they are superior to the rest of humanity because they have memorized a certain number of facts and dates and who rattle them off at every opportunity, so turning them into a barrier between themselves and others. It serves to create the kind of weak and colourless intellectualism ... which has given birth to a mass of pretentious babblers... this is not culture, but pedantry, not intelligence, but intellect, and it is absolutely right to react against it ." (Gramsci, as translated by Hoare, Lawrence and Wishart, 1977).

Gramsci argued that the Enlightenment was an emancipatory cultural movement which questioned the status quo and laid the foundations of the French revolution. He saw the socialist critique as a similar emancipatory philosophy, within which new

ideas do not just emerge (in some quasi-naturalistic manner) but are 'reactions against' and questionings about the established order :

"A critique implies ... self-consciousness ... Consciousness of a self which is opposed to others, which is differentiated and, once having set itself a goal, can judge facts and events other than in themselves or for themselves but in so far as they tend to drive history forward or backward." (Gramsci, 1977 as above).

Thus Gramsci was arguing that society is neither merely constructed by nor operates just in terms of material divisions, but is more fundamentally the product of the way different groups wield ideas. The 'cultural critique of medicine' account is a direct descendant of such a notion, both in the way it is seen by its proponents as a specific challenge to the taken-for-granteds of the orthodox ideas of biomedicine as enculturated into popular discourse and in its refutation of the assumption that knowledge is ever empirically based or value free.

8.2.4 The healthy lifestyle account

Unlike the three described so far, this account has been institutionally promoted and popularised as a matter of social policy, to serve the explicitly defined function of creating social change. In Britain institutions like the (now defunct) Health Education Council were set up with the purpose of persuading people to alter their habits and lifestyles to conform more closely to those that have been defined (predominantly by sectors of the medical profession) as 'more healthy', by way of advertising campaigns and health education in schools, colleges and within the training of health

professionals.

In North America, where health care is privately funded and hence costs employers large sums of money (The Chrysler Corporation estimated in 1984 that employee medical insurance cost the company $373 million a year and added $600 to the cost of each car they sold, Carlson, 1984), health education and promotion is being funded increasingly by large corporations and insurance companies, in an effort to reduce corporate expenditure on medical care and insurance.

However, as Crawford (1984) has noted, from its origins in social and corporate policy, the 'healthy lifestyle' account has been taken up commercially. Its moral desirability aspects have acquired it an image of high social desirability, so that the promoters of 'health foods' and designer jogging suits have been able to make huge profits by exploiting its culturally sanctioned positive images. For example, 'Tesco' have attributed much of their 34% (£176m) increase in profits in 1986/7 to their investment in the production of free 'healthy living' leaflets, improved labelling and introduction of new ranges of 'healthier' foods (Polunin, 1987).

Underlying the deliberate promotion of this account is an assumption that in order to promote healthy living, people need to be informed, and to develop appropriate attitudes and motivations. Early health education strategies assumed that it was merely necessary to provide accurate information and this would be sufficient to modify behaviour. More recent health promotion strategies have assumed that attitude change is also

needed : increasing the value placed on health (Kristiansen, op cit), and persuading people to adopt a more 'internal control' attribution (see Nash, 1987, for a review).

Crawford comments that as an account it has both liberatory and 'false consciousness' potentials. As publicised by right-wing politicians like Edwina Currie, it is an account which can be used, like the stress account, to devolve responsibility for health to the individual and to deny structural and politico-economic causes of ill health, and hence government culpability for the inequalities between rich and poor. Currie's (1987a) suggestions that Northerners are less healthy because of their poor diet and lack of exercise absolves her (as junior Minister for Health) from the need to consider social and economic disadvantage as within her remit; her invectives about the effects of alcohol abuse among doctors (1987b) absolve her from the need to consider whether the demands of professional life may need review. The impression given by such articulations of this account is that people, as individuals, need to 'pull themselves together and act sensibly'.

However, Crawford additionally argues that the 'healthy lifestyle' account also contains a message of self-empowerment which has had considerable emancipatory impact, particularly upon women in relation to its redefinition of the desirable female body image. The promotion of fitness and muscle as more desirable for women than the "tyrany of slenderness" has reconstituted the female body from its earlier ideal (in our culture) of frailty to one of physical power and competence.

He also noted that the adoption of a healthier lifestyle does improve health and wellbeing, and can provide people with a self-image of greater confidence and self-esteem. Certainly changes in lifestyle are assumed to be the reason for the reductions in coronary disease in the United States and other Western countries (a trend much less marked in Britain).

It is therefore important to recognise that the ʼhealthy lifestyleʼ account has different potentials and meanings according to whether it is utilised by an individual to plan and ʼmake sense ofʼ their own actions (where it can be emancipatory); or used as a form of ʼvictim blamingʼ to marginalise and deny the structural problems faced by the disadvantaged.

8.2.5 The ʼtraditionalʼ account.

In contrast to the four hegemony-derivative accounts described so far, the traditional account has its bases within indigenous, popularly sedimented discourse.[1] It is the account described by Helman (See Chapter 2, Section 2.1.2) in terms of ʼfeed a cold and starve a feverʼ, by Blaxter (See Section 2.2.1), Pill and Stott (See Section 2.2.2) - particularly as articulated by their ʼlowʼ and ʼmediumʼ SLI scorers - and in Cornwellʼs ʼpublic accountsʼ (See Section 2.3.3). Although, as Helman (1978) described, it has drawn upon biomedicine in its incorporation of notions of infection (modified by processes such as figuration, as described by Moscovici and Hewstone, op cit), its roots are very much within traditional epistemology.

1: Which is probably why it was so much less evident in this research than in other studies like Cornwell's and Blaxter's. Q sorting may well be inappropriate for explicating traditional accounts of this kind.

Horton (1982) has argued that whereas scientific theorisation assumes epistemological progress, traditional epistemology is based upon the assumption that knowledge handed down from former generations is necessarily better than new adaptations because it is 'time-tested'. Horton also drew a contrast between the "competitive mode of theorising" which epitomises science, and the assumed "consensual mode of theorising" of traditional accounts. Boyer (1987) has surmised about a third potential difference: that while scientific epistemologies are theoretical, traditional 'knowledge' may be merely representational or pre-theoretical "... networks of beliefs that are not strictly constrained in terms of consistency or explanatory power.". Boyer does not support or reject this contention, but rather argues that the task of anthropology is to seek to answer the question.

Most of our current theorisation about traditional accounts derives from anthropological investigations of indigenous cultures in non-Western settings. The best known theorist about accounting for health and illness in Western culture is Foucault, particularly in his Naissance de la Clinique (1963), a complex and painstaking analysis of what he calls the "architecture of medical perception" as articulated both within medical professionalism and outside it. He proposed that accounting for illness has, throughout history, been moulded by and in its turn has moulded, the more general conceptualisations and discourses operating in culture. More recently Herzlich and Piarret (1985) have summed up this analysis in terms of :

"... a collective discourse that draws the full and meaningful picture of biological misfortune. Each person's conceptions link the nature of his(sic) bodily experience and 'medical history' to

the symbols and frames of reference of his group or society ..."
(p 146).

They note that in Western culture such symbols and frames of reference are both provided by cultural traditions and by medical progress, so that the 'traditional' accounts of today, while they incorporate biomedical ideas, are more than mere popularisation of the 'medical' account. Williams (1986b) has made similar points, arguing that these include not just 'folk' theories about health and illness but also a broader range of sedimented conceptions of personhood and morality, images and ideas about such things as "... respect for neighbourliness, for authority, for perseverence and thrift."

In the analysis of this account as identified in the Q studies, the most pervasive theme was that of stoicism about illness (that it was not to be 'given in to'), a responsibility to 'take care' of oneself, but strong denial of blame when illness does occur. Rorty (1987) attributes this kind of self-perception to a number of traditions (e.g. Judeo-Christianity and the Renaissance) which have constructed our modern perceptions of 'authentic personhood'; the characterization of a person as somebody who will be taken seriously and with respect, despite illness, ageing, poverty or misfortune :

"... assuring us of a certain kind of regard, to be treated as ends not means, with activities that are rational (or at least reasonable) and good-willed (or at least well-intentioned) ... persons should be respected because they are capable of critical reflective rationality, or because they are free inventors of their lives, or because they have divinely donated souls, or because they can be harmed, frustrated in living out their life plans." (p 57).

Hence the 'traditional' account is at least as much predicated on deeply culturally sedimented constructions of personhood and

authenticity as upon specific notions about health and illness per se. Turner (1986) has argued that our images of selfhood are about embodiment : "... we are not persons with bodies, but persons who are embodied." The 'traditional' account seeks to reconcile bodily discontinuity (cf Dingwall, 1976) with personal continuity and theoreticity (Voysey, 1975) which it does by ascribing to people what may seem to be paradoxical qualities – responsibility for sensible health protecting actions and yet non-culpability for illness.

In this I am proposing something more global than the suggestions of Blaxter (1984), Cornwell (1984) and Pill and Stott (1985) that denial of blame for illness is a realistic response to disadvantage. Within my analysis, denying blame is more fundamentally to do with our traditional notions of authentic personhood. But in this I am not claiming (as many attribution theorists, for example, have done) that denying blame is an universal characteristic of human cognition; nor (as many psychodynamic theorists have done) that blame-denial is merely a form of ego-defense. Rather I am suggesting that blame-denial is a core construct within our culturally sedimented account of authentic personhood, and it is its account-specific taken-for-grantedness that imbues it with its pervasive sense of 'What else could a person be but this ?'.

The remaining three accounts are predicated upon other, alternative, assumptions about authentic personhood. Rorty (op cit) has argued that there have been dramatically discontinuous

changes in the characterisation of personhood across history, and that such conceptualisations differ across and within cultures. For example, she lists conceptions of person-as-rational-being, person-as-creative-being, person as <u>dramatis persona</u>, and person as socially formed ´in the eyes of others´.

8.2.6 The individual autonomy account

This account portrays a very clear perception of authentic personhood in terms of self-determination and self-defintion. Rorty (op cit) described this particular version as :

"... primarily negative (and) defensive ... that concentrates on fending off external interference : ´Noli me tangere´, or, in Amerispeak, ´Don´t tread on me buddy.´." (p 56).

She argued that it emerged within Enlightenment political theory as the way ´personhood´ could be protected against tyranical or unjust authority. It began within the Christian conception of the person as defined by the capacity for free-will. Within our secular society, where such an ´Old Order´ has lost its authority, the concept of free-will has been retained, and, unfettered from the higher authority of God, has developed into our contemporary notion of the person as a constructive, self-determining legistator - the Enlightenment image of an independent, inquiring, rational self, free from the claims of any dogmatic doctrine.

However Henriques et al (1984) argue (as do many sociologists and Marxist theorists) that the emergence of this emphatically individualist image is also the product of the profit motive of industrial capitalism. McClelland´s (1971) achievement motivation

formulation is clearly salient in this regard, a rare but welcome example of psychological theorisation which sought to explore the interplay between individual and collective features in the linkages it drew between the level of achievement endorsement of a culture within an historical era (e.g. as indicated by the themes in its literature) and its level of production (e.g. as evidenced by the number of artefacts produced). Within McClelland's thesis, the higher the press for 'making things' (i.e. 'making profits' in capitalist terms) in a society, the more individual achievement is valued in that society. Hence, within this analysis, the value base of a competitive capitalist system is one within which rewards are earned and misfortunes deserved, wherein a class of 'self-made-men' were encouraged to see themselves as dictated to by nobody, answerable only to themselves.

Turner (op cit) traced the history of this image of personhood along similar lines to Rorty, from the philosophy of John Locke, through the impact of competitive capitalism (Macpherson, 1962) and Calvanistic Protestantism (Nelson, 1969), to its importance in the maintenance of social order within bourgeois society. However, he has taken it further towards our contemporary culture, arguing that whereas the individualistic self-perception tended, historically, to be the prerogativeof the ruling classes, because there has been a democratisation of the availability of life-styles (and hence ideologies) within the period of post-war economic recovery, this kind of self-concept is now a reflection of status rather than class consciousness.

The comments made by people whose Q sorts identified the individual autonomy account, when directed to the topic of health and illness, showed that it can be articulated in different ways. In Account 9 in Study 2, for example, the principle of autonomy was seen to imply a conception of health as a commodity to be bought, sold, invested in and insured, endorsing 'private medicine' as a means by which people can assert their freedom by buying services. In Q Account [8] in Study 3 autonomy was expressed in terms of embodiment :

"It's my body, my risk to die young, my lungs, and I reserve the absolute right to decide, and not to be dictated to by a doctor or so-called expert from the Health Education Council." (Participant 18).

Thus the autonomy account, like the cultural critique account, is one which challenges the hegemony-derivative accounts, although the motivation is different. Whereas in the cultural critique it is the 'false consciousness' of individual culpability that is denied (i.e. hegemony is seen as a source of exploitation and oppression) here what is denied is the right of the State, or of self-defined experts, to 'interfere' (i.e. hegemony is seen as the 'Nanny State' or intrusive professional bureauocracy). The autonomy account has its exponents both from the 'new Right' (e.g. Scruton, 1986) and the 'left' (e.g. Donzelot, 1980).

8.2.7 The Theistic account

Herzlich and Pierret (op cit) have traced European 'lay' accounting for illness from roots within Christianity. Seventeenth century Christian conceptions tended to portray a wrathful, punitive God who scourged humankind with diseases as tests of faith, as punishments for misdeeds, and as routes to

spiritual salvation. As an example, in a prayer written in 1654, Pascal expressed his understanding of his illness thus :

"You have given me health to serve You, and I have used it profanely. Now you send a sickness to correct me ... Do not suffer me to use Your punishment badly ... Make me clearly realize that the body's afflictions are nothing other than both punishment and the image of the soul's affliction." (Quoted in Herzlich and Piarret, op cit, p 148).

Within the 17th century even medical professionals assumed that healing began with the purification of the soul, and that sickness was often an offer of redemption. The shift within the 18th and 19th centuries to our dominant modern traditional conception, according to Herzlich and Piarret, was a product of : improvements in health (and hence, illness becoming less of a mass phenomenon); the growing capability of biomedicine to offer efficacious cures; the emerging image of the person as 'worker' within a system of industrial production; and the gradual loosening of the Church's hold over society.

Up until recently most theorists investigating accounting for health and illness have assumed that spiritual and religious conceptions of health and illness have become marginalised almost to the point of extinction within contemporary Western culture. The importance of Theism has continued to be recognised in 'other' cultures, including its salience in the medical systems of 'immigrants' (e.g. Snow, 1987, who cites more than fifty studies of minority culture beliefs in North America, based on a diversity of religious doctrines); and in indigenous cultures (such as those of the Amerindians in North America). But the sociological and psychological literature about accounting for health and illness leaves anybody reading it with a strong sense

of a highly secularised culture in which religion plays a negligible part. Religious beliefs find no place, for example, in · the MHLC scale or the 'Health Beliefs Model'. Indeed, Csordas (1986) has argued that a similar denial of Theistic elements has occurred in medical anthropology. In its emergent focus upon Western culture, it has tended to increasingly ignore the problem of explaining the "...existential relation between medical and sacred realities."

In the last few years, however, a few workers have begun to recognise that despite increasing cultural secularisation, religious beliefs and Theistic conceptions continue to play an important role within the 'lay' accounting for health and illness of 'ordinary people'. Williams (1986b), for instance, writing about the accounting of older people in Scotland, noted the salience of an :

"...'invisible religion' of a world view which, often selective in doctrine and uncommited to the church, nevertheless drew on universal statements of faith or ethics to make sense of experience, in a way which showed a number of debts to Scottish Calvinism." (conference paper abstract, p 1).

He argued that irrespective of the Church as an institutional constructor of discourse, such an 'invisible religion' provides a competing set of ideas to indigenous concepts of an individuated self (an image of authentic personhood which reads very similarly to those described in the 'traditional' and 'individual autonomy' accounts).

Several accounts within the studies conducted for this thesis (mostly in Study 3) included Theistic elements, drawing both from conventional Christianity and from other religious creeds and

ideologies, including Christian Spiritualism, charismatic Christian faith, Hinduism and the Baha'i faith. Spiritual and religious concepts were woven into the following (Willpower) account, but such formulations also emerged as the basis of a specifically Theistic account, founded upon notions of faith, 'right living' and spirituality as central to wellbeing, and crucial to healing.

The research in this thesis has only touched, in a very limited way, upon the salience of religion and spirituality to accounting for health and illness which is central in many of the comsmopolitan (cf Dunn, 1977, see Section 1.2.3) medical systems such as Traditional Chinese and Ayurveda medicine. Nevertheless, the ability of Q analysis to draw out uncommon and unusual accounts (which other approaches to participant sample selection and data interpretation tend to submerge) did remind us that although religion may contribute little to the accounting of many people in our culture (other than as a set of ideas to be strenuously denied, as one participant described them, as 'mumbo jumbo'), for a non-trivial number of people, religious belief is highly, and often centrally salient.

The Theistic account assumes that God is the pre-eminent 'Powerful Other' who watches over all aspects of the individual's life, is the ultimate source of healing and wellbeing, and is the authority to whom the individual must answer for their actions. Within this account bodily health cannot be divorced from spiritual wellbeing, and the actions which promote health are those of 'right living' within religious creed :

"I believe in a God who loves and cares for me, who watches over me, and who judges me. He is my strength, and He is my guide. If I follow His commandments, then my soul will be strong, and as my soul, so too my body and my mind." (Participant 77, Study 3).

Rorty (op cit) argued that the Christian conception defines a person as having free-will and a conscience. This was evident in the Q identified Theistic account, with strong antagonism to 'fatalism' or any denial of personal responsibility; but, as the IHIQ identified version of this account in Study 3 demonstrated, this assumption of moral responsibility is not restricted to Christianity, for it was equally salient for the Hindu student. I suspect that one of the most interesting aspects of this account, at which, so far, my research has really only been able to hint, is the different ways that Theistic accounting deals with notions of 'fate' and personal responsibility and culpability - i.e. with the moral and ethical aspects of the relationship between the person and their God(s).

The combination of submission to a higher authority and yet strong moral codes of personal behaviour and a deep sense of responsibility to that authority is one which is problematic for any simple internal/external control analysis. And yet it is evident that such a system is both highly meaningful to, and strongly prescriptive for those individuals who found their lives upon a strong religious faith. Any attempt to model accounting or action that ignores the role of religious faith, I believe, will not only fail to account for the 'realities' of the religious, but will be inadequate to account for the wider moral 'realities' constructed by the 'hidden religion' in our culture as a whole.

8.2.8 The 'Willpower' account.

This account has already received considerable attention within Chapter 7 (Section 7.6.1), its origins traced back to nineteenth century notions of the 'Will' as the means needed to control a person's 'base animal nature', and forward to its central role within many contemporary expositions of 'healthism' and 'New Age Healing'. The kinds of context now provided by the work of Turner (op cit) and Rorty (op cit), concerning the historical development of concepts of 'personhood', show that even before the nineteenth century, self-determination and free-will were well sedimented within Western popular discourse. Rorty described the 'Will' focus as the more positive articulation of the self-determination image, stressing the positive aspects of autonomy, expressed in two ways. The first emphasises critical rationality and independent evaluation which portrays the person as :

"... capable of stepping back from his(sic) beliefs and desires to evaluate their rationality and appropriateness, ... capable of (at least) <u>attempting</u> to form and modify his beliefs and desires, his actions, on the basis of rational evaluations." (p 61)

The second expression emphasises a person's capacity to be creative and 'world making', forming the world in which they live either as a social and political domain (e.g. by participating in public life) or as a visionary-poetic domain by shaping, choosing and constructing systems of values. These two articulations are reflected, respectively, by the 'Enlightenment' theorisation about human conceptualisation (as argued by Voltaire, Diderot, and Condorcet; before them Socrates, Spinoza and Hobbes; after them Chomsky, Levi-Strauss, and Piaget) and the 'Romantic' theorisation (of Goethe and Schiller; before them the Sophists,

Hume and Leibnitz; after them Levy-Bruhl, Whorf, Kuhn, Feyerabend and Geertz). Shweder (1984) provides a thorough review of this theoretical tension. The point is that although these alternative constructions portray personal self-determination in very different ways, both assume, fundamentally, that authentic personhood is bound into the capacity for the individual's willed self-making and self-control.

Haley (1978) and Whorton (1982) both found that self-control was an image that has appeared in the health discourses of Western cultures throughout much of the nineteenth and twentieth centuries. Crawford (op cit) has argued that within our culture generally, health has increasingly acquired the status of a moral imperative within an expectation that to be healthy requires self-control, and has thus become increasingly seen as a goal to be reached through intentional action :

"Health is not a given; nor is it just the result of good luck or heredity ... (n)either is it believed to be the outcome of normal life activities ... Health must be achieved ... To speak of health in this way is to speak of resolve. Health as a goal necessitates the adoption of a more determined regime of restraint and denial - more 'perseverence'.". (p 67).

Crawford argued that this account reflects a number of origins, including : practical reasoning (based upon the popularisation of medical research about the links between lifestyle and preventable disease); a developing sense of somatic vulnerability (particularly as a result of the politicisation of public health issues and media messages about the toxicity of food additives, pollution, the ill-effects of stress and so on); and the re-emergence of self-control as a cultural symbol for authentic personhood. He too traced this construction of personhood through from the nineteenth century 'work ethic'

(Weber, 1930), whereby :

"... self control became the supreme virtue of a triumphant bourgeoisie, the foundation of ʾcharacterʾ and achievement, the bedrock of an ideology of self-determination ... as a guide to action and morally as a legitimation of privilege   (p 77).

He also mentioned the impact of psychodynamics as the major force in constructing the self in terms of the unending war between biological instinct and social necessity (citing Marcuse, 1955). Thus within contemporary American culture, he argued, to be healthy is to demonstrate to oneself and to others an appropriate concern for the virtues of self-control, self-discipline, self-denial and will-power.

This ʾWillpowerʾaccount emerged within the Q studies predominantly as expressed by a variety of ʾalternativeʾ medical practitioners. According to Aakster (1986), alternative medicines, while differing in their specific theory-bases and techniques, share the belief that the individual is to be expected to take sole responsibility for maintaining their own health, and when ill, to cure themself. Alternative practitioners regard themselves as supporting (not treating) the individual, and their therapies as means of strengthening the constructive forces of healing that are present within the body and the soul. As was mentioned earlier, Theistic concepts were also woven into this account, which is primarily one concerned with the concept of ʾbalanceʾ, both within the person (between body and spirit) and between the person and either God or some other spiritual force.

Contrasting with the individual autonomy account, which claims

for the individual the right to set their own moral standards and denies, therefore, the notion of any absolute moral values or norms, the 'Willpower' account is one in which the individual accords the setting of moral standards to some higher authority (usually, but not always, Theistic), and judges themself by their ability to live up to those absolute standards. Whereas the comments from those who expressed the autonomy account repeatedly mentioned 'my rights' and 'my freedom', those who expressed this account wrote about responsibility, duty, the need to avoid selfishness, traps of 'blaming others' and striving to be a better person :

"If I were a perfect 'Christian' person I might not be ill" (Participant 36, Study 3).

The image is one Mischel (1966, 1977) has termed the 'Puritan', typified by high levels of self-control, high achievement motivation and a strong sense of personal and social responsibility. Crawford (op cit) asserts that such a puritanical self-image is likely to become increasingly pertinent within times of economic recession, when its links to the work ethic promote its moral features, and its links to the biological status of the body allow people to, literally, 'embody' the mandate of hard work, self-sacrifice and discipline :

"... Our bodies, the 'ultimate metaphor' refract the general mood. We cut out the fat, tighten our belts, build resistance, and extend our endurance. Subject to forces that lie beyond individual control, we attempt to control what is within our grasp. Whatever practical reasons and concerns lead us to discipline our bodies in the name of health or fitness, the ritualized response to economic crisis finds in health and fitness a compatible symbolic field." (p 80).

Although this account was mainly exemplified in Study 3 by the Q sorts of alternative practitioners, it was identified by the

factor to which the highest proportion of overall variance in the data was attributed, showing that its expression was shared by the accounting of a much wider diversity of people in the participant sample. Thus the Q study conducted for this thesis supports Crawford's assertion for North American samples, that self-control is an important theme in accounting for health in Britain today.

8.3 ACCOUNTING

The terms 'account' and 'accounting' (cf Harré, 1979) as used in this thesis have strong conceptual links to Moscovici's (1961, 1971) 'social representation' formulation, itself resonant of Kelly's 'personal construct' concept (Fransella, 1984, makes this point explicitly). I chose 'account' and 'accounting' because they express in a direct and simple manner the knowledge-source/knowledge-use aspects of the way people 'make sense' of the world and of events. Also, because 'accounts' and 'accounting' are are neither pinned down by the prefix 'social' nor that of 'personal', they elide more comfortably between accounts as individual and as collective property.

However, although 'accounting' is sometimes restricted to just the activities of explaining or justifying action, my utilization of this term is intended to convey an active process of 'making sense' which incorporates 'meaning' and 'moral' as well as explanatory elements. Hence, in this thesis, accounting is treated as predictive and hypothesis generating as well as retroactive and analytical, and as covering attempts to 'make sense' of actions (one's own and other people's), and events and

states of beingness in the natural and physical as well as the social domain. The term 'accounts' covers both the social representation/personal construct aspect of a schematization to be drawn upon for accounting, and the expositions that are the results of accounting.

This final Section examines the results obtained in the thesis in terms of what they offer to an understanding of accounting, with respect to three themes : account sympatricity; the selection, use and production of accounts; and the links between accounting and action.

8.3.1 Account sympatricity

I based this thesis on the assumption that people have access to and utilise a range of alternative accounts to 'make sense of' health and illness. I argued that this was a more plausible understanding of what they do than assumptions that there are specific, enduring personality traits, psychological mechanisms or social forces that constrain people to think in particular ways.

A typical example of the personality theory approach is Mischel's (1977) formulation of self-control as a characterological attribute :

"At one extreme is the person who predominantly chooses larger, delayed rewards or goals for which he(sic) must either work or wait. This person is more likely to be orientated towards the future ... and to plan for distant goals. He (or she) also is apt to have high scores on 'ego-control' measures, to have high achievement motivation, to be more trusting and socially responsible, to be brighter and more mature, to have a high level of aspiration, and to show less uncontrolled passivity. ... At the opposite extreme is the individual who predominantly prefers immediate gratification and rejects the alternative of waiting or

working for larger, delayed goals. Correlated with this is a
greater concern with the immediate present than with the future,
and greater impulsivity." (p 37)

Such a reification portrays people as dispositionally driven,
insensitive to situational and contextual influences. But more
importantly, by treating self-control as an ʿessence in the headʾ
it denies the cultural reality of self-control as a concept which
people argue about, gossip about, read about in books, watch in
movies and contemplate upon; one which is culturally sedimented
in fables (such as Aesopʾs ʿThe ant and the grasshopperʾ) and
aphorisms like ʿDonʾt spoil the ship for a haʾpʾth oʾ tarʾ or ʿa
bird in the hand is worth two in the bushʾ. It assumes that only
experts are aware of such a dispositional tension, and that
ordinary people are atheoretic and lacking in any reflexive
self- or other-awareness.

Brownʾs (1985) description of ʿperceived control as a coping
mechanismʾ for reducing anxiety is a typical example of the
psychological mechanism approach. This portrays people as
ʿpossessed byʾ an objectified psychological force. The
underlying modelling is of thought as a kind of
psychodynamically pre-programed control routine that once
triggered, runs systematically through its sequence. Threat,
fear and worry, in this analysis, start up the sequence, and in
order to reduce the ensuing anxiety, the person is driven
inexorably to construe themself as ʿin controlʾ.

Sociological theorisation such as Friedsonʾs (1970) assertion
that doctors are the ʿarchitects of medical knowledgeʾ is a
typical example of the sociological forces approach. Within this

kind of theory-base, people are portrayed as the passive recipients of understandings moulded for them by others. Thinking, in this analysis, is modelled as a mindless, automatic response to the string-pulling of the puppeteers.

All three kinds of theorisation are bound into the reality-constructs-person moment of the dialectic; all deny self-awareness and theoreticity. As such they fail to address the subjectively familiar experience of thinking based upon confused and contradictory images, ideas and possible understandings; states of 'being in two minds' or 'having half a mind to ...', of feeling both 'in control' and 'controlled'.

What an accounting framework does is to offer a way out of these conceptual straitjackets. In construing accounts as both things that individuals internalise and consider subjectively, and as things that are debated and communicated within interpersonal discourse, (spoken and written), the 'text' from which people 'make sense' is neither conceptualised as writ, immutable, inside the head, nor as read, uncritically, from external canons. By proposing that such 'texts' are many and varied, offering people (individually and collectively) a range of alternative knowledge sources from which to choose, the kinds of contradictions, confusions, half-formed thoughts and half-believed explanations that form the basis of experience can be accomodated within a perception of social cognition that nonetheless reflects its constructive, organised, effort-after-meaning qualities.

Boyer (op cit) argues a similar case for the traditions of a culture; that they should be considered as "... a text people can

use, cite and manipulate", but "(w)hat is on people´s minds at any moment is only a certain idiosynchratic version.".

Crawford (op cit) goes further, and argues that "...(L)ogically entailed in any discourse ... is its opposite ... One discourse does not exist without the other, ... the interplay between them ... apparent within individuals as well as within society." In other words, like Adam (1987) he sees accounts (discourses in his terminology) as implicating as well as explicating.

Rorty (op cit) suggests a similar "patchwork" construal of our conceptualisations of personhood :

"The various functions performed by our contemporary concept of persons don´t hang together: there is some overlap, but also some tension. Indeed, the various functions that ´the´ notion plays are so tensed that distinctive attempts to structure or relate them to one another express quite different norms and ideals. Disagreements about primary values and goods reappear as disagreements about priorities and relations among the various functions the concept plays, disagreements about what is essential to persons. Not only does each of the functions bear a different relation to the class of human beings, but each also has a different contrast class." (p 56).

In this she goes further than Crawford, suggesting that what each one implicates is different; that one conceptualisation is not a mere opposite of another, but that they are, conceptually, topologically dislocated - they must be viewed, in Stephenson´s (1986b) terminology, as complementary. It is this image of multiple, contrary and complementary accounts that I have tried to convey with the term ´sympatricity´. Originating in ecological biology, applied to accounting sympatricity allows us to portray a situation in which diverse accounts dynamically co-exist in the same ´ecological domain´ within which they have evolved in

competition with one another.

However, such a biological analogy has a limited range of convenience, and sympatric accounting is perhaps more broadly approachable as a process of ⌐making sense⌐ of a difficult topic by reference to a variety of texts of different kinds, some on philosophy, some story books, some encyclopaedias. Like the thesis I am writing, the result is no mere re-exposition of just one, but the product of my searching first here and then there to weave the story that, informed by the texts, is still my own.

The accounts as described in the previous Section do convey a certain library-like quality. Having read them all, one is left with a sense of different ⌐texts⌐ that a person could, at different moments and in different circumstances, pull off the shelf, digest, use where they are helpful to push the story along, thrust back when they seem irrelevant or look nonsensical - ⌐texts⌐ one would cite, use, manipulate, reject. In the inherent plausibility and hanging-togetherness of each one within its own narrative, they convey the sense one often feels when reading a particular text that its argument is powerfully credible. But we never read texts in literal isolation, but always against the backcloth of all the other texts we are consulting. However compelling the being-read-now argument, we continue to have the arguments of other texts ⌐at the back of our mind⌐.

Nevertheless, when you come to write your own narrative, moment to moment you can only explicate one storyline at a time. Accounting is transitive over time (in its library-search and

reading form) but momentarily substantive in exposition (in its writing-at-a-particular-moment form).

A theory of accounting based upon a notion of account sympatricity is thus one which portrays people as storymakers who weave a narrative in and out of different ´texts´. This description is most similar to those proffered in Cornwell´s (1984) descriptions of ´private accounts´ in which people continually ask the question "What if ?" and seek to answer it, and Young´s (1987, personal communication) perception of accounting as a narrative process which weaves explanatory models into (and out of) a fabric also made up of episodic reminiscences, comments about similarity and analogy, expectations about social relations and norms of behaviour, together with statements about emotions and feelings. Some accounts are communal, as those described in the previous Section; some will be more personal (as with Young´s 1982 ´prototypes´ and ´chain complexes´, see Section 1.2.4). Storymaking selects from one ´text´ and then another, gradually weaving a narrative that ´makes sense´ of the topic or issue in question.

8.3.2 The selection, use and production of accounts

Given such an analogy of person-as-storymaker, and the primary assumption that the function of accounts is to enable people to ´make sense´ of their world and the events within it, it becomes possible to surmise the kinds influences upon the selection of accounts at particular points in ´the story´. These are of at least three kinds :

* ways in which they are useful for the individual themself;

* ways in which they serve interpersonal functions;

* ways in which they serve collective functions.

So far as the individual is concerned, accounts are likely to be selected at least in part in terms of their explicatory power. When people ask questions like "What do I do now ?", the selection of the account to which they will turn will depend upon what kind of answer they are seeking. Asking yourself "What do I do now ?" when you have been bitten by a rabid dog is unlikely to lead to the ´cultural critique´ or the ´stress´ or the ´Willpower´ account; I suspect there are only two that would serve the purpose for most of us - ´the wonders of modern medicine´ (find a doctor, fast) or the ´Theistic´ (pray, hard), and many people would draw on both. Other accounts would be better for answering "Why me ?" questions; others for "Why now ?".

The accounts each of us, as individuals, draw upon to ´make sense of´ health and illness will also be influenced by other, broader, aspects of our accounting, such as our political ideology, our religious beliefs (or lack of them), our constructions of authentic personhood and how we see ourselves, how we see our relations with other people; these in their turn mediated by our experiences, upbringing, stage in the lifecycle, access to media and so on. They will also be influenced by shorter-term factors, such as moods, emotional states and frames of mind, and shorter-term autodidactic world-making, such as

attempts to 'get better and better every day', 'pull ourselves together', 'cheer ourselves up' and so on.

The use of accounts interpersonally will relate, for example, to the way an individual seeks to construct reality for others, for either their own purposes (e.g. to persuade them to act in certain ways, like visit a doctor, or 'take it easy') or to meet the other person's needs (e.g. to comfort, or reassure them).

Many aspects of collective functions have been described already in the previous Section, such as using one account to deny, negate or villify another (e.g. the use of the 'healthy living' account to deny structural causes of ill-health). Smith, Bruner and White (1956) note that opinion expression can act to define and maintain group-membership, and Moscovici (1984) also stresses the function of social representations as a basis for group cohesion and solidarity, a purpose accounting can clearly accomplish too (e.g. the expression of the 'cultural critique' at medical anthropology conferences, and of the 'Theistic' account at prayer meetings).

All of these may influence account selection directly (where the account explicitly constructs the desired or functional reality) by implication (where accounts say more by what they can destroy or negate than by what they explicate) and by allusion (where accounts are polysemic, and their 'meaning' is as much in their subtexts as within their overt dialogue). Indeed, the selection of accounts and their expression will often be multiply mediated, with the account conveying a number of subtexts at different levels (e.g. personal and interpersonal).

Thus an account-selection framework offers a dialectical theory-base, which can incorporate reality-constructs-person and person-constructs-reality elements. Whereas the person-as-storymaker focusses on the individual, and the image of the texts-in-the-library implies a personal search, account selection and use should be seen much more as a process of negotiation, both between an individual and their realities, and between one person and another. Accounting is communal storymaking in which the roles of 'teller' and 'listener' are inter- and intrapersonally reflexive.

8.3.3 The links between accounts and action

In this thesis I have made no claims that gaining a better understanding of the accounts available for making sense of health and illness should, per se, enable researchers to predict which health related or responding-to-illness actions people will adopt. There are two main reasons for such a disclaimer.

First, as Harré (1979) has noted, accounting is not just about social actions, it is itself a social activity. This is more profound than saying that people respond to being the subjects of study by treating the activity as a social encounter, but that accounting is always, wherever and whenever it occurs, a story-making act-in-itself. As Section 8.3.1 made clear, accounts should not be construed as lever-like 'things in the head' that trip a person into action, but rather as 'texts' from which people 'make sense' of action.

The second reason why accounting may not relate directly to action is that account sympatricity reflects the ways that

thinking is often confused and contradictory. Within such a system, action is, by definition, unpredictable. People themselves, when they are ´in two minds´, are uncertain what they will do until they do it. Their thought is transitive until it becomes substantiated in action. If actors themselves are uncertain about what they will do up until the very moment of action, an external observer can clearly do no better.

To make this point more explicitly, imagine the situation where a researcher interviews somebody concerning their ´beliefs about health and illness´. Imagine further that the influences stack up within the interview so that the throughout most of the conversation the exposition of the ´healthy lifestyle´ account becomes the most functional and socially acceptable (as negotiated by interviewer and interviewee). The interviewer returns with the interviewee neatly categorised as a believer in ´healthy living´, and predicts that she will act accordingly.

This assumption is legitimate within a theory-base that regards ´health beliefs´ as fixed and singular essences. But it is quite invalid within an account sympatricity formulation, for that has to assume that in different circumstances, with different influences, other accounts (e.g. the ´individual autonomy´ account) may be more salient, and hence action would be predicated not upon a ´healthy lifestyle´ but upon, say, ´my body, my lungs, my right to do with them as I choose´. Account sympatricity would portray this person as continually faced with dilemmas and choices, so that sometimes they would act one way, sometimes another; their actions would be, in that sense, contradictory because the accounts from which they are operating

are complementary and hence contradictory.

However, an account sympatricity interpretation does not deny that there can be links between accounts and actions. Accounts can relate to actions in at least three ways :

* as sources from which to plan action;

* as sources with which to predict action (one's own, or the actions of others);

* as sources from which actions (again, one's own and the actions of others) can be 'made sense of' - explained, understood or justified.

Accounts as sources from which to plan action have already been examined in Section 8.3.1., as the basis for answering questions like "What do I do now ?". Which account will be selected will be dependent upon the events or issues or dilemmas to be responded to. Being bitten by a rabid dog is an extraordinarily threatening event demanding fast action and rapid and clear-cut account selection, and people are unlikely to prevaricate. Deciding whether or not to give up smoking, go on 'the pill', seek out alternative healing or give money to a medical research charity are more complexly instigated actions, and accounting is therefore likely to be a much-more-considered, vascilating -between-accounts process.

Furthermore, some accounts are more action-prescriptive than others. For example, the 'wonders of modern medicine' account contains within it specific action-plans and rules such as 'always follow doctor's orders' and 'keep taking the tablets'. Other accounts are more interpretational and less

action-orientated, such as the 'stress' account (which, within
its psychodynamic roots, largely denies that the sufferer is able
to act purposively) and the 'cultural critique' account (which
may stop you donating to medical research charities, but in its
specific denial of individual responsibility, contains few
action-specific prescriptions).

Treating accounts as the 'texts' from which we may be able to
predict action permits two important insights. The first is
providing a framework for understanding what psychologists have
been doing in much of their theorisation. As many
interpretational social psychologists (e.g. Gergen, 1982 ;
Moscovici, 1971; Jahoda, 1986) have recognised, such theorists
have not been (as they have assumed that they have been)
constructing and testing theories about universal psychological
processes.

What they have actually been doing is utilising their own
'implicit understandings', drawn from the accounts they share
with the subjects of their experiments, as a common 'text' from
which to predict action. The researchers were able to predict the
actions of their experimental subjects, not because they had
access to action-predictive psychological theories, but because
the experimental subjects knew (by drawing upon the same
culturally sedimented 'texts' the experimenters used to plan the
experiment) what was expected of them. It is the very combination
of the taken-for-grantedness of culturally sedimented and
sanctioned accounts, their prescriptive qualities (and hence
their power to specify action) and the cultural homogeneity of

experimenters and experimental subjects that has led so many psychologists up the primrose path, into offering their culture- and even class-specific accounts for action as universal rules to explain human behaviour.

The other insight is that action can only be predicted (if at all) by access to the account upon which it is predicated. I have a neighbour who smiles wanly each year as she asks me to donate to cancer research, clearly unable to understand how anybody could refuse on moral grounds. Her incomprehension is, I believe, the consequence of her having no access to my 'cultural critique account of medicine (however hard I try to explain it). If such a complete lack of comprehension can occur between two people who ostensively share, in any demographic analysis, a single socio-economic class, gender and age-group, how much more is it likely to occur between people whose social and cultural origins and roles differ more widely ?

The eight accounts listed in Section 8.1 and described more fully in Section 8.2 and elsewhere within the thesis should, I hope, offer food for thought for theorists attempting to understand the ways people account for health and illness as routes for predicting their actions.

Formulations like 'Health Locus of Control' have singularly failed to predict action (See Chapter 6) because the researchers using them assumed that people would only 'make sense' of health and illness by reference to the constructs incorporated into the HLC scale. People who scored high on 'external control' were classified as 'fatalists'. However, while

workers like Pill and Stott, Blaxter, and Cornwell have avoided this simplistic assumption, they have tended to offer only singular antithetical positions (e.g. 'external control' as a realistic appraisal of structural inequality).

I hope that my descriptions of the the diversity of accounts will persuade other researchers to consider that there are likely to be, for example, many different reasons for refusing to adopt a 'healthy lifestyle', and that these are not simply matters of interpersonal variation, but intrapersonal variability too. For instance, the argument that people act in particular ways as a function of self-presentation (as Cornwell, 1984, suggested) assumes that there is a singular 'self' to be presented. The strikingly different portrayals of authentic personhood embodied within the different accounts deny such singularity. To understand the role of self-presentation in accounting for health and illness requires much more sophisticated analysis of the way people construe themselves differently according to different situations (cf Weinreich, 1983).

Similarly, the observation that different religious and ethical beliefs and ideologies are salient to the accounting of many people, and the broader recognition that accounts are not just explicatory but contain moral and meaning elements as well, should, I hope, persuade researchers to move outside of their portrayals of people as mere 'rational' or even 'rationalising' beings, and seek to understand them as feeling, moral and spiritual beings, whose values and life-plans go beyond pleasure-seeking, and risk reduction. In their very

different ways the people who articulated the Theistic and 'cultural critique' accounts demanded to be understood as morally authentic persons, with more important life-agendas than the pursuit of physical health.

It is no longer good enough for researchers to just look within their own understandings in their attempts to predict the actions of others. Before we can even begin to predict what people will do, we need to gain a better understanding about why people do what they do, based upon their understandings of their actions. Action-predictive studies may well need to wait until we have made a better job of that.

In fact, treating accounts as the basis from which to interpret actions is a growing field of interest, already engendering subtle and complex theorisation (e.g. Giddens, 1977; Harré 1974, 1979; Marsh et al, 1978; Scott and Lyman, 1968). Semin and Manstead (1983) provide a thorough and clearly articulated review and analysis of this area. A number of complex typologies have already been generated in attempts to clarify the large variety of social cognitive functions that accounting can serve for the explication of action, working from Goffman's (1959) perception of interaction as an 'expressive order' within which accounting plays a crucial role, particularly when there is any fragmentation or interuption of the smooth flow of social intercourse.

Goffman himself (1971), Tedeshi and Reiss (1981) and Schlenker (1980) have explored accounts as apologies; Hewitt and Stokes (1975) examined accounts as disclaimers; Schonbach (1980) sought

to typologise varieties of : explaining refusals to act; excuses; and justifications. Semin and Manstead (op cit) have drawn these together in an over-arching typology of accounting which covers such constructs as scapegoating, sad tales, appeals to religious and moral authorities and face maintenance.

I believe the data and theorisation here in this thesis have two main suggestions to contribute. The first is that although the kind of typologisation engaged in by Semin and Manstead is analytically illuminating, its list-like, ʹcoding-frameʹ qualities (quite possibly unintentionally, but compellingly nonetheless) portray an image of accounting strangely decoupled from any cultural or social context. The kinds of accounts described in Sections 8.1 and 8.2 offer an alternative portrayal, in which action-explication is a process much more like seeking out an appropriate ʹstorylineʹ than, each time an action demands explaining, re-constructing an articulated justification or excuse anew. It also offers a sense of the way that once one becomes ʹkeyed inʹ to a particular storyline in order to excuse a rule infraction or whatever, it carries with it a lot of extra conceptual baggage so that the excuse becomes a convincing ʹstoryʹ in and of itself, woven around and weaving the event, its actions, and its contextual elements.

The second contribution is that because Semin and Manstead have focussed selectively upon social norm infraction as the kinds of actions that accounts are needed to explain, the typology, though lengthy, gives only a partial picture of accounting. It de-emphasises biological and other ʹnaturalʹ discontinuities

(e.g. those arising from temporal features, cf Stainton Rogers, 1987 and 1988, forthcoming) and, in its specific concern with discontinuities, omits consideration of accounting for continuity (e.g. in the case of chronic illness) and 'wholeness'.

Although theorists like Harré (1979) have argued that the smooth flow of ordinary social interaction, in its taken-for-granted qualities, requires no explaining, Dingwall (1976) (See Section 1.3.3) has argued that the social pressure to do usual, expected, normal things at usual times in usual places requires a great deal of fluency with commonsense knowledge, and that our understandings of illness are thus predicated upon our conceptions of 'ordinariness'. Hence, I would argue, we cannot gain understanding of people's accounting simply by reference to the way they account for discontinuity and the fracturing of 'ordinariness'. We must find out how people account for 'being ordinary' too.

I deliberately chose the topic of health and illness as a subject matter because it offers biological as well as social discontinuities that need explication, and it incorporates the reflexivities of continuity/discontinuity, wholeness/dislocation. Thus the accounts identified and described in this thesis cover a more comprehensive field. I agree with Henriques at al (1984) that :

"...whilst we should avoid founding a theory of subjectivity on a taken-for-granted biological origin, we cannot construct a position which altogether denies biology and its effects." (p 21)

If we are to gain understanding of the role that accounting plays in social being, we need to develop a comprehensive theory of

accounting that includes the ways people account for their biological as well as their social realities, and 'ordinariness' as well as 'disorder'. This thesis is offered as a contribution to that endeavour.

REFERENCES

Aakster,C.W. (1986) 'Concepts in Alternative Medicine' Social Science and Medicine, 22(2) 265-273

Abelson, R.P. (1976) 'A script theory of understanding, attitude and behaviour', in Carroll, J.S. and Payne, J.W. (Eds) Cognition and Social Behaviour, Hillsdale, NJ, Erlbaum.

Abramson, L.Y., Seligman, M.E.P. and Teasdale, J.D. (1978), 'Learned helplessness in humans : Critique and reformulation', Journal of Abnormal Psychology, 87, 49-74.

Ackerknecht, E.H. (1942) 'Problems of primitive medicine' Bulletin of the History of Medicine, 11, 503-521

Ackerknecht, E.H. (1971) Medicine and Ethnology : Selected Essays, Baltimore, John Hopkins.

Adam, B. (1987), 'We need time', paper presented to the Royal Institute of Anthropology conference 'Time, Health and Illness', Windsor, February; also forthcoming (1988) in Frankenberg, R (Ed) Anthropological perspectives on time in health and sickness.

Adorno, T.W., Frenkel-Brunswick, E., Levinson, D.J. and Sanford, (1950), The authoritarian personality, New York, Harper.

Ajzen, I. and Fishbein, M. (1969) 'The prediction of behavioural intentions in a choice situation', Journal of Experimental Social Psychology

Ajzen, I. and Fishbein, M. (1972) 'Attitudes and normative beliefs as factors influencing behavioural intentions' Journal of Personality and Social Psychology, 21(1), 1-9.

Albino, J.E. (1981) 'Development of methodologies for behavioural measurements related to malocclusion', National Institute of dental Research Contract Report, University of New York State.

Alexander, F. (1936) Uber das Verhaltnis von Struktur zu Triebkonflikten, Internationale Zeitschrift fur Psychoanalyse 20, 33-53.

Alland, A. (1966) 'Medical Anthropology and the Study of Biological and Cultural Adaptations' American Anthropologist, 68, 40-51.

Alland, A. (1970) Adaptation in Cultural Evolution : An Approach to Medical Anthropology, New York, Columbia University Press.

Amanico, L. and Soczka, L (1986) 'Why are women discriminated against at work ? A study on implicit theories', Paper presented to the European Association of Experimental Social Psychology Advanced Workshop on Social and Environmental Psychology, Lisbon, (September).

Antaki, C. (1981) The Psychology of Ordinary Explanations of Social Behaviour, London, Academic Press.

Antaki, C. and Fielding, G. (1981) 'Research on Ordinary Explanations', in Antaki, C. (Ed) The Psychology of Ordinary Explanations of Social Behaviour, London, Academic Press.

Apple, D. (1960) Sociological Studies of Health and Illness, New York, McGraw Hill.

Ardell, D.B. (1977) High Level Wellness : An Alternative to Doctors, Drugs and Disease, New York, Bantam.

Areni, A., Mannetti,L. and Sabino, G. (1986) 'Influence des schemas culturels traditionnels sur le choix de la contraception' Contraception, Fertilite et Sexualite 14(4), 347-358.

Aronson, E. (1969) 'The Theory of Cognitive Dissonance : a Current Perspective', Advances in Experimental Social Psychology 4, 1-34.

Asher, W. (1986), 'Subjectivity and Policy Studies', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October)

Barchak, L.J. (1985), 'Reproductive Journalism : A Q Methodological Foundation for the Scientific Theory and Practice of News gathering and Reporting', Paper presented at the First Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (July).

Barlow, J. (1843), Man's Power Over Himself to Prevent or Control Insanity, London, William Pickering.

Barnes, B. and Law, J. (1976) 'Whatever should be done with Indexical expressions ?', Theory and Society, 3, 223-37.

Barrett, M. and Roberts, H. (1978) 'Doctors and their patients : the social control of women in General Practice' in Smart, C. and Smart, B. (Eds) Women, Sexuality and Social Control, London, Routledge and Keegan Paul.

Barthes, R. (1985) The Fashion System, London, Vape.

Bartlett, F.C. (1932) Remembering, Cambridge, Cambridge University Press.

Baughman, M.K. (1978), 'The relationship of locus of control and value beliefs to health status and behaviour among clerical workers', Unpublished doctoral diddertation, University of Cincinnati.

Baumann, B. (1961) 'Diversities in conceptions of health and physical fitness', Journal of Health and Human Behaviour, 2, 39-46

Bauman, B. (1978), in Miles (Ed) 'The Wholistic Handbook', New York, Simon and Shuster.

Beck, S.J., Molish, H.B. and Sinclair , J.,(1956) Concerning researchers thinking in schizophrenia research', American Journal of Orthopsychiatry, 26, 792-800.

Becker, H.S. (1963) Outsiders, New York, Free Press.

Becker, M.H., Nathanson, C.A., Drachman, R.H. and Kirscht, J.P. (1977), 'Mothers' Health Beliefs and Children's Clinic Vistits', Journal of Community Health, 3, 125-135.

Bennet, T., Martin, G. , Mercer, C. and Woollacott, J. (1981), 'Antonio Gramski' in Bennet, T., Martin, G. , Mercer, C. and Woollacott, J. (Eds), Culture, Ideology and Social Processes, London, Batsford Academic Press.

Berlin, I. (1969) 'A note on Vico's concept of knowledge', in Tagliacozzo, G. and White, H.V. (Eds) Giambattista Vico: an International Symposium, Baltimore, John Hopkins.

Berlin, I.(1976). Vico and Herder, London, Hogarth.

Berger, P. and Berger, B. (1972), Sociology : A Biographical Approach, New York, Basic Books.

Berger, P. (1979) The Heretical Imperative, New York, Doubleday.

Berger, P. (1977), Facing up to Modernity, New York, Basic Books.

Berger, P. and Luckmann, T. (1966) The Social Construction of Reality, Harmondsworth, Penguin.

Berger, P. and Pullberg, S. (1965) 'Reification and the Sociological Critique of Consciousness' History and Theory, 4, 198.

Binik, Y. M. and Devins, G. (1979), 'Personal Control in end-stage renal disease', paper presented at the American Psychological Association, New York City.

Birchall, E. and Birchall, J (1987) 'Time, habit and the AIDS pandemic', paper presented at the Association for the Social Studies of Time conference on 'Time in Health and Sickness', Dartington, (July).

Blaxter,M. and Paterson,L.(1982) Mothers and Daughters : a Three-generational Study of Health Attitudes and Behaviour. London, Heinemann.

Blaxter,M. (1983) 'The Causes of Disease: Women Talking', Social Science and Medicine, 17(2) 59-69.

Blaxter, M. (1987) 'Beliefs about the Causes of Ill-health' (In Press).

Bloom, J.R. (1979), 'Psychosocial measurement and specific hyptheses : A research note', Journal of Consulting and Clinical Psychology, 47, 637-639.

Blum, A.F. and McHugh, P. (1971) 'The Social Ascription of Motives', American Sociological Review, 36, 98-109.

Blumhagen, D. W. (1980) 'Hypertension : a folk illness with a medical name', Culture, Medicine and Psychiatry, 5, 337-40.

Blumhagen, D.W. (1981) 'On the Nature of Explanatory Models', Culture, Medicine and Psychiatry, 5, 337-340.

Bohm, D. (1971), ' Quantum Theory and an indication of a new ordar in physics : the development of new orders as shown through the history of physics', Foundations of Physics 1, 359-381.

Bohm, D. (1973), ' Quantum Theory and an indication of a new ordar in physics : Implicate and explicate order in physical law', Foundations of Physics, 3, 139-168.

Boyer, P. (1987), 'The stuff "Traditions" are nade of : On the implicit ontology of an ethnographic category', Philosophy of Social Science49-65.

Brenner, D. J. (1985) 'Beyond Diffusion : Q and the Convergence Model', Paper presented at the First Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (July).

Brown, R. (1985) Social Psychology : The Second Edition New York, Free Press.

Brown, S. (1972) 'A fundamental incommensurability between objectivity and subjectivity' in Brown, S. and Brenner, D.J. (Eds) Science, psychology and communication, New York, Teachers College Press.

Brown, S. (1980) Political Subjectivity : Applications of Q Methodology in Political Science, New Haven, Yale University Press.

Brown, S. (1984) 'The Subjective communicability of meta-ethics : A note on Fishkin's methodology', Political Methodology, 10, 465-478.

Brown, S. (1985) 'Comments on the Search for Structure', Political Methodology, 11, 109-117.

Brown, S. (1986) Review of 'Data, instruments and theory', by R.J.Ackermann,Operant Subjectivity, 9, 107-108.

Budd, R.J. and Spencer, C.P. (1985) 'Exploring the role of personal beliefs in the theory of reasoned action : the problem of discriminating between alternative path models', European Journal of Social Psychology, 15, 299-313.

Budd, R.J. Blieiker, S. and Spencer, C (1983) 'Exploring the use and non-use of marijuana as reasoned actions : An application of Fishbein and Ajzen methodology', Drug and Alcohol Dependence, 11, 217-224.

Burt, C. (1972) 'The Reciprocity Principle' in S.R. Brown and D.J. Brenner (Eds) Science, Psychology and Communication : Essays honouring William Stephenson, New York, Teachers Press.

Bury, M. R. (1986) 'Social Constructionism and the Development of Medical Sociology', Sociology of Health and Illness, 8(2), 137-169.

Buss, A.R. (1979) A Dialectical Psychology, New York, Invington.

Butler, R. and Haigh, T. (1954), 'Changes in the relation between Self-concepts and Ideal concepts consequent upon client-centred counselling', in Rogers, C.R. and Dymond, R.F. (Eds), Psycho-Therapy and Personality Change, Chicago, University of Chicago Press.

Caldwell, P.S. (1985), 'College physical educators' perceptions of program objectives consistent with three curriculum models', Unpublished Doctoral Dissertation, University of Houston.

Calnan, M. and Johnson, B. (1985) 'Health, health risks and inequalities : an exploratory study of women's perceptions', Sociology of Health and Illness, 7(1) 55-75.

Carlson, E. (1984) 'Is our care system killing us ?', Modern Maturity April-May.

Carnahan, T.M. (1979) 'The development and validation of the multidimensional dental locus of control scales', Unpublished doctoral dissertation, State University of New York.

Chase, P.H. (1957), 'Self Concepts in Adjusted and Maladjusted Hospital Patients', Journal of Consulting Psychology, 21(6), 495-497.

Chassin,L., Presson, C. C., Brensberg, M., Corty, E. and Sherman, S.J. (1981), 'Predicting adolescents' intentions to smoke cigarettes', Journal of Health and Social Behaviour, 22, 445-455.

Chen, M.S. and Land, K. 'Testing the Health Belief Model : LISREL Analysis of Alternative Models of Causal relationship between Health Beliefs and Preventive Dental Behaviour', Social Psychology Quarterly 49(1) 45-60.

Chomsky, N. (1966) Cartesian Linguistics : A Chapter in the History of Rationalist Thought, New York, Harper and Row.

Cicourel, A.V. (1973) Cognitive Sociology, Harmondsworth, Penguin.

Clark, M. (1970) Health in the Mexican-American Culture, Berkley, University of California Press.

Claxton, G. (1987) 'Beliefs and behaviour : why is it so hard to change ?' Nursing 3(18) 670-673.

Clements, F. (1932) 'Primitive Concepts of Disease', American Archives of Ethology, 32, 185-252.

Cohen, S. (1971) Images of Deviance, Harmondsworth, Penguin.

Collins, B.E. (1974) 'Four Components of the Rotter Internal-External Scale : Belief in a difficult world, a just world, a predictable world, and a politically responsive world', Journal of Personality and Social Psychology, 29(3) 381-391.

Cornwell, J. (1984) Hard-earned lives : accounts of health and illness from East London, London, Tavistock.

Cornwell, J. (1986a) 'British Research into lay beliefs : a review', paper prepared for ESRC Franco-British Programme.

Cornwell, J. (1986b) 'Health Beliefs in Old Age : The Theoratical Grounds for Conceptualising Older People as a Group', in Working Together for Health : Older People and their carers, F. Glendenning (Ed), Stoke-on- Trent, Beth Johnson Foundation.

Cosminski, S. (1977) 'The impact of Methods of Analysis of illness concepts in a Guatemalian community', Social Science and Medicine, 11, 325-332.

Csordas, T.J. (1986) 'Religion and Health', paper presented to the British Medical Anthropology Society/Society for Medical Anthropology Meeting, Cambridge, (July).

Crawford, R. (1980) 'Healthism and the Medicalisation of Everyday Life', International Journal of Health Services, 10(3) 365-388.

Crawford, R. (1984) 'A cultural account of "health" : control, release and the social body', in Issues in the Political Economy of Health Care, J.B. McKinlay (Ed), London, Tavistock.

Creaser, J.W. (1955), 'An aid in calculating Q-sort factor arrays', Journal of Clinical Psychology, 11, 195-96.

Cronbach, L.J. and Gleser, G.C. (1954) Psychometrika, 19 327-330.

Currie, E. (1987a), as quoted in national press, March-April.

Currie, E. (1987b), as quoted in The Oxford Journal, July 16th.

Currier, R.L. (1966) 'The hot-cold syndrome and symbolic balance in Mexican and Spanish-American folk Medicine', Ethnology, 5, 251-263..

D'Agostino, 'Q Factors and developmental Models : The Case of Changing Attitudes towards Nuclear Weapons', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October).

de Haas, P.A. and van Reken, M.K. (1979), 'Menstrual cycle symptoms as a function of health locus of control', Paper presented at the Association for Women in Psychology Conference, Dallas.

Devereux, G. (1972) Ethnopsychanalyse complementariste, Paris, Flammarion.

DHSS (1980) Inequalities in Health Report of a research working Group (The Black Report). London HMSO.

Diller, L.G., Gordon, W.A., Friedenbergs, I., Ruckdeschel -Hibbard, M.. Levine, L.R. Wolf, C., Ezrachi, O., Lipkins, R., Lucido, D. and Francis, A. (1979), 'Demonstration of benefits of early identification of psychosocial problems and early intervention towards rehabilitation of cancer patients', National Cancer Institute Report, New York University Medical Center.

Dingwall, R (1976) Aspects of Illness. London, Martin Roberston.

DiVito, A.J. Reznikoff, M. and Bogdanowicz, J. (1979), 'Actual and intended health-related information seeking and health locus of control', Paper presented at the American Psychological Association, New York City.

Doise, W. (1978) 'Images, representations, idiologies et experimentation psychosociologique, Social Science Information, 17, 41-69.

Doise, W. (1986) Levels of explanation in social psychology, Cambridge, Cambridge University Press.

Donzelot, J. (1977) The Policing of Families: Welfare versus the State, London, Hutchinson.

Doran, G.A. (1983) 'Scientism vs Humanism in Medical Education', Social Science and Medicine, 17(23), 1831-1835.

Douglas, M. (1978) Implicit Meanings : Essays in Anthropology, London, Routledge and Keegan Paul.

Douglas, M. (1982), In the Active Voice, London, Routledge and Keegan Paul.

Doyal, L. (1981) The Political Economy of Health, London, Pluto.

Dulany, D.E. (1961) 'Hypotheses and habits in verbal "operant conditioning"', Journal of Abnormal and Social Psychology, 63, 251-263.

Dulany, D.E. (1964) 'The separable effects of the information conveyed by the reinforcer', Paper presented at the meeting of the Psychonomic Society, St Louis.

Dulany, D.E. (1968) 'Awareness, roles and propositional control : a confrontation with SR behaviour theory', In Horton,D. and Dixon, T. (Eds) Verbal Behaviour and S-R Behaviour Theory, New York, Prentice-Hall.

Dunn, F.L. (1968) 'Epidemiological Factors: Health and Disease among Hunter-Gatherers', in Lee, R.B. and DeVore, I. (Eds) Man the Hunter, Chicago, Aldine.

Dunn, F.L. (1977) 'Traditional Asian Medicine and Cosmopolitan Medicine as Adaptive Systems', in Leslie, C. (Ed) Asian Medical Systems : A Comparative Study, Berkley, University of California Press.

Durkheim, E. (1898) 'Representations individuelles et representations collectives' Revue de Metaphysique et de Morale, VI, 273-302).

Ebbinghaus, H. (1885) Uber das Gedachtnis, Leipzig, Dunker.

Ehrenreich, B. and English, D. (1973) Witches, Midwives and Nurses, New York, The Feminist Press.

Ehrenreich, B. and Ehrenreich, J. (1978) 'Medicine and Social Control', in Ehrenreich, J. (Ed) The Cultural Crisis of Modern Medicine, New York, Monthly Review Press.

Ehrenreich, B. and English, D. (1978) 'The "sick" women of the Upper Classes', in Ehrenreich, J. (Ed) The Cultural Crisis of Modern Medicine, New York, Monthly Review Press.

Ehrenreich, J. (1978) The Cultural Crisis of Modern Medicine, New York, Monthly Review Press.

Engel, M. (1959) 'The Stability of the Self-Concept in Adolescence', Journal of Abnormal and Social Psychology, 58, 211-215.

Erikson, E. H. (1953) 'On the sense of inner identity', in Health and Human Relations, Report of a conference held at Hiddesen, New York, Blakiston.

Erikson, E.H. (1959) 'Identity and the Lifecycle', Psychological Issues, 1(1), New York, International Universities Press.

Fabrega, H. (1974) Disease and Social Behaviour : an Interdisciplinary Approach, Cambridge, MIT Press.

Farr, R.M. and Anderson, T. (1983), 'Beyond actor-observer differences in perspective : extensions and applications', in Hewstone. M. (Ed) Attribution Theory : Social and Functional Extensions, Oxford, Blackwell.

Farr, R.M. and Moscovici, S. (1984) Social Representations, Cambridge, Capmbridge University Press.

Festinger, L. (1957) A Theory of Cognitive Dissonance, Evanston, Row and Peterson.

Finkelstein, V. (1980), 'Attitudes and Disabled People', World Rehabilitation Fund Monograph, No 5.

Fishbein, M. (1980) 'A theory of reasoned action : some applications and implications' in Howe, H.E. (Ed) Nebraska Symposium on Motivation, 1979, Lincoln, University of Nebraska Press.

Fishbein, M. Jaccard, J.J. Davidson, A.R. Ajzen, I. and Loken, B. (1980), 'Predicting and understanding family planning behaviours : Beliefs, attitudes and intentions, in Ajzen, I and Fishbein, M (Eds) Understanding Attitudes and Predicting Social Behaviour, Englewood Cliffs, Prentice Hall.

Foster, G. (1976) 'Disease etiologies in non-Western medical systems', American Anthropology, 78, 773.

Foucault, M. (1963) Naissance de la Clinique, , Paris, Presses Universitaires de France. English Translation (1973) The Birth of the Clinic, London, Tavistock.

Foucault, M. (1970) The Order of Things, Tavistock, London.

Frankl, V.E. (1955) The Doctor and the Soul, republished, 1973, London, Souvenir Press.

Frankl, V.E. (1969) The Will to Meaning, London, Souvenir Press.

Frankl, V.E. (1973) Psychotherapy and Existentialism : selected papers in logotherapy, Harmondsworth, Penguin.

Fransella, F. (1984) 'The relationship between Kelly's constructs and Durkheim's representations', in Farr, R.M. and Moscovici, S. (Eds) Social Representations, Cambridge, Capmbridge University Press, pp 149-167.

Freud, A. (1936) The ego and the mechanisms of defense, London, Hogarth.

Freud, S. (1926) Hemmung, Symptom und Angst, Leipzig, Internationale Psycholoanalytischer Verlag.

Friedson, E. (1970) Profession of Medicine : a Study of the Sociology of Applied Knowledge, new York, Dodd Mead.

Furnham, A. and Henderson, M. (1983) 'Lay theories of delinquency', European Journal of Social Psychology, 13, 107-120.

Gaito, J. (1962), 'Forced and Free Sorts', Psychological Reports, 10, 251-254.

Gardner,C. and Young, R. (1981), ''Transforming Television', Screen, 25(1).

Garfinkel, H. (1967) Studies in Ethnomethodology, Englewood Cliffs, Prentice Hall.

Garfinkel, H. (1974) 'On the origins of the Term "Ethnomethodology" ', in Turner, R. (Ed) Ethnomethodology, Harmondsworth, Penguin.

Gauld, A. and Shotter, J. (1977), Human Action and its Psychological Investigation, London, Routledge and Keegan Paul.

Geertz, C. 'Religion as a Cultural System', In Banton, M. (Ed) Anthropological Approaches to the Study of Religion, London, Tavistock.

Gergen, K.J. (1973), 'Social Psychology as History', Journal of Personality and Social Psychology, 26, 309-320.

Gergen, K.J. (1982) Towards transformation in Social Knowledge, New York, Springer-Verlag.

Ghaffaradli-Doty, P. and Carlson, E.R. (1979), 'Consistency in attitude and behaviour of women with a liberated attitude towards the rights and roles of women', Sex Roles, 5(4), 395-404.

Giddens, A. (1977) Studies in Social and Political Theory, London, Hutchinson.

Giddens, A. (1979), Central Problems in Social theory, London, Macmillan.

Glass, D.C. (1977) Behaviour Patterns, Stress and Coronary Disease, Hillsdale, Erlbaum.

Gleeson, K. (1986), 'The social construction of 'insanity'', Reading University Mimeograph.

Goffman, E. (1959) The presentation of self in everyday life, New York, Doubleday.

Goffman, E. (1963) Stigma : Notes on the management of spoiled identity, Englewood Cliffs, Prentice-Hall.

Goffman, E. (1968) Asylums, Harmondsworth, Penguin.

Goldman, I. (1984) 'Communication and Culture : A Q methodological study of psycho-social meanings from photographs in Time magazine', Unplublished doctoral dissertation, University of Iowa.

Goldman, I. (1985) 'A Subjective Scientific Investigation into Cultural Narcism', Paper presented at the First Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (July).

Goldman, I. (1986), 'A Subjective Scientific Investigation into Canadian Identity', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October).

Good, B.J. (1977) 'The heart of what's the matter : the semantics of illness in Iran', Culture, Medicine and Psychiatry, 1, 25-58.

Good, B.J. and Good, M.J. (1981) 'The meaning of sysmptoms : a cultural hermeneutic model for clinical practice', in Eisenberg, L. and Kleinman, A. (Eds) The Relevance of Social Science for Medicine, Dortrecht, Reidel.

Gore, P.M. and Rotter, J.B. (1963) A personality correlate of social action', Journal of Personality, 31, 58-64.

Graham, H. (1984), Women, Health and the Family, London, Harvester Press.

Graham, H. (1986) The Human Face of Psychology, Milton Keynes, Open university Press.

Gramski, A. (1971) Selections from the Prison Notebooks, Hoare Q and Nowell-Smith, G., (Transl.) London, Lawrence and Wishart.

Grube, J.W., Morgan, M. and McGree, S.T. (1966) 'Attitudes and normative beliefs as predictors of smoking intentions and behaviours : A test of three models', British Journal of Social Psychology, 25, 81-93.

Guess, V.A. (1984) 'Comparative medical systems : an Anthropological Perspective', in Ruffini, J.L. (Ed) Advances in Medical Social Sciences, New York, Gordon and Breach.

Habermas, J. (1970) Towards a Rational Society : Student Protest, Science, and Politics, Boston, Beacon.

Habermas, J. (1983) The Theory of Communicative Action, Boston, Beacon.

Hack Tuke, D. (1872) The Influence of the Mind on the Body, London, John Churchill.

Haley, B. (1978), The Healthy Body in Victorian Culture, Cambrifge, Harvard University Press.

Hall, S. (1980), 'Encoding/Decoding', in Hall, S. et al (Eds) Culture, Media and Language, London, Hutchinson.

Hall, S. (1986), 'Where is Social Science Going ?', paper presented to Faculty of Social Science Seminar Series, The Open University.

Hallpike, C.R. (1979) The Foundations of Primitive Thought, Oxford, Clarendon.

Harré, R. and Secord, P.F. (1972) The Explanation of Social Behaviour, Oxford, Blackwell.

Harré, R. (1974), 'Blueprint for a new science', in Armistead, N. (Ed), Reconstructing Social Psychology, Harmondsworth, penguin.

Harré, R. (1979) Social Being : A Theory for Social Psychology, Oxford, Blackwell.

Harwood, A. (1971) 'The hot-cold theory of disease : Implications for treatment of Puerto Rican patients', Journal of the American Medical Association, 216, 1153-1158.

Health Education Council, (1987) The Health Divide, London.

Heelas, P. (1981), ' Introduction : Indigenous Psychologies', In Heelas, P. and Lock, A. (Eds) Indigenous Psychologies : The Anthropology of the Self, London, Academic Press.

Heider, F. (1944) 'Social Perception and Phenomenal Causality', Psychological Review, 51, 358-74.

Heider, F. (1958) The Psychology of Interpersonal Relations, New York, Wiley.

Heinzmann, F. and Bagley, R.W. (1970) 'Response to physical activity programs and their effects'.

Helman, C.G. (1978) '"Feed a cold and starve a fever" - Folk models of infection in an English suburban community, and their relation to medical treatment', Culture, Medicine and Psychiatry, 2, 107-137.

Henriques, J., Holloway, W., Urwin, C., Venn, C. and Walkerdine, V. (1984) Changing the Subject : Psychology, regulation and subjectivity, London, Methuen.

Herzlich, C.(1973) Health and Illness, London, Academic Press.

Herzlich, C and Pierret, J. (1985) 'The Social Construction of the Patient : Patients and Illnesses in other Ages', Social Science and Medicine, 20(2) 145-151

Hewitt, J.P. and Stokes, R. (1975), 'Disclaimers', American Sociological Review, 38, 367-374.

Holland, R. (1977) Self and Social Context, London, Macmillan.

Illich, I. (1976) Limits to Medicine - Medical Nemesis : The Exploitation of Health, Harmondsworth, penguin.

Jahoda, G. (1986) 'Nature, culture and social psychology', European Journal of Social Psychology, 16, 17-30.

James, W. (1878) 'Remarks on Spencer's Definition of Mind and Correspondence', Journal of Speculative Philosophy.

James, W. (1891) The Principles of Psychology, London, MacMillan.

James, W. (1909) The Meaning of Truth, London, MacMillan.

Janet, P. (1932) 'Les sentiments dans le delire de persecution', Journal Psychol. norm. path.,29, 161-240.

Janoff-Bulman, R. and Brickmann, P. (1980), 'Expectations and what people learn from failure', in Feather, N.T. (Ed), Expectancy, Incentive and Action, Hillsdale, Earlbaum.

Jones, A. (1956), 'Distribution of Traits in current Q-sort Methodology', Journal of Abnormal and Social Pychology, 52, 90-95.

Jones, E.E. and Nisbett, R.E. (1971), The actor and the observer : Divergent perceptions of the causes of behaviour, Morristown, General Learning Press.

Jones, W.T. (1977) 'World-views and the Asian Medical System : Some Suggestions for Further Study', in Leslie, C. (Ed) Asian Medical Systems : A Comparative Study, Berkley, University of California Press.

Kaplan, G.D. and Cowles, A. (1978) 'Health Locus of Control and health value in the prediction of smoking reduction', Health Education Monographs,6, 129-137.

Kasl, S.V. (1974) 'The Health Belief Model and chronic illness behaviour', Health Education Monographs, 2, 433-444.

Kelley, H.H. (1967) 'Attribution theory in social psychology', in Levine, D. (Ed) Nebraska Symposium on Motivation, Lincoln, University of Nebraska Press.

Kelly, G.A. (1955) The Psychology of Personal Constructs Vols 1 & 2, New York, Norton.

Kelly, G. A. (1966) 'A Brief Introduction to Personal Construct Theory' in, Bannister D. (Ed) (1970) Perspectives in Personal Construct Theory, London, Academic Press.

Kerlinger, F.N. (1964), Foundations of behavioural research : Educational and Psychological enquiry, New York, Holt, Rinehart and Winston.

Kerlinger, F.N. (1972) 'Q methodology in behavioural research', in Brown, S.R. and Brenner, D.J. Science, Psychology and Communication, New Yourk, Teachers College Press.

Keulartz, J., Kwa, C. and Radder, H. (1985) 'Scientific and Social Problems and Perspectives of Alternative Medicine : Analysis os a Dutch Controversy', Radical Philosophy, 41, 2-9.

Kingham, M. (1987) 'AIDS, a Comedy of Terrors ?', paper presented to the Association for the Social Studies of Time Conference 'Time Medicine, Health and Healing', Dartington, July.

Kitzinger, C. (1984), 'The Constructing of Lesbian Identities', unpublished doctoral dissertation, University of Reading.

Kitzinger, C. (1986), 'A Q-methodological investigation of accounts of moral development' (In press).

Kitzinger, C. (1987), The Social Construction of Lesbianism, London, Sage.

Kitzinger, C. and Stainton Rogers, R. (1985), 'A Q methodological study of lesbian identities', European Journal of Social psychology, 15, 167-87.

Kitzinger, J. (1985) 'Alternative constructs of feminism in the womens peace movement', Paper presented to the BPS Symposium on Q Methodology, Cardiff (April)

Klandermans, P.G. (1983), 'Rotter's EI Scale and Socio-Political Action Taking : The Balance of 20 Years Research', European Journal of Social Psychology, 13, 399-415.

Kleinman, A. (1978) 'What kind of model for an anthropology of medical systems ?' American Anthropologist, 80, 661.

Kleinman, A. (1980) Patients and Healing in the Context of Culture : an exploration of the borderline between anthropology, medicine and psychiatry, Berkley, University of California Press.

Kleinman, A. (1984) 'Clinically Applied Medical Anthropology : The View from the Clinic', in Ruffini, J.L. (Ed) Advances in Medical Science, New York, Gordon Breach.

Kohlberg, L. (1963) 'Psychological analysis and literary form : A study of the doubles in Dostoevsky', Daedalus, 92, 345-62.

Koos, E.L. (1954) The Health of Regionville, New York, Columbia University Press.

Koshansky, J. (1985), 'The use of Q methodology to study how American students define politics', Unplublished doctoral dissertation, University of Tennessee.

Kruglanski, A.W. (1975) 'The Endogenous - Exogenous Partition in Attribution Theory', Psychological Review, 82(6), 387-406.

Kristiansen, C.M. (1985) 'Value Correlates of Preventive Health Behaviour', Journal of Personality and Social Psychology, 49(3), 748-758.

Kuhn, T.S. (1962) The Structure of Scientific Revolutions, Chicago, University of Chicago Press.

Laing, R.D. (1959) The Divided Self, London, Tavistock.

Laing, R.D. (1983) The Voice of Experience: experience, science and psychiatry, London, Allen Lane.

Lalljee, M. and Abelson, R.P. (1983), 'The organization of explanations', in Hewstone, M. (Ed) Attribution Theory : Social and Functional Extensions, Oxford, Blackwell.

Langer, E.J. (1978), 'Rethinking the role of the social interaction', in Harvey, J.H. et al. (Eds) New Directions in Attribution Research(Vol 2), Hillsdale, Erlbaum.

Lasch, C. (1975) 'What the Doctor Ordered', New York Review of Books, 11, December.

Lefcourt, H.M. (1981) Research with the Locus of Control Construct Vol 1 : Assessment Methods , New York, Academic Press.

Lefcourt, H.M. (1982) Research with the Locus of Control Construct Vol 2 : Current Trends, Theory and Research, New York, Academic Press.

Lefcourt, H.M. (1983) Research with the Locus of Control Construct Vol 3 : Developments and Social Problems, New York, Academic Press.

Lefcourt, H.M. (1984) Research with the Locus of Control Construct Vol 4 : Extensions and Limits , New York, Academic Press.

Lemon, N. (1973), Attitudes and their Measurement, London, Wiley.

Lepine, L.T. and Chodorkoff, B. (1955) 'A Q Sort Study', Journal of Clinical Psychology, 11, 395-397.

Leslie, C. (1976) Asian Medical Systems : A Comparative Study, Berkley, University of California Press.

Lesser, J. and Hughes, M.A. (1986) 'The generalizability of photographic market segments across geographic locations', Journal of Marketing, 50, 18-27.

Levin, A. and Shultz, M.A. (1980), 'Multidimensional Locus of Control and compliance in low and high participation hemodialysis programs', Unpublished manuscript, University of Wisconsin.

Levin, J.S. and Coreil, J. (1986) 'New Age Healing in the US', Social Science and Medicine, 23(9), 889-897.

Levinson, H. and Miller, J. (1976) 'Multidimensional Locus of Control in Sociopolitical Activists of Conservative and Liberal Ideologies', Journal of Personality and Social Psychology, 33(2), 199-208.

Levy, D. (1985) 'The use of Q methodology for Developing Marketing Strategies', Paper presented at the First Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (July).

Levy, D (1986) 'Implementation of Segmented Marketing Strategies Using Q-Methodology', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October)

Lewis, F.M., Morisky, D.E. and Flynn, B.S. (1978) 'A test for construct validity of health locus of control : Effects of self-reported compliance for hypertensive patients, Health Education Monographs, 6, 138-146.

Linn, L.S. and Lewis, C.E. (1979) 'Attitudes towards self-care among Practicing Physicians', Medical Care, 17(2) 183-190.

Litton, I and Potter, J. (1985) 'Social representations in the ordinary explanations of a "riot" ', European Journal of Social Psychology, 15, 371-388.

Livson, N.H. and Nichols, T.F. (1956), 'Discrimination and reliability in Q-sort Personality Descriptors, Journal of Abnormal Psychology, 52, 159-165.

Lowenstein, V.H. (1979) 'The relationship between pregnant women's belief of health locus of control and reported health maintenance behaviour', Unpublished Masters Thesis, Pennsylvania State University.

Maiman, L.A., Becker, M.H., Kirscht, J.P., Haefner, D.P. and Drachman, R.H. (1977), 'Scales for measuring the Health Belief Model Dimensions : A test of predictive value, internal consistency and relationshipes among beliefs', Health Education Monographs, 5, 215-230.

Marcuse, H. (1966) Eros and Civilisation : A Philosophical Enquiry into Freud, Boston, Beacon.

Marsh, P., Rosser, E. and Harre, R. The Rules of Disorder, Lonfon, Routledge and Keegan Paul.

Maslow, A.H. (1968) Towards a Psychology of Being, New York, Van Nostrand.

Maudlin, C. (1985) 'Q Method, Operancy and the Scientific Study of Subjectivity', Paper presented at the First Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (July).

Maudlin, C. (1986) 'Attitude Segmentation and Community Action : communication Strategy for Sex Education for the Retarded', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October).

McClelland, D.C. (1971), Motivational Trends in Society, New York, General Learning Press.

McCracken, R.D. (1971) 'Lactase Deficiency : an example of dietary evolution', Current Anthropology, 12, 479-517.

McCusker, J. and Morrow, G. (1979), 'The relationship of health locus of control to preventive health behaviours and health beliefs', Patient Counselling and Health Education, 1, 146-50.

McDonnell, D. (1986), 'Attitudes towards the Accord : An Australian Study', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October).

McGuire, W.J. (1986) 'The vicissitudes of attitudes and similar representational constructs in twentieth century psychology', European Journal of Social Psychology, 16, 89-130.

Mead, G.H. (1934) Mind, self and Society, Chicago, University of Chicago Press.

Miles, R. (1978), The Wholistic Handbook , New York, Simon and Shuster.

Mischel, W. (1966), 'Theory and research on the antecedents of self-imposed delay of reward', in Maher, B.A. (Ed) Progress in experimental personality research, 3, New York, Academic Press.

Mischel, W. (1977) 'Self-control and the self', in Mischel, T. (Ed), The Self, Oxford, Blackwell.

Mitchell, J. (1984) What is to be done about illness and health ?, Harmondsworth, Penguin.

Morgan, D.L. and Spanish, M.T. 'Social interaction and the cognitive organisation of health-relevant knowledge', Sociology of Health and Illness, 7(3), 401-422.

Moscovici, S (1961) La psychanalyse : son image et son public, Paris, Presses Universitaires de France

Moscovici, S. (1984) 'The phenomenon of social representations' in Farr, R.M. and Moscovici, S. (Eds) Social Representations, Cambridge, Capmbridge University Press, pp 3-70.

Moscovici, S. and Hewstone, M. 'Social representations and social explanations : from the "naive" to the "amateur" scientist', in Hewstone, M. (Ed) Attribution Theory : Social and Functional Extensions, Oxford, Blackwell.

Murrell, R.K. (1987), 'Telling it Like it Isn't : Representations of Science in "Tomorrow's World"', Theory, Culture and Society, 4, 89-106.

Nagelberg, D.B. (1979) 'Evaluating the BGSU health risk reduction program : A comparison of differing methods of providing health information to college students', Unpublished Doctoral Dissertation, Bowling Green State University.

Nash, C.L. (1987) 'An Enquiry into the Concept of Locus of Control and its Relationship to Health', Unpublished PhD Dissertation, University of London.

Nassi, A.J. and Abramowitz, F.I. (1980), 'Discriminant validity of Mirels' personal and political factors on Rotter's E-I scale : Does a decade make a difference ?', Journal of Personality Assessment, 44, 4.

Navarro, V. (1977) Medicine under Capitalism, London, Croom Helm.

Nicholson, J. (1980), 'Childbirth events and changes in maternal health locus of control', paper presented at the American Psychological Association Meeting, Montreal.

Nisbett, R.E. and Ross, L. (1980), Human inference : strategies and shortcomings of social judgement, Englewood Cliffs, Prentice-Hall.

Noble, D. (1853), Element of Psychological Medicine, London, John Churchill.

Nowiki, S. and Duke, M.P. (1983), 'Nowiki-Strickland Lifespan Locus of Control Scale : Construct Validity', in Lefcourt, H.M. (Ed) Research with the Locus of Control Construct Vol 3 : Developments and Social Problems, New York, Academic Press.

O'Brien, G.E. (1984), 'Locus of Control, work, and retirement', in Lefcourt, H.M. (Ed) Research with the Locus of Control Construct Vol 4 : Extensions and Limits , New York, Academic Press.

Olbrisch, M (1975), 'Perceptions of responsibility for illness and health related locus of control in gonorrhea patients', Unpublished Masters Thesis, Florida State University.

Parsons, T. (1951) The Social System, Glencoe, The Free Press.

Parker, K., (1986), 'Storylistener Subjectivity in Response to Mark's Passion - Resurrection Narrative', Paper presented at the Second Institute for the Scientific Study of Subjectivity, Columbia, Missouri, (October).

Paul, B.D. (1955) Health, Culture and Community : Case Studies of Public Reactions to Health Programs, New York, Russell Sage.

Pellegrino, E.D. (1963) 'Medicine, History and the Idea of Man' in Clausen, J.A. and Stauss, R. Medicine and Society

Peretore, P. (1986), 'Field Notes on the use of Q methodology in the study of the Brazilian Left', Operant Subjectivity, 10, 10-20.

Phares, E.J. (1955), 'Changes in expectancy in skill and chance situations', Unpublished doctoral dissertation, Ohio State University.

Phares, E.J. (1976), Locus of Control in Personality, Morristown, General Learning Press.

Pill, R. and Stott, N. (1981) 'Relationship between health locus of control and belief in the relevance of lifestyle to health', Patient Counselling and Health Education, 3(3), 95-99.

Pill, R. and Stott, N. (1982) 'Concepts of illness causation and responsibility: some preliminary data from a sample of working class mothers', Social Science and Medicine, 16(1), 43-52.

Pill, R. and Stott, N. (1985a) 'Choice or chance : further evidence on ideas of illness and responsibility for health' Social Science and Medicine, 20 (10), 981-991.

Pill, R. and Stott, N. (1985b) 'Preventive procedures and practices among working class women : new data and fresh insights' Social Science and Medicine 21(9), 975-983.

Pill, R. and Stott, N. (1987) 'Development of a measure of potential health behaviour : a salience of lifestyle index' Social Science and Medicine, 24(2), 125-134.

Potter, J. (1984) 'Testability, Flexibility : Kuhnian Values in Scientists' Discourse concerning Theory Choice', Philosophy of Social Science, 14, 303-30

Potter, J. and Litton, I. (1985) 'Some problems underlying the theory of social representations', British Journal of Social Psychology, 24, 81-90.

Potter, J. and Wetherell, M. (1987) Discourse and Social Psychology : Beyond Attitudes and Behaviour, London, Sage.

Poulnin, M. (1987) 'Healthy Profits', She, August, 102.

Press, I. (1980) 'Problems in the Definition and Classification of Medical Systems', Social Science and medicine, 14B, 45-57.

Pribram, K.H. (1986) 'The Cognitive Revolution and Mind/Brain Issues', American Psychologist, 41(5) 507-520.

Puccetti, R. (1968) Persons : A Study of Possible Moral Agents in the Universe, London, Macmillan.

Reason, P. and Rowan, J. (1981), Human Inquiry : A Sourcebook for New Paradigm Research, Chichester, Wiley.

Reigel, K.F. (1978) Psychology Mon Amour, Boston, Houghton Mifflin

Reznikoff, M., and Toomey, L.C. (1958), 'The Weighted Q sort : A Procedure for Quantitatively Estimating Emotional Disturbance and Personality Change, Journal of Consulting Psychology, 22,187-190.

Richards, M.P.M. (1984) The Integration of the Child into the Social World, Cambridge, Cambridge University Press.

Rief, P. (1966) Triumph of the Therapeutic : Uses of Faith after Freud, New York, Harper & Row.

Rivers, W.H.R. (1924) Medicine, Magic and Religion, New York, Harcourt Brace.

Rivers, W.H.R. (1926) Psychology and Ethnology, London, Routledge.

Rohrbaugh, M. (1986), 'Q Sort Comparisons of the structural, strategic and systemic family therapies', American Journal of Family Therapy, 14, 40-48.

Roberts, A.E. and Reed, P.N. (1978). 'Dimensionality of the Rotter E-I Scale', Journal of Social Psychology, 106, 129-30.

Rogers, C.R. and Dymond, R.F. (1954) Psychotherapy and Personality Change, Chicago, University of Chicago Press.

Rokeach, M. (1960) The Open and Closed Mind, New York, Basic Books.

Rokeach, M. (1968) Beliefs, attitudes and values : a theory of organization and change, San Francisco, Jossey-Bass.

Rorty, A.O. (1987) 'Persons as Rhetorical Categories', Social Research, 54(1), 55-72.

Rose, H. and Rose, S. (1976), '"Press Freedom" : A Socialist Strategy', in Gardner, C. (Ed), Media, Politics and Culture : A Socialist View, London, Macmillan.

Rosenstock, I.M. (1966) 'Why People Use Health Services' Millbank Memorial Fund Quarterly 44, 94-124.

Rosenblum, E.H. (1979) 'Maternal compliance in immunization of pre-schoolers as related to health locus of control, health value and perceived vulnerability', Unpublished doctoral dissertation, University of New Mexico.

Rosenstock, I.M. (1974) 'Historical origins of the Health Belief Model', Health Education Monographs, 2, 328-335.

Rosenwald, G.C. (1986) 'Why Operationalism Doesn't Go Away : Extrascientific Incentives of Social-Psychological Research', Philosophy of Social Science, 16, 303-30.

Ross, L. (1977), 'The intuitive psychologist and his shortcomings : Distortions in the attribution process', in Berkowitz, L. (Ed), Advances in Experimental Social Psychology(Vol 10), New York, Academic Press.

Rotter, J.B. (1966) 'Generalised expectancies for internal versus external control of reinforcement' Psychological Monographs, 80(1).

Rotter, J.B., Seeman, M. and Liverant, S. (1962), 'Internal versus external control of reinforcement : A major variable in behaviour therapy', in Washburne, N.F. (Ed), Decisions, values and groups, (Vol 2), New York, Pergamon.

Rozeboom, W. W. (1961), 'Ontological induction and logical typology of scientific variables', Philosophy of Science, 28, 337-377.

Rozeboom, W.W. (1972) 'Scientific Inference : The Myth and the Reality', In Brown, S. and Brenner, D.J. Science, Psychology and Communication, New York, Teachers College Press.

Saltzer, E.B. (1979), 'Causal Beliefs and loosing Weight', Unpublished Doctoral Dissertation, University of California at Irvine.

Saunders,L. and Hewes, G.W. (1953) 'Folk Medicine and Medical Practice' Journal of Medical Education 28, 43-46.

Saussure, F. (1974) Course in General Linguistics, London, Fontana.

Savage, R.L. (1985) 'Images of community action in a Southern City', Arkansas Political Science Journal, 6, 35-54.

Schlenker, B.R. (1980), Impression Management : The Self-Concept, Social Identity, and Interpersonal Relations, Monterey, Brooks/Cole.

Schonbach, P.A. (1980), 'A category system for account phases', European Journal of Social Psychology, 10, 195-200.

Scotch, N.A. (1963) 'Medical Anthropology' in Siegel, B. J. (Ed) Biennial Review of Anthropology, Stanford, Stanford University Press.

Scott, M.B. and Lyman, S. (1968) 'Accounts', American Sociological Review, 33, 46-62.

Scruton, R (1986) Sexual Desire : A Philosophical Investigation, London, Weidenfeld and Nicholson.

Searle, J.R., Keifer, F., and Bierwisch, M. (Eds) (1979) Studies in Semantics and Pragmatics, Dortrecht, Reidel.

Sedgwick, P. (1982) Psychopolitics, London, Pluto Press.

Seligman, M.E.P. (1975) Helplessness - On depression, development and death, San Francisco, Freeman.

Semin, G.R. and Manstead, A.S.R. (1983) The Accountability of Conduct : A Social Psychological Analysis, London, Academic Press.

Semin, G.R. and Rogers, R.S. (1973), 'The Generation of Descriptive-Evaluative Responses to Scale-Answering Behaviour : A Model', European Journal of Social Psychology, 3, 311-28.

Shank, R. and Abelson, R.P. (1977), Scripts, plans, goals and understanding : an enquiry into human knowledge structures, Hillsdale, Earlbaum.

Shaver, K.G. (1970) 'Defensive attribution : Effects of severity and relevance of the responsibility assigned for an accident', Journal of Personality and Social Psychology, 14, 101-113.

Shaver, K.G. and Drown, D. (1986) 'On Causality, Responsibility and Self-Blame : A Theoratical Note', Journal of Personality and Social Psychology, 50(4), 697-702.

Sherlock, P.K. (1984) 'The Feminine Q-set : New research on Wolff's feminine images and theories', Journal of Analytical Psychology, 29, 187-199.

Schiller, P.L. Steckler, A. Dawson, L. and Heyman, H. 'Report of the evaluation of the McDowell County health education program, Year II, University of North Carolina.

Shotter, J. (1974) 'The development of personal powers', in Richards, M.P.M. (Ed) The Integration of the Child into the Social World, Cambridge, Cambridge University Press.

Shotter, J. (1981) 'Vico, Moral Worlds, Accountability and Personhood', inHeelas, P. and Lock, A. Indigenous Psychologies : The Anthropology of the Self, London, Academic Press.

Shultz, A. (1962), Collected papers - The problem of social reality, The Hague, Martinus Nijhoff.

Shultz, A. (1967), The Phenomenology of the Social World, Evanston, Northwestern University Press.

Shultz, A. and Luckmann, T. (1973), The Stuctures of the Life World (Zaner, R. and Engelhardt,T. transl.) Evanston, Northwestern University Press.

Shweder, R.A. (1984), 'Anthropology's romantic rebellion against the enlightenment, or there's more to thinking than reason and evidence', in Shweder, R.A. and LeVine, R.A. Culture Theory : Essays on Mind, Self and Emotion, Cambridge, Cambridge University Press.

Silvern, L.E. and Nakamura, C., (1971), 'Powerlessness, social political action, social political views and their inter-relation among college students', Journal of Social Issues, 27(4), 137-157.

Smith, M.B., Bruner, J and White, R.W (1956) Opinions and Personality New York, Wiley.

Smith, T.W. and Anderson, N.B. (1986) 'Models of Personality and Disease : An Intercultural Approach to Type A Behaviour and Cardiovascular Risk', Journal of Personality and Social Psychology, 50(6), 1166-1173.

Snow, L.F. (1974) 'Folk Medical Beliefs and Their Implications for care of Patients', Annals of Internal Medicine, 81, 82-96.

Sontag, S. (1977) Illness as Metaphor, New York, Farras, Straus and Giroux

Stainton Rogers, R. and Kitzinger, C. (1985) 'Human Rights : A Q Methodological Investigation', Research Report for the European Council on Human Rights.

Stainton Rogers, R. and Stainton Rogers, W. (1986) 'The Social Construction of Addiction : Accounts of Aetiology and Social Policy', Paper Presented at the ESEP Advanced Workshop on Environmental and Social Psychology, Lisbon, (September)

Stainton Rogers, W. (1987) 'Episodic and Measured Time', paper presented to the Association for the Social Studies of Time Conference on 'Time in Health and Sickness', Dartington, (July) and forthcoming (1988) in Frankenberg, R. Anthropological perspectives on time in health and sickness

Stainton Rogers, W., Stainton Rogers, R. and Lowe, I, (1986) 'Energy Policy : A Q Methodological Investigation', Paper Presented at the ESEP Advanced Workshop on Environmental and Social Psychology, Lisbon, (September).

Stephenson, W. (1935a) 'Technique of factor analysis', Nature, Vol 136, p 297.

Stephenson, W. (1935b) 'Correlating persons instead of tests', Character and personality, 4, 17-24.

Stephenson, W. (1936) 'The foundations of psychometry : Four factor systems', Psychometrika, 1, 195-209.

Stephenson, W. (1949), 'The Q-technique study of personality', Transations of the New York Academy of Sciences, 2(Ser 2), 215-19.

Stephenson, W. (1950a) 'The significance of Q-technique for the study of personality', in Reymert, M.L. (Ed) Feelings and Emotions, New York, McGraw-Hill.

Stephenson, W. (1950b) 'A statistical approach to typology : the study of trait-universes', Journal of Clinical Psychology, 6, 26-38.

Stephenson, W. (1952), 'Some observations on Q technique', Psychological Bulletin, 49, 483-98.

Stephenson, W. (1953) The Study of Behaviour : Q Technique and its Methodology, Chicago, University of Chicago Press.

Stephenson, W. (1961) 'Scientific creed - 1961 : Abductory Principles', Psychological Recors, 11, 9-17.

Stephenson, W. (1962) 'Image of public health and medicine : 1' Report to the Director of Public Health, State of Missouri, Jefferson City.

Stephenson, W. (1963) 'Image of public health and medicine : 2' Report to the Director of Public Health, State of Missouri, Jefferson City.

Stephenson, W. (1963) 'Image of public health and medicine : 2' Report to the Director of Public Health, State of Missouri, Jefferson City.

Stephenson, W. (1980), 'Consciring : A General Theory for Subjective Communicability', in Nimmo, D. (Ed), Communication Yearbook 4, New Brunswick, Transaction Books.

Stephenson, W. (1967) The Play Theory of Mass Communication, Chicago, The University of Chicago Press.

Stephenson, W. (1986a) 'William James, Neils Bohr and Complementarity - 1 Concepts', Psychological Record, 36, 519-527.

Stephenson, W. (1986b) 'William James, Neils Bohr and Complementarity - 2 Pragmatics', Psychological Record, 36, 529-543.

Stephenson, W. (1986c) 'Quantum Theory of Advertising', Paper presented to the Second International Institute on Q Methodology, (October) Columbia, Missouri

Stephenson, W. (1986d) 'Protoconcursus : The Concourse Theory of Communication', Operant Subjectivity, 9(2) 30-72.

Stephenson, W. (1986e) 'Protoconcursus : The Concourse Theory of Communication - Conclusion', Operant Subjectivity,9(3) 73-96.

Stephenson, W. (1987) 'Sir Geoffrey Vickers and the Art of Judgement', American Psychologist,42(5), 5-8-519.

Stoetzel, J. (1960) 'La maladie, le malade et le medicin esquisse d'une analyse psychosociale', Population, 12, 613-624.

Stuart, R.B. (1979), 'Locus of control Scale, : A dialogue on predictive compliance', paper presented at the American Psychological Association, New York City.

Swift, D.J., Watts, D.M. and Pope, M.L. (1983) 'Methodological Pluralism and Personal Construct Psychology : A case for Pictorial Methods of Eliciting Personal Constructions', Paper presented to the 5th International Conference on personal Construct Psychology, Boston, Mass.

Sunderland, D.M. (1962), 'The Construction of Q Sorts : A Criticism', Psychological Review, 69, 62-64.

Taussig, M. (1980) 'Reification and the Consciousness of the Patient', Social Science and Medicine, 14B, 3-13.

Taussig, M. (1986) 'The Nervous System', Paper presented to the British Medical Anthropology Society Conference, Cambridge, England (July).

Taylor, S.E. (1981) 'The interface of cognitive and social psychology', in Harvey, J.H. (Ed) Cognition, social behaviour and the environment, Hillsdale, Erlbaum.

Tedischi, J.T. and Riess, M. (1981) 'Verbal strategies in impression management', in Antaki, C.(Ed), The Psychology of Ordinary Explanations of Social Behaviour, London, Academic Press.

Tennen, H., Affleck, G. and Gershman, K. (1986), 'Self-Blame Among Parents of Infants With Perinatal Complications : The Role of Self-Protective Motives', Journal of Personality and Social Psychology, 50(40, 690-696.

Thomas, A. (1987) 'An Investigation of Gender Identity', Doctoral Dissertation, University of Reading (forthcoming).

Thompson, G.H. (1935) 'On complete families of correlation coefficients, and their tendency to zero tetrad-differences', British Journal Of Psychology (General section), 26, 63-92.

Tolor, A. (1978), 'Some antecedents and personality correlates of health locus of control', Psychological Reports,43, 1159-1165.

Tulving, E. (1972) 'Episodic and Semantic Memory' in Tulving, E. and Donaldson, W (Eds) Organization of Memory, New York, Academic Press.

Turner, B.S. (1986) 'Personhood and Citizenship', Theory, Culture and Society, 3(1), 1-15.

Valabrega, J.P. (1962) La Relation Therapeutique. Malade et Medecin, Paris, Flamarion.

Valla-Salvador, J. and Leite-Viegas, J.M. (1987) 'Political Culture in urban Portugal', paper presented to the workshop on the European Consortium for Political Research, University of Amseterdam (April).

van der Veen (1983) 'Clasification and pluralism of medical systems', Paper presented to the conference on 'Traditional Medicine in South Esat Asia, Groningen, Netherlands.

Vleeming, R.G. (1976), 'Bezetters en niet-bezetters: een persoon lijkheids onder zoek', Gedrag Tijbschrist voor Psychologie,2, 98-107.

Von Glaserfeld, E. (1984) 'An Introduction to Radical Constructivism', in The Invented Reality : How do we know what we know ? Contributions to Constructivism, P. Watzlawick (ed), New York, Norton.

Voysey, M. (1975) A Constant Burden, London, Routledge and Keegan Paul.

Vygotsky, L.S. (1962) Thought and Language, Cambridge, MIT Press.

Waitzkin, H. (1979) 'Medicine, superstructure, and micropolitics', Social Science and medicine, 13A, 601-609.

Wallston, B.S., Wallston, K.A. Kaplan, G.D. and Maides, S.A. (1976), 'Development and validation of the health locus of control (HLC) scale', Journal of Consulting and Clinical Psychology, 44, 580-585.

Wallston, B.S. and Wallston, K.A. (1978), 'Locus of Control and Health : A Review of the Literature', Health Education Monographs 6(2), 107-116.

Wallston, K.A. and McLeod, E. (1979) 'Predictive factors in the adherence of antihypertensive regimen among adult male outpatients', Unpublished manuscript, School of Nursing, Vanderbilt University.

Wallston, K.A. and Wallston, B.S. (1981),'Health Locus of Control Scales',in Lefcourt, H.M. (Ed), Research with the Locus of Control Construct (Vol 1), Academic Press.

Walster, E. (1966) 'Assignment of responsibility for an accident', Journal of Personality and Social Psychology, 3, 73-79.

Watzlawick, P. (1984) The Invented Reality New York, Norton.

Weber, M. (1930), The Protestant Ethic and the Spirit of Capitalism, London, Allen and Unwin.

Wegner, D.M. and Vallacher, R.R. (1977), Implicit Psychology: An Introduction to Social Cognition, Oxford, Oxford University Press.

Weinreich, P. (1979) 'Ethnicity and adolescent identity conflict' in Saifullah, K. (Ed) Minority Families in Britain, London, Macmillan.

Weinreich, P. (1980) Manual for Identity Exploration using Personal Constructs, London, ESRC.

Weinreich, P. (1983) 'Psychodynamics of personal and social identity : Theoretical concepts and their measurement' in Jacobson-Widding, A. (Ed) Identity : Personal and Socio-Cultural, Atlantic Highlands, Humanities Press.

Weinreich, P (1986), 'The operationalisation of identity theory in racial and ethnic relations', in Rex, J. and Mason, D (Eds) Theories of Race and Ethnic Relations, Cambridge, Cambridge University Press.

Weisenberg, M., Kegeles, S.S. and Lund, A.K., (1980) 'Children's health beliefs and acceptance of a dental preventive activity', Journal of Health and Social Behaviour, 21, 59-74.

Wellin, E. (1978) 'Theoretical orientations in Medical Anthropology : Change and Continuity over the past half-century', in Logan, M.H. and Hunt, E.E. (Eds) Health and the Human Condition, Belmont, California, Wadsworth.

Whorton, J. (1982), Crusaders for Fitness : The History of American Health Reformers, Princeton, Princeton University Press.

Williams, R. (1981a) 'Logical analysis as a qualitative method I : Themes in old age and chronic illness', Sociology of Health and Illness, 3(2), 140-163.

Williams, R. (1981b) 'Logical analysis as a qualitative method II : Conflict of ideas and the topic of illness', Sociology of Health and Illness, 3(2), 165-185.

Williams, R. (1983) 'Concepts on health: an analysis of lay logic', Sociology, 17(2) 185-205.

Williams, R. (1986a) 'Images of Age and Generation', paper presented to the British Sociological Association Conference, also forthcoming in Bryman, A. and Bytheway, W. (Eds) Life cycle Perspectives, London, Macmillan.

Williams, R. (1986b) 'Religion and other resources in coping with illness', Paper presented to the Joint Conference of the British Medical Anthropology Society and the Society for Medical Anthropology, Cambridge (July).

Wittenborn, J.R. (1961), 'Contributions and Current Status of Q Methodology', Psychological Bulletin, 58, 132-142.

Wong, P.T.P. and Sproule, C.F. (1982), 'An Attribution Analysis of the Locus of Control Construct in the Trent Attribution Profile', in Lefcourt, H.M. (Ed) Research with the Locus of Control Construct Vol 2 : Current Trends, Theory and Research, New York,

Young, A. (1976), 'Internalizing and Externalizing Medical belief Systems : An Ethiopian Example', Social Science and Medicine, 10. 147-156.

Young, A. (1980), 'The Discourse on Stress and the Reproduction of Conventional Knoweldge', Social Science and Medicine, 14B, 133-146.

Young, A. (1981) 'When rational men Fall Sick : an inquiry into some assumptions made by Medical Antrhropologists', Culture, Medicine and Psychiatry, 5, 317-335.

Young, A. (1982) 'The Anthropologies of Illness and Sickness' Annual Review of Anthropology, 11, 257-85.

Young, A. (1983), 'Rethinking Ideology', International Journal of Health Services, 13(2), 203-219.

Young, A. (1987) 'Peace-time and Past-time in the clinical construction of combat-related post-traumatic stress disorder', paper presented to the Royal Anthropological Institute conference on 'Time in sickness and Health', Windsor, England, (February).

Zola, I. (1972) 'Medicine as an Institution of Social Control', Sociological review, 20, 487-504.

APPENDIX 1

INTERVIEW SCHEDULE AND SAMPLE INTERVIEW FOR STUDY 1

INTERVIEW SCHEDULE

1: Biography (health history and experiences of illness, medical care, professional involvement).

2: What first interested you in ..... (health context) ?

3: Definition of 'health'

4: Can disabled people, the elderly be healthy ?

5: What do you think causes - the common cold ?
                             - cancer ?
                             - heart disease ?
                             - obesity ?
                             - allergy ?

6: How should ill health be treated/ managed ?'

7: What role does an individual play in their own state of health ?

8: What is the role of conventional medicine ? Other alternatives ?

9: Do people have unrealistic expectations (e.g. diagnosis, cure, long evity) ?

10: What is the most important thing we as a society could do to improve health ?

11: What are the most important problems we face ?

12: What is the most desperate need for research ?

13: Realtionship between health and personal attractiveness ?

14: Any gender differences ?

15: Are you healthy ? Do you practice what you preach ?

16: Are there/why are there social class differences ?

17: Are there/why are there national differences ?

18: Define 'a healthy personality' ?

19: What influence are social, psychological and emotional factors ?

20: Anything else you consider important ?

Interview Summary   Participant No.9 : <u>Dr Peter North</u> (pseudonym)

Biographical details

Dr North was a GP who worked in a village in the south of England, in at a small group practice which served three surrounding villages and also had some patients from a local small town. The practice had three GPs, a part-time practice nurse, part-time health visitor, part-time district nurse, a practice manager and clerk. I contacted Dr North for interview because he was well known in his community as a doctor who frequently prescribed homeopathic medicines.

Dr North was in his fourties. He had trained initially as a psychiatrist, and had worked for several years in a mental hospital. However, he had become increasingly unhappy with psychiatry, because, he said, it was an "unreal world" that did not give him the opportunities he wanted to "... really make an impact". He described his motives for going into medicine as "... a desire to, I suppose it is a cliche, but to make some contribution to human good". Psychiatry within the NHS failed to give him this satisfaction :

"Most of the people I work with need a lot, lot more than I can ever offer them. It´s a patch up service at best, and very reliant on drugs which ... even at that time I was disturbed with ... I felt I was doing little more than zonking them out half the time."

He therefore re-trained as a GP, though he still maintained a part-time post at the mental hospital and did two or three sessions a week. He had been a GP for five years when I interviewed him. In the last three years he had become increasingly interested in homeopathy, and was in the process of gaining extra training in this area. In fact, a year after the interview, he gave up general practice, and took up homeopathy full-time.

Interest in homeopathy

When I asked Dr North to describe his reasons for using homeopathy, he laughed :

"It´s a funny story, I suppose. It didn´t start out with any deep commitment, indeed to tell you the truth ... I was very sceptical. But as a GP I found myself coming more and more into conflict with my patients. It started off as a way out of that conflict. ... (Y)ou see, a lot of the people who came to me for help, well, people today have lost faith in their body´s ability to heal itself. They think when they are ill they won´t get better unless they have medicine. It´s ´Doctor, I need some antibiotic for my throat´ or they want a ´pick me up´ ... basically they want a prescription. People today... are convinced that every little ache and pain is serious, or if not serious will turn into something serious unless they take something for it and so they tend to run to the doctor with every little ache and pain and expect you to offer an instant cure. They don´t recognise that most illness is self-limiting. People

don't recognise the body's own powers of self-healing. But they have a very fragile image of their bodies, as though once it gets attacked it's powerless and they need help.

Well, part of the reason I wanted out of psychiatry ... was its reliance on drugs and the ... (problems of) side-effects, and here I was being expected to pump my patients full of drugs, often just to make them feel that somebody was taking some notice of their illness, or because they were frightened that they wouldn't get better unless they took some sort of magic potion... And so I got into conflicts, a lot of conflicts, some people got very angry... so I couldn't win. If I gave them a prescription, which is what a lot of GPs do, I knew that they didn't need and would quite possibly make the situation worse, then I had to square that with my conscience, or I told them to go away, and, you know, take it a bit easy and let their body do the work it was designed to do, either way I couldn't win. And so I thought I would try it because in those dilutions it couldn't really do any harm, and they would go away happy."

He described, however, that fairly soon he thought he had better make at least some attempt to prescribe according to some kind of homeopathic principles, and so started reading up in books about it :

"Well, it had two effects really. I had to take a history in a different way and ask a lot of much more detailed questions, and although that itself causes problems in terms of time, you know, it was also a plus, because I had to learn a lot more and listen a lot more. ... But also, to my surprise ... it seemed as though they had some action ... it did seem to work."

Consequently he had become increasingly involved in homeopathy, both as a means of offering patients 'a prescription' which validated their illness but did them no harm, and more and more as the treatment of choice for a range of illnesses. He mentioned that the "...rituals attached" to taking homeopathic medicines (these include taking the pills from the bottle cap and not touching them, and giving up coffee and ordinary toothpaste while taking a course of medication, all necessary to ensure that there were no competing substances) made them "...excellent placebos" but that he also became more and more convinced that the medication and indeed the whole system worked.

"I do continue to prescribe all opathic drugs, I'm not doctrinaire. But I am now able to use, say, antibiotics, very much more sparingly in the few cases I consider them really necessary, and I feel a lot more comfortable about that. ... But it also gives me a dialogue, a way of talking to patients that they understand and can relate to. When I tell them that what I am doing is trying to help their body marshall its own defences, and that the drug they are getting is to do that, then I find that we are talking a language that makes sense to them."

The status and management of health

Not surprisingly given his background and involvement in homeopathy, Dr North saw health wholistically, and in terms of equilibrium :

"Health is a positive, it's ... to do with having the resources, both physical and psychological, to take on life's demands and ... onslaughts. It has a lot to do with something inside, with a sense of purpose and tranquility and something ... of being there, of being in control, of a balance of life."

In seeing health in this way, he was convinced that both older people and the chronically sick can be healthy, basically can reach their own potential, and maintain their balance and control so long as they had the will to do so. He felt that health is something to be sought primarily by psychological management :

"Of course there are the basic things like diet and exercise and not smoking. At that level, the body is a bit like a machine and if it's neglected or abused, it will cease to function properly. But it's a lot ....more than a machine, or at least, at that level, a very complicated one with enormous powers to fight off infection and to heal so long as ... these capacities have not been undermined by drugs and other abuses... But you know, that's only at the one level ... beyond that there is the person, and they ... can be a victim of their body, or their worry, or their circumstances and feel that they are weak and powerless, or they ... can feel strong, and it is that strength that is what really matters."

He spoke at some length about the homeopathic viewpoint on the management of illness. That for the vast majority of 'health problems' the task is to do three main things. First, to maintain a sensible lifestyle "... though there needs to be a balance between being sensible and having fun ... I don't always follow my own advice - I do not take the exercise I should, I let my job take over my life ... I eat food that I enjoy sometimes, even if it's not ideal, I even smoke cigars sometimes." Second, for the person to gain a sense of purpose and to fight feelings of powerlessness. Third, at a bodily level, to work in ways that promote self-renewal and self-healing, with homeopathic remedies if necessary, and certainly by avoiding substances (particularly prescribed drugs) that throw the balance of the body. Clearly within this context he favoured alternative medicine, and although homeopathy weas his own particular concern, saw other forms of alternative medicine as useful:

"All share two important things. A respect for the body and its powers ... working with it rather than against it .... and a wholistic approach, both in terms of time ... looking at health and illness within the sequence of life from one time to another... and ... in terms of all the aspects of a person, not just the body, and ... especially not just one set of symtoms of one organ separate from another."

Causes of illness

Common colds, Dr North said, were not in one sense really illnesses at all. A person's body is in a constant state of balance with other organisms, always having to maintain itself in a kind of homeostasis that keeps organisms at bay. Colds are symptoms which arise out of this process, when the balance is

disrupted (which it can be by a wide range of different things, both internal and external). But the symptoms are functional, and should not be treated but allowed to run their course and do their work.

Cancer, he suggests, is similarly a continual process. All of us have 'cancer' in the sense that cells replicate in dysfunctional ways at times, but most of the time for most of us the body's own fine tuning mechanisms cope and the process only becomes troublesome (i.e. disease) when the coping mechanisms break down.

Heart disease he says has a complex aetiology. It is impossible to talk of simple cause-and-effect because it arises "... within a complex network of things going on." Thus he accepted many of the received biomedical explanations to do with hypertension, smoking, blood fats, exercise, but spoke at length about the need to place these within the context of the person's psychological approach to life, and their social context.

Obesity is, according to Dr North, a social not a personal illness :

"Let's be frank about this, obesity is not about being fashionably emaciated like a model in 'Vogue' and anything else is obese. There are degrees of carrying too much weight that are bad for health, but they are much less tough than many people claim. And overweight, which is a problem because ... say, of the strain it puts on the system, is much more a product of a society in which 'naughty but nice' is the message ... the sickness is in that ... and in a world in which over half of the world's population is starving. Now that is really sick. ... Looked at worldwide, obesity is not the problem, hunger and malnutrition and starving are the problem."

Allergies were something that intereste d him, but he felt unsure of himself at answering :

"I don't think we have begun to understand, and of course, I am learning a whole new way of looking at this ... I don't think orthodox medicine is even close in its current understanding."

Social responsibility

As his comments on obesity showed, and hus motivations for moving into general practice, Dr North was a man for whom moral and broad social issues were important. He spoke for some time, in answer to this question, about the Black report, inequalities in health, and the undesirable professional bias in medicine towards high technology and the consequent neglect of its duty to the chronically sick, the old and to the causes of illness that are the products of poverty. He also mentioned that as a doctor, commited by oath to preserving life, he felt it a moral duty to be a member of CND and to refuse to co-operate with any plans for responding to nuclear war :

"Living as we do here so close to Greenham and Upper Hayford, to make any kind of plans is irresponsible in the extreme... it is giving a message to people that some kind of civilisation would survive... and it wouldn't ... I see nuclear war as the greatest

threat we have to face."

He felt, not surprisingly, that research endeavour should be shifted away from developing ever more high technology surgery and drug testing towards looking at the psychological aspects of illness, at people's everyday lifestyles, at health education, and in particular at alternative medicine :

"Though I don't expect it to happen, people have too much at stake and fixed ideas. But I for one would like to know a lot more about why homeopathic treatment seems to work."

He saw major gender and social class differences, arising from social forces and "... things like the way a person sees themself. We force ... a lot of people (in)to lives that strip them of their self-confidence and how can they be expected to have the confidence not to run all the time looking for a doctor with a magic wand who will solve all their problems for them ... we take away their faith and their ability to solve (them) ... for their selves."

Finally, he defined a 'healthy personality' thus :

"It is to do with living by your own lights, a person ... who lives according to their own reasons and goals and has the personal courage and tranquility to do that... and at ... the same time, is sensitive to others... in a way (in which) they define their own worth, and live up to that worth, and other people value them for it. This is their strength, and their strength is very powerful, and their health would be in and come from that."

APPENDIX 2

DERIVATION OF Q ITEMS FOR STUDY 1

Q Item	Source

1. However complex the programming, computers will never be as good at medical diagnosis as doctors.

Interview [1]

2. To allow the prescription of tranquillisers on the NHS makes no more sense than dishing out State subsidised beer or whisky.

Conversation, recorded in notebook after TV programme

3. People who take overdoses as a 'cry for help' are abusing the Health Service and misusing its facilities.

Interview [2]

4. It is foolish and pig headed to go against your doctor's advice.

Interview [3]

5. Disease and bodily decay are inevitable aspects of being alive, and anyone who promises you different is a liar or a fool.

Interview [4]

6. Medicine is first and foremost a science and must be based on rigorous scientific principles.

Interview [5]

7. We have every reason to be proud of our National Health Service.

Interviews, [2,6,7]

8. Many so-called 'mental illnesses' are really just the signs of weakness or the unwillingness to face reality.

Conversation recorded in notebook

9. Much of the illness we suffer is caused by the unhealthy way we live our lives.

Interviews [8,3,10]

10. Hard as it may be to understand, disease and injury are all part of God's plan for us all.

Comment made in post office

11. Modern medical triumphs like heart transplants are among the major achievements of our time.

From TV programme

12. Working class people are 'off sick' from work more often than middle class people because they don't take the trouble to look after themselves properly.

Radio news

Q Item	Source

13. In medicine a little knowledge is a dangerous thing.

Interview [8]

14. Fringe medicine is a dangerous intrustion upon proper medical care.

Comment from notebook

15. Doctors can only treat symptoms; they can seldom resolve the real underlying causes of illness.

Academic Conference

16. There is far too much 'meddling' in medical matters by lay people.

Interview [8]

17. If we want to improve health we should provide more sporting facilities, not more health centres.

Interview [7]

18. Doctors are quite right to keep the truth from their patients if they feel they could not cope with it.

Interview [8]

19. Doctors should be free to prescribe the 'pill' to girls of less than sixteen, even against their parent's express wishes.

Gillick Action

20. It is crucial to keep yourself and your home clean and hygenic or you will fall prey to disease.

Comment from notebook

21. Primitive societies which lack the benefits of modern medicine are bound to contain a high proportion of people who are ill.

Medical Conference

22. It is no concern of the doctor if their patient lives an unhealthy lifestyle. Their job is to cure illness.

Zola

23. It is wrong to test out new drugs on animals, even if this may save human life.

From notebook

24. A doctor does not recommend surgery unless it is absolutely necessary.

Interview [11]

25. The care of the elderly is a social not a medical responsibility.

Interview [9]

Q Item	Source

26.   Big Business - like the Tobacco Alcohol and Food Industries - prevents the Government from implementing an effective policy of preventive medicine. — 'Observer'

27. Decisions about who should live and who should die are moral not medical questions; they should not be left just to doctors. — From notebook

28. People are far too ready to run to the Doctor with every little ache and pain. — Interview [9]

29. Treating people as 'mentally ill' is often a means by which society controls those who don't conform. — Comment from notebook

30. The health of people in our society will only improve overall when we have overcome the injustices between the 'haves' and the 'have-nots'. — Ehrenreich

31. The ability of the body to heal itself is much greater than most people realise. — Interview [8]

32. Good health is a fundamental human right. — WHO

33. Health education is a critical element in ensuring that people are fit and well. — Interviews [10,3]

34. People suffering from incurable illness should have the right to be painlessly dispatched. — Notebook

35. Whether an individual is healthy or not is largely a matter of choice. — Interview [12]

36. Modern drugs are very effective and have few unwanted side-effects. — From notebook

37. Far too much rubbish is written about the psychological aspects of illness. Nearly all diseases are caused by infection or bodily dysfunction and have no psychological element whatsoever. — Notebook

Q Item	Source
38. Some people are born with a disposition to be 'sickly'.	Interview [13]
39. Even when you feel completely healthy you should have regular health check-ups.	Interview [6]
40. Many people use the excuse of being ill to draw attention to themselves.	Notebook
41. There is a lot to be said for a compulsory medical examination at regular intervals for the whole population.	Notebook
42. Good medicine requires good teamwork, with the doctor collaborating with a full range of professionals for the patient's care.	Interview [3]
43. A woman should have the right to have medical treatment from a woman.	Interview [14]
44. Being healthy is far more than an absence of disease, it is to do with a positive sense of wellbeing.	Notebook
45. The vast majority of doctors have no sympathy for their patients.	Interview [15]
46. Sensible people plan their lives to promote positive health and wellbeing.	Interview [3]
47. To care for and cure the sick is one of the highest callings in life.	Interview [13]
48. Vegetarians are usually healthier than meat eaters.	Notebook
49. Doctors have a moral duty to support Nuclear Disarmament.	Interview [9]
50. The worry and stress of modern life is society's major health hazard.	Herzlich

Q Item	Source
51. Our modern environment is full of pollution which undermines health.	Notebook
52. More often than not, tranquillisers are prescribed to help people put up with intol erable conditions under which they are forced to live.	Interview [9]
53. The 'will to live' is a major factor in whether people recover from a serious illness.	Interview [9]
54. Wherever practical, a doctor should offer an ill person a range of treatments and they themselves should choose which one they wish to follow.	Interview [4]

APPENDIX 3

MATERIALS USED IN STUDY 1

INSTRUCTIONS FOR COMPLETING THE Q SORT

Enclosed you will find seven sheets of paper, on each of which are numbered statements about health and illness; there are 54 statements in all. These are mostly things that people have said in interviews, but also include statements in books, magazines and on TV and radio. Your task will be to sort them in a way that gives an impression of how _you_ feel about them. You will also find a further pink sheet, on which there are numbers marked from -5 through 0 to +5. To carry out the Q sort you will need to cut all of these out, so that you have two piles of small bits of paper, one pile of 54 statements, and one pile of 11 pink numbers. You will also need a large, clear table or desk - or the floor ! (as the process takes up a fair bit of space).

Your task will be to sort the statements according to a profile, from **STRONGEST DISAGREEMENT** (-5) to **STRONGEST AGREEMENT** (+5). If you look now at the response grid on the back page, you will see the format of choices. As you will see, the pattern is such that at the extreme ends you will need to place just three statements - those with which you feel strongest disagreement at one end, and those with which you most strongly agree at the other. In between, you will place increasingly more statements, in a V shape.

In this way you should be able to give a rough account of your views about health and illness. I say "rough account" because a technique like this can only go so far, and cannot represent a lot of detail, or take account of the "...yes, but..." feelings we all have about any issue or topic. However, this technique is pretty good at describing the basic viewpoints that people hold, and is very useful guide for further research using more detailed techniques (e.g. interviews).

What you should do to begin, is to sort the statements into three piles fairly roughly :

Pile A	Pile B	Pile C
Those statements with which you **disagree**	Don´t know No strong feeling Ambivalent Don´t understand	Those statements with which you **agree**

At this stage it´s probably worth going through the piles a second time, just to make sure that you are happy with where you have placed the statements. Incluce in pile A all of those with which you disagree, even if only mildly; and in pile C ensure that there are all the statements with which you agree, even if your agreement is pretty small. You can go on changing statements from pile to pile as long as you want, right up to the end of the sort, but people usually find that the sorting gets easier later on if they make sure they are fairly happy at this stage. When you are satisfied with your three piles, your

need for lots of space arises. Set out the pink numbers in a row in front of you like this, with plenty of space below :

| -5 | -4 | -3 | -2 | -1 | 0 | +1 | +2 | +3 | +4 | +5 |

P L E N T Y   O F   S P A C E

Your task from this point on is to sort the statements according to two considerations. First and foremost, consider the extent to which you agree or disagree with each one. When a decision gets hard, however, you should also consider the importance of the subject matter to your beliefs and opinions - place those statements that are salient to you before those that are of less concern.

Now, using the grid on the back page, begin to sort your statements according to the specified profile. Most people start by selecting one pile (e.g. Pile A) and chosing from it the three statements with which they feel strongest disagreement, placing these under the -5 marker. The object from this point on is to gradually refine your strength of disagreement by next selecting four statements to go under -4, then five statements to go under -3 and so on, working from pile A until you have used them all up. Then you should move on to pile C, and in a similar manner first find your three statements of greatest agreement to put under the +5 marker, moving on in turn to choices for +4, +3 and so on.

When you have used up all of your statements from piles A and B, go on to place pile B. Here you should still aim as far as possible to work from disagreement to agreement, but these statements in the middle of the grid don't matter so much, and you should not worry over them for too long. While for some people the 0 row will be sufficient for all of pile B, for others you may be using + or - columns. Again, don't worry too much - nor be concerned if, say, you have more agrees or more disagrees than the grid alows - the numbers are actually only there to help you make your sort, and it is the order of your responses which matters.

At the end of your sorting, you should have something in front of you that looks like this :

Even at this stage if you want to (and have the time) you should feel free to move the statements around. When, however, you are reasonably happy with your choices, fill in the grid with the numbers of the statements. Please note, however, that for the purposes of the analysis I will carry out on the responses, it is absolutely crucial that you stick to the format specified by the grid, with exactly the right number of statements in each column (i.e. you should not put, say, four statements under the +5 column, however much you may feel you would like to do so !).

SO PLEASE DO STICK TO THE RIGHT NUMBER OF STATEMENTS IN EACH COLUMN - OTHERWISE THE COMPUTER WILL SPIT OUT THE DATA, AND I WILL TEAR MY HAIR OUT !!!

Thankyou very much for helping me with my research, I appreciate the time and effort required, and your willingness to give me your support.

ITEMS FOR Q SORT

These 54 items should be cut up carefully, and used for sorting. The back page contains markers to help you position the sort correctly.

1. However complex the programming, computers will never be as good at medical diagnosis as doctors.	2. To allow the prescription of tranquillisers on the NHS makes no more sense than dishing out State subsidised beer or whisky.
3. People who take overdoses as a 'cry for help' are abusing the Health Service and misusing its facilities.	4. It is foolish and pig headed to go against your doctor's advice.
5. Disease and bodily decay are inevitable aspects of being alive, and anyone who promises you different is a liar or a fool.	6. Medicine is first and foremost a science and must be based on rigorous scientific principles.
7. We have every reason to be proud of our National Health Service.	8. Many so-called 'mental illnesses' are really just the signs of weakness or the unwillingness to face reality.
9. Much of the illness we suffer is caused by the unhealthy way we live our lives.	10. Hard as it may be to understand, disease and injury are all part of God's plan for us all.
11. Modern medical triumphs like heart transplants are among the major achievements of our time.	12. Working class people are 'off sick' from work more often than middle class people because they don't take the trouble to look after themselves properly.
13. In medicine a little knowledge is a dangerous thing.	14. Fringe medicine is a dangerous intrustion upon proper medical care.
15. Doctors can only treat symptoms; they can seldom resolve the real underlying causes of illness.	16. There is far too much 'meddling' in medical matters by lay people.

17. If we want to improve health we should provide more sporting facilities, not more health centres.	18. Doctors are quite right to keep the truth from their patients if they feel they could not cope with it.
19. Doctors should be free to prescribe the ´pill´ to girls of less than sixteen, even against their parent´s express wishes.	20. It is crucial to keep yourself and your home clean and hygenic or you will fall prey to disease.
21. Primitive societies which lack the benefits of modern medicine are bound to contain a high proportion of people who are ill.	22. It is no concern of the doctor if their patient lives an unhealthy lifestyle. Their job is to cure illness.
23. It is wrong to test out new drugs on animals, even if this may save human life.	24. A doctor does not recommend surgery unless it is absolutely necessary.
25. The care of the elderly is a social not a medical responsibility.	26. Big Business - like the Tobacco, Alcohol and Food Industries - prevents the Government from implementing an effective policy of preventive medicine.
27. Decisions about who should live and who should die are moral not medical questions; they should not be left just to doctors.	28. People are far too ready to run to the Doctor with every little ache and pain.
29. Treating people as ´mentally ill´ is often a means by which society controls those who don´t conform.	30. The health of people in our society will only improve overall when we have overcome the injustices between the ´haves´ and the ´have-nots´.
31. The ability of the body to heal itself is much greater than most people realise.	32. Good health is a fundamental human right.

33. Health education is a critical element in ensuring that people are fit and well.	34. People suffering from incurable illness should have the right to be painlessly dispatched.
35. Whether an individual is healthy or not is largely a matter of choice.	36. Modern drugs are very effective and have few unwanted side-effects.
37. Far too much rubbish is written about the psychological aspects of illness. Nearly all diseases are caused by infection or bodily dysfunction and have no psychological element whatsoever.	38. Some people are born with a disposition to be ´sickly´.
39. Even when you feel completely healthy you should have regular health check-ups.	40. Many people use the excuse of being ill to draw attention to themselves.
41. There is a lot to be said for a compulsory medical examination at regular intervals for the whole population.	42. Good medicine requires good teamwork, with the doctor collaborating with a full range of professionals for the patient´s care.
43. A woman should have the right to have medical treatment from a woman.	44. Being healthy is far more than an absence of disease, it is to do with a positive sense of wellbeing.
45. The vast majority of doctors have no sympathy for their patients.	46. Sensible people plan their lives to promote positive health and wellbeing.
47. To care for and cure the sick is one of the highest callings in life.	48. Vegetarians are usually healthier than meat eaters.

49. Doctors have a moral duty to support Nuclear Disarmament.

50. The worry and stress of modern life is society's major health hazard.

51. Our modern environment is full of pollution which undermines health.

52. More often than not, tranquillisers are prescribed to help people put up with intol erable conditions under which they are forced to live.

53. The 'will to live' is a major factor in whether people recover from a serious illness.

54. Wherever practical, a doctor should offer an ill person a range of treatments and they themselves should choose which one they wish to follow.

- 1	+ 1
- 2	+ 2
- 3	+ 3
- 4	+ 4
- 5	+ 5
	0

Q SORT ABOUT HEALTH AND ILLNESS

NAME ....

STRONGEST
DISAGREEMENT <---------------------> STRONGEST
                                     AGREEMENT

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5
(3)	(4)	(5)	(5)	(6)	(8)	(6)	(5)	(5)	(4)	(3)
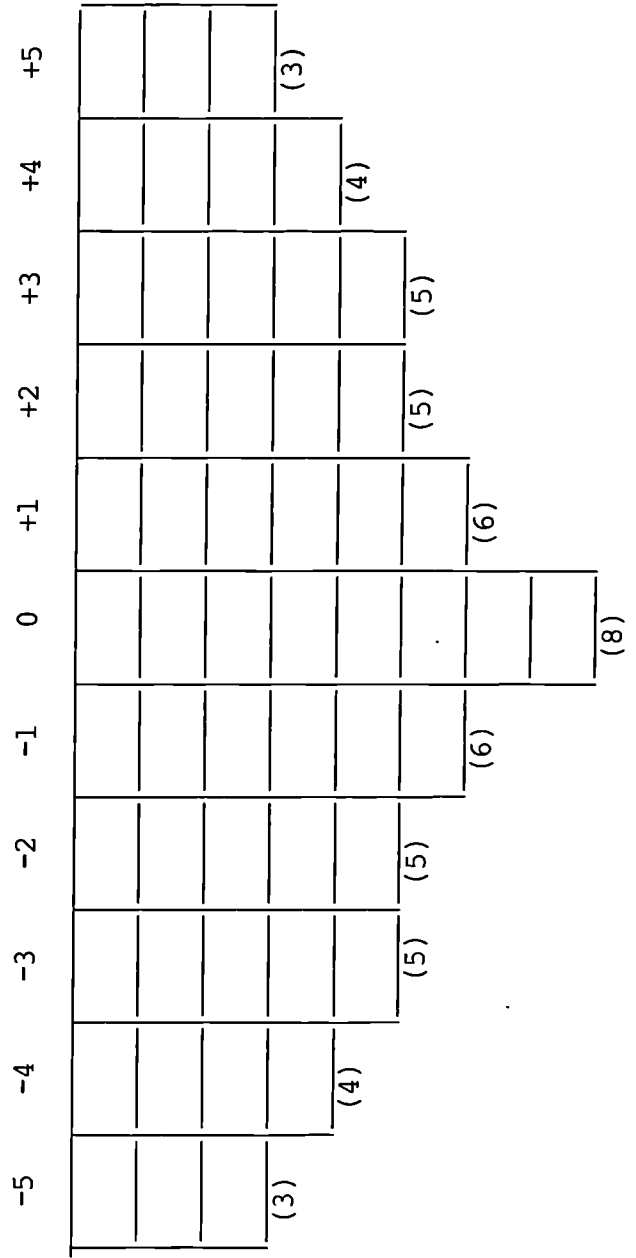
COMMENTS FORM

Here are all the Q sort items listed on
sheets of paper. Please use the spaces
provided to make any comments about the
items that you think will be useful in
planning the next study - things like
wording, whether or not they are easy to
understand, and any reactions you have
to them, or problems with them.

1. However complex the programming, computers will never be as good at medical diagnosis as doctors.

2. To allow the prescription of tranquillisers on the NHS makes no more sense than dishing out State subsidised beer or whisky.

3. People who take overdoses as a 'cry for help' are abusing the Health Service and misusing its facilities.

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52. More often than not, tranquillisers are prescribed to help people put up with intol erable conditions under which they are forced to live.

53. The 'will to live' is a major factor in whether people recover from a serious illness.

54. Wherever practical, a doctor should offer an ill person a range of treatments and they themselves should choose which one they wish to follow.

ANY SUGGESTED ADDITIONAL ITEMS :

<u>Q SORT PILOT TEST</u>   PARTICIPANTS´ FORM

NAME ....
(or pseudonym)

ADDRESS..

....

....

Telephone   WORK .... HOME ....

Gender .... Age ....

Occupation or other description
of yourself
....

....

....

Any other information you think
might be salient (e.g. experience of illness) : ....

....

....

....

Would you be willing to   Yes [ ]   No [ ]
participate in further
Q studies ?

Would you be willing to   Yes [ ] ·No [ ]
be interviewed ?

Do you know anybody I might contact to ....
participate in future studies,
particularly with interesting or   ....
unusual ideas about health and
illness ? If so, please provide name   ....
and address :

                  ....

Q SORT PILOT TEST   RESPONSE FORM

NAME.............................

---

1 : Were the instructions clear and easy to follow ?

If not, suggest improvements

---

2 : List any items you found difficult to understand. If you can, say what the problem was.

---

3 : Were any important issues/ideas missed out ? If so, suggest statements to describe them.

---

4 : Describe any problems you faced completing the task

ANY OTHER COMMENTS ?

APPENDIX **4**

FACTOR LOADINGS FOR STUDIES 1,2 AND 3

Factor loadings obtained in Study 1

Part. Number	Factors				
	1	2	3	4	5
1	0.37	0.70	0.08	0.03	0.18
2	0.23	0.16	0.54	0.38	0.06
3	0.46	0.28	0.20	0.27	0.09
4	0.01	0.38	0.50	0.47	0.01
5	**0.85**	0.23	-0.04	0.19	-0.13
6	0.47	0.38	0.51	0.13	0.03
7	0.07	0.36	0.70	-0.08	0.26
8	0.35	0.59	0.22	0.05	0.04
9	0.23	0.28	0.25	0.15	-0.02
10	0.69	0.37	0.08	0.20	-0.02
11	0.43	-0.02	-0.05	0.05	0.08
12	**0.68**	0.18	0.15	-0.09	0.04
13	0.43	0.63	0.26	0.14	0.09
14	-0.15	0.10	0.21	0.14	**0.76**
15	0.31	0.54	-0.09	0.25	0.14
16	0.50	0.41	-0.01	0.09	-0.07
17	**0.74**	0.25	0.22	0.26	0.06
18	0.06	0.56	0.14	0.14	-0.19
19	-0.03	0.28	0.34	0.02	0.06
20	0.15	**0.72**	0.32	0.16	-0.03
21	-0.24	0.07	0.23	0.04	0.18
22	0.23	0.16	-0.04	**0.72**	0.03
23	**0.87**	0.19	0.04	0.15	-0.09
24	0.09	0.33	0.17	0.10	0.08
25	0.18	0.38	0.03	0.62	0.26
26	**0.74**	0.27	0.15	0.09	-0.12
27	0.08	-0.05	**0.68**	-0.09	0.03
28	0.50	0.64	0.09	0.10	0.18
29	0.36	0.49	0.43	0.19	0.31
30	0.23	**0.78**	-0.10	0.40	0.03

Exemplars marked in **bold**

All data rounded up to two decimal places

Factor loadings for Study 2

Partic'pt Number	FACTORS								
	1	2	3	4	5	6	7	8	9
1	.14	.54	.22	.08	.30	.06	.02	.14	-.31
2	.00	.32	.59	-.05	.21	-.06	.01	-.05	.10
3	.34	.40	.14	.41	-.08	-.01	.32	-.07	.07
4	.11	.23	.08	.55	.36	-.13	.17	.14	-.15
5	.40	.27	.52	.03	.43	-.02	-.04	.05	.15
6	**.88**	-.07	.03	.07	.12	.21	-.03	-.00	.00
7	.12	.46	08	.10	.12	.29	.15	-.18	-.06
8	.57	.20	.26	.10	.03	-.03	.06	.18	-.16
9	.10	.46	.02	.12	.05	.19	-.04	-.01	.15
10	-.02	.37	.43	.16	.33	.21	.15	-.03	.12
11	.30	.43	.04	.07	-.09	-.16	.03	.33	.02
12	.14	.33	.56	.19	.19	.25	.09	.13	-.10
13	.57	.12	.32	-.10	.05	-.16	.32	.23	.05
14	.35	.36	.42	.17	.06	-.05	.01	.04	.05
15	.10	.61	.01	.57	.07	.15	-.07	.17	-.01
16	**.69**	-.05	.00	.15	.11	-.04	-.03	.22	-.23
17	.27	.36	.24	.17	-.01	.03	.42	.05	.00
18	.12	.31	.22	.41	.17	.02	.15	.20	.10
19	.28	.57	.04	.31	-.09	.05	.16	-.05	.02
20	.12	.12	.11	.10	**.63**	.25	.08	-.05	.04
21	.54	.03	.14	.39	.29	.06	.50	.01	-.02
22	.04	.45	.47	.29	.16	.00	.14	.22	.15
23	.07	.29	.21	-.01	.49	-.03	.18	.05	.19
24	.13	.34	.05	.15	.10	.10	.11	-.06	-.05
25	**.90**	-.06	.01	.04	.01	.19	.06	-.08	.02
26	.05	.18	.35	.02	.18	.11	.02	.15	.04
27	.06	.22	.25	**.72**	.13	.15	.00	-.09	.07
28	.33	.49	.20	.07	.23	.19	.31	.08	.11
29	-.11	.28	.33	.37	.05	.34	.08	-.08	.19
30	.41	.19	.08	.14	.33	.02	.04	.09	.19
31	.00	.55	.20	.14	.14	.03	.11	-.20	.06
32	.57	.08	.07	.15	.20	-.15	-.00	.03	.05
33	.17	.27	.26	.18	.24	.26	.37	.01	.28
34	.53	.21	.23	.10	.12	.04	.14	-.01	.24
35	.32	.21	.32	.04	.03	.04	.14	.15	.50
36	.37	-.10	.22	.00	.18	-.04	-.06	.07	.14
37	.16	.05	.19	.03	.14	.26	**.66**	.09	.08
38	-.07	.19	.12	.10	.25	-.00	.06	-.00	**.69**
39	.19	.15	-.02	.56	-.08	.18	-.00	-.13	.09
40	-.05	.35	.11	.15	.23	-.13	.12	.03	.03

Exemplificatory Q sorts marked in **bold**
Data rounded to two decimal points.

Factor loadings for Study 2 /cont.

Particip't Number	F A C T O R S								
	1	2	3	4	5	6	7	8	9
41	-.02	.15	.19	.13	.23	.12	-.03	.04	.18
42	-.22	.41	.19	.08	.18	.01	.09	-.23	.14
43	.02	.29	.20	.17	**.60**	-.03	.09	.02	.17
44	**.85**	-.02	.16	.00	.09	.03	.11	.13	-.03
45	-.22	.50	.01	.07	-.08	-.02	-.14	-.29	-.25
46	.67	.29	.23	.16	.02	.18	.17	.03	.13
47	.05	.55	.26	-.11	.33	-.07	.04	-.01	.08
48	.29	.01	**.71**	.20	.18	.24	.09	.08	.04
49	-.14	.50	.05	.38	.27	.11	.06	-.09	.11
50	**.84**	-.14	.11	.05	-.03	.03	-.06	.00	.02
51	-.22	.52	.01	.16	.06	.16	.15	-.12	.03
52	-.11	**.67**	.26	.15	.14	-.09	.10	.07	.11
53	.26	-.01	.15	-.04	.02	.22	.07	**.71**	.03
54	.52	.22	.33	.11	.06	.36	.05	.14	.05
55	.41	.07	.29	.09	-.25	.43	.19	.19	.10
56	.09	.46	.06	.12	.00	.00	.06	.10	.11
57	.65	-.02	-.01	-.09	-.06	.06	.10	.34	-.05
58	.14	.03	-.13	.04	.09	.55	.12	.19	-.15
59	**.79**	.03	.11	-.03	-.12	.15	.08	.04	.03
60	.41	.29	.42	.10	-.12	.08	-.00	.33	.01
61	.22	.17	.23	.29	.04	.10	.09	-.01	.03
62	.47	.05	.55	.08	-.02	-.00	.19	.25	.08
63	-.10	.16	.20	.12	.11	.02	.03	.10	.06
64	.13	.16	.39	.30	.27	-.00	.20	-.12	.09
65	.48	.13	.58	-.06	-.15	.03	.11	-.05	.11
66	.17	.29	.55	.15	.01	.10	.13	.03	.06
67	.55	.01	.42	-.01	.01	.04	.12	-.13	-.12
68	-.15	**.69**	.17	.02	.15	-.09	-.04	.15	.14
69	.26	.03	.19	.12	.11	**.67**	.12	.08	.02
70	.45	.15	.13	.15	.16	-.09	.17	.09	-.05

Exemplificatory Q sorts marked in **bold**
Data rounded to two decimal points.

Factor loadings obtained with by-person factor analysis of Locus of Control scores in Study 3

Participant number	Factors						
	1	2	3	4	5	6	7
1	.39	.30	.36	-.02	.11	.05	-.05
2	.18	**.76**	.15	-.03	-.05	.29	.07
3	.13	.50	.20	-.03	-.13	.07	.12
4	.35	.44	-.04	.32	.52	-.05	.32
5	.25	.43	.15	.32	.22	.42	-.07
6	.42	-.00	.18	.31	.20	.23	-.06
7	.37	.48	.16	-.07	.11	.15	-.09
8	.66	.22	-.05	-.13	.23	-.05	.04
9	.01	.27	.51	-.14	-.10	.15	-.32
10	.68	-.03	.24	.03	.14	.23	-.15
11	.25	.30	.55	.08	.26	-.05	.06
12	**.87**	-.13	.02	.03	-.02	.09	.07
13	.35	.06	.14	.06	.08	**.86**	-.10
14	**.87**	.08	-.06	-.13	.14	.10	-.05
15	**.77**	.05	-.02	.22	-.00	-.03	-.02
16	.61	.02	-.00	.07	.03	.21	-.49
17	.60	.08	.02	-.03	.22	.20	.06
18	-.24	**.90**	.08	.10	-.02	-.06	-.01
19	.53	.08	.00	-.01	.29	-.04	-.08
20	.60	-.02	.12	.16	.31	.16	.16
21	.52	.06	-.08	-.01	.10	-.02	.06
22	**.80**	-.15	.29	.10	.09	.11	.04
23	.60	-.10	.41	.11	.06	-.18	.14
24	-.35	.20	.02	.33	-.22	-.00	-.05
25	-.01	.29	.20	.25	**.81**	.10	-.02
26	-.05	.29	.44	.16	.05	.41	.30
27	.18	.49	.35	.45	.07	.11	-.10
28	**.87**	.04	.02	.12	-.05	-.09	-.01
29	.67	.26	.26	.14	.12	-.07	.08
30	.13	.39	-.28	.15	.30	-.13	-.02
31	**.90**	.20	.12	-.04	-.14	.05	-.03
32	.34	.35	.15	.13	.09	.24	.34
33	.51	.51	-.03	.19	.07	.01	.04
34	.47	-.01	.06	-.05	-.02	.32	-.10
35	**.81**	-.10	.29	-.12	.08	-.11	.04
36	**.82**	.08	-.12	.04	-.01	.11	.28
37	.32	.02	.00	.02	.03	-.05	**.81**
38	.36	-.10	.39	-.10	.22	.15	-.02
39	**.83**	.02	.01	-.08	.18	.11	-.08
40	-.16	**.73**	-.16	-.15	.23	-.03	-.08

Factor loadings obtained with by-person factor analysis of Locus o Control scores in Study 3/ cont.

Participant number	Factors						
	1	2	3	4	5	6	7
41	.62	.17	.17	.13	-.17	.21	.00
42	.55	.09	-.12	.02	.23	.01	.27
43	.51	.40	.04	-.05	.03	-.35	.11
44	.38	.12	.21	.10	.01	.13	-.14
45	.03	.50	.11	-.00	.09	.15	.22
46	.72	-.03	.27	-.02	-.05	.14	-.11
47	.15	.41	.01	.69	.23	.04	-.10
48	.93	.09	-.13	-.00	.02	.03	.04
49	.91	-.06	.02	.05	.06	-.03	.07
50	-.11	.80	.04	.16	.03	-.07	-.12
51	.21	.15	.82	.09	.09	.14	.01
52	.61	-.08	.38	.12	.35	.22	.07
53	.21	.12	.47	.12	.38	.10	.00
54	.33	-.08	.15	.27	.12	-.05	-.11
55	.12	.02	-.08	-.03	.04	.08	.13
56	.35	.60	.34	-.00	.23	-.15	.00
57	-.08	.30	-.04	.17	.09	-.03	.12
58	.03	.13	.04	.24	-.03	.02	-.05
59	.23	.56	.15	.16	.31	.14	.06
60	-.14	.05	.23	.75	.17	.05	.15
61	.88	-.24	.11	-.12	.11	.04	.08
62	.75	-.05	.23	.23	.09	-.01	.05
63	.82	-.23	.25	.08	.08	.12	.20
64	.76	.01	.14	.07	-.27	.13	.06
65	.70	.25	-.06	.16	.10	.06	.13
66	.55	.45	-.07	.32	-.03	.13	.00
67	-.39	.75	.08	.07	.00	.10	-.01
68	.04	.80	-.20	.07	.01	-.03	.18
69	.37	.19	.10	.20	.16	.04	.08
70	.42	-.26	.63	.36	-.09	-.03	.02
71	.82	.26	.11	.29	.06	.09	.05
72	.71	-.32	.04	-.04	.09	.31	.25
73	.01	.17	.03	-.01	.07	-.04	-.03
74	.15	.44	-.03	.01	.06	-.01	-.06
75	.53	.04	.16	-.03	.01	.07	.25
76	.89	-.17	.16	.05	-.02	.07	.00
77	.76	.09	.44	.04	-.08	.07	-.09
78	.81	.10	.00	-.24	.10	-.11	-.09
79	.62	.41	.25	.03	.10	-.06	-.02
80	.64	.15	.25	.32	-.18	-.02	.31
81	.46	.15	.05	-.00	-.05	.10	-.14
82	-.04	.58	.14	-.06	.06	-.10	-.02
83	-.06	.22	.19	.10	.11	-.16	-.03

Factor Scores obtained from by-person factor analysis of
IHIQ data

Participant Number	Factors						
	1	2	3	4	5	6	7
1	.68	.05	.19	.25	-.19	.05	.02
2	.10	-.04	.73	.20	-.30	.16	.03
3	.70	.04	.13	.23	-.25	-.01	.07
4	.60	.01	-.16	-.02	.14	-.12	.16
5	.53	.12	.04	.10	.11	-.12	.12
6	.18	.23	-.12	-.07	.63	-.35	.15
7	.56	.08	.04	.10	-.16	-.33	.02
8	.68	.17	.03	.07	-.10	.03	.01
9	.40	.13	.15	.34	-.03	-.02	.10
10	.42	.23	.30	.22	-.04	-.03	.15
11	.59	.19	.20	-.02	-.03	-.02	-.09
12	.55	.20	-.20	-.10	.30	-.05	.30
13	.05	.12	.24	.17	-.01	.15	.07
14	.03	.64	.14	.16	.08	-.12	.07
15	.73	.11	.07	-.09	.08	.16	-.11
16	.18	.10	-.02	.05	-.01	.10	-.09
17	.76	-.04	.08	.01	-.18	.09	.02
18	.18	-.03	.11	.70	-.20	-.26	.16
19	.60	.07	.40	.22	-.03	.03	.10
20	.46	.19	.19	.18	.03	.07	.06
21	.46	.11	-.30	-.14	.24	.12	-.03
22	.17	.51	-.14	-.03	.25	-.15	.39
23	.64	.21	.16	.17	-.15	.09	.12
24	.10	.05	.43	.27	-.06	-.07	.24
25	.63	.07	.16	.19	.20	-.18	.27
26	.20	.17	.58	.08	.03	-.13	-.00
27	.24	.14	.41	.07	.14	.02	.00
28	.41	.20	-.11	-.20	-.00	.11	.24
29	.69	.25	.07	.11	.01	-.14	-.03
30	.44	-.08	.31	.08	.03	.12	.28
31	.49	.29	.10	.22	-.00	.13	-.16
32	.43	.29	.21	.07	-.12	-.01	.16
33	.36	.27	.17	.21	.19	.10	.17
34	.22	.17	.26	.19	-.09	.26	.13
35	.73	-.03	.03	-.09	.06	-.04	-.01
36	.24	.69	-.07	-.02	.21	-.07	.01
37	-.16	.16	-.14	-.08	.66	-.02	-.00
38	.68	.07	.21	.18	.02	-.04	.18
39	.37	.28	.32	.11	-.13	.18	.08
40	.20	.10	.07	.04	-.05	-.08	-.09

Factor Scores obtained from by-person factor analysis of
IHIQ data

Participant Number	Factors						
	1	2	3	4	5	6	7
41	.05	.52	.24	.17	-.13	.19	.16
42	.79	.34	.05	.16	.02	.04	-.04
43	.50	.15	.28	.38	.07	-.03	.02
44	.72	.17	.27	-.00	-.02	.20	.13
45	.57	.01	.17	.09	-.02	.25	.10
46	.78	.16	-.01	.00	.22	-.02	.11
47	-.04	.36	-.02	-.02	-.10	.19	.14
48	.31	.67	.02	-.09	.05	.04	.06
49	.20	.60	.09	.07	.17	-.04	-.13
50	.38	-.20	.31	.30	-.17	.01	-.08
51	.39	-.07	.30	.19	-.24	.39	-.05
52	.77	-.07	-.04	.17	-.00	.17	.07
53	.55	.03	.20	.23	-.12	-.15	.05
54	.60	-.07	.12	.18	-.12	.20	.21
55	-.04	.30	.30	.23	.27	.23	.36
56	.29	.06	.03	.30	-.04	.02	-.00
57	.72	.10	-.04	-.06	-.04	.11	.10
58	.16	.02	.00	-.12	-.11	.61	.22
59	.43	-.02	.13	.30	-.14	-.15	.27
60	.15	.08	.06	.10	.01	.13	.61
61	.70	.24	-.04	-.13	.00	.07	.02
62	.20	.20	.25	.15	.06	.29	.06
63	.25	.39	.17	.04	.09	.12	.36
64	.42	.35	.02	.12	-.05	.17	.13
65	.46	.31	-.12	.05	-.05	.04	.01
66	.54	.19	.09	.17	.07	.17	-.09
67	.08	-.10	.64	.23	-.15	.11	.07
68	.06	.08	.30	.77	.01	.06	.01
69	.25	.21	.20	.15	.09	.10	.08
70	.36	.18	.20	.11	-.18	.17	.21
71	.52	.26	.14	.05	-.04	.10	.17
72	.08	.42	.04	.02	.18	.13	.17
73	.60	.19	.37	.13	-.16	.11	-.04
74	.10	.19	.04	.07	.07	-.02	.12
75	.14	.25	.08	.17	-.06	-.00	-.10
76	.51	.29	.01	-.12	-.08	.15	.24
77	.14	.24	-.02	.06	.06	.11	.00
78	.79	.23	.21	.07	-.00	-.10	.00
79	.23	.18	.31	.43	-.14	.28	.12
80	.44	.19	.33	.03	.03	.08	-.04
81	.24	.07	.13	-.02	-.17	-.03	.21
82	.37	.18	.15	.23	-.07	-.07	-.05
83	.58	.08	.22	.16	-.06	.12	-.03

Factor loadings from Q sort data obtained in Study 3

Q item no :	Factors							
	1	2	3	4	5	6	7	8
1	.37	.19	.41	.55	.20	.05	.04	.07
2	-.17	.39	.50	.26	-.08	.19	.28	.14
3	.36	.08	.45	.60	.01	.10	-.04	.08
4	.44	.03	.31	.22	.44	-.03	-.15	.19
5	.04	.50	.16	.04	.22	.06	.21	.37
6	.42	.07	-.34	-.21	.42	.11	-.15	.11
7	.17	.13	.24	.28	.19	.06	.00	-.03
8	.20	.17	.33	.29	.19	.02	-.00	.03
9	.00	.37	.57	.16	.13	-.05	-.09	.25
10	-.06	**.68**	.05	.23	.10	.04	.18	-.02
11	.29	.21	.56	.13	.09	-.32	-.14	-.06
12	**.81**	-.13	.03	-.01	-.04	.10	-.13	.13
13	.19	.53	.30	-.16	.10	.20	.28	.05
14	.20	.31	-.41	.11	.19	.22	.17	-.03
15	.50	.06	.53	.33	-.28	.07	.06	-.05
16	-.03	**.79**	-.02	.03	-.02	.16	-.05	.02
17	.28	.19	**.69**	.17	.01	.02	.09	-.01
18	-.15	.28	.15	.10	.11	.16	.25	**.77**
19	.17	**.71**	.23	.01	.06	-.04	.15	.17
20	.29	.27	.38	-.03	.37	.08	.12	.02
21	**.61**	.08	.17	-.08	.07	-.04	-.04	-.01
22	.56	.18	.17	.11	.29	.16	-.13	.11
23	.19	.45	.37	.25	.15	.25	.19	.02
24	-.51	.58	.16	.04	-.11	.26	.16	.10
25	.02	-.00	.19	.37	.49	.02	-.02	.31
26	.12	.25	-.09	.24	.23	.20	-.08	.02
27	.34	.51	.09	-.00	-.04	.34	-.03	.13
28	**.65**	.25	.16	.04	-.08	.27	.10	.01
29	.44	.38	.47	.38	.06	.04	.08	.06
30	.05	.43	.12	.03	.00	.03	.58	.10
31	.44	.26	.10	.50	.03	.24	.10	.07
32	-.02	.15	.11	.07	.15	.07	.08	.07
33	.05	.13	-.01	.27	-.22	.05	**.66**	.17
34	.09	**.78**	.08	.11	.14	.12	.15	.21
35	.56	-.10	.32	.27	-.04	-.20	.01	.06
36	**.83**	-.13	-.10	.23	.14	-.05	.15	-.12
37	.46	-.18	-.27	-.15	.23	-.06	-.00	.00
38	.22	.40	.36	.33	.19	-.25	-.06	.04
39	.28	.50	.24	.47	.04	.05	.13	-.00
40	.01	.13	.29	.01	.00	.06	.10	.07

Q item no :	Factors							
	1	2	3	4	5	6	7	8
41	.40	.05	.11	.29	.16	.37	.12	.13
42	.47	.22	.24	.67	-.01	.05	.11	.14
43	-.01	.10	.16	.78	.22	-.06	.23	.02
44	.14	.43	.24	.31	.26	.13	.08	-.03
45	.05	.70	.05	.17	.16	-.00	.03	-.04
46	.44	.36	.30	.28	-.02	.13	.07	-.04
47	.05	.14	-.12	-.12	.04	.85	.03	.10
48	.83	-.08	.08	.17	.07	.04	.04	-.06
49	.66	.11	.15	.06	.33	-.01	-.00	-.11
50	-.25	.30	.59	.23	-.11	.43	.19	.18
51	.09	.32	.73	.15	.11	-.05	.02	.10
52	.47	.17	.55	.24	.10	-.00	-.03	.16
53	.07	.44	.24	.05	.37	.05	-.03	.03
54	.12	.29	.23	.08	.46	-.11	-.03	.24
55	.25	-.08	.03	.15	.51	.00	-.04	-.04
56	.01	.45	.26	.24	-.09	-.16	.45	.08
57	.25	-.04	.58	.09	.14	-.05	-.01	.12
58	.13	.42	.23	.21	.42	.27	-.07	-.14
59	-.01	.34	.11	.16	.01	.08	-.07	.21
60	.04	.23	-.02	.00	.39	.60	.03	-.07
61	.65	.34	.25	-.10	.20	.06	-.03	.10
62	.33	.08	.18	.15	.21	.10	-.15	-.07
63	.44	.32	.10	.07	.52	.34	-.10	.07
64	.39	.19	.03	.38	.10	.39	-.08	.03
65	-.03	.27	.23	.11	.06	.31	.22	.12
66	.04	.22	.33	.46	.46	.33	.03	.06
67	-.23	.54	.43	.22	.08	.19	.21	.21
68	-.12	.17	.22	.33	.16	.18	.36	.13
69	.23	.15	.39	.10	.42	.28	-.13	.24
70	.23	.50	.28	.07	.30	.34	-.04	.05
71	.52	.24	.30	.36	.21	.22	.04	-.04
72	.51	-.09	.12	-.40	.28	.09	.12	-.01
73	.16	-.02	.64	.25	.26	-.14	.31	-.17
74	.33	.31	.16	.30	.28	-.04	.06	.31
75	.48	.07	.03	.24	.16	-.07	-.00	.02
76	.83	.19	-.00	.06	.17	-.06	.08	-.09
77	.25	.10	-.04	.04	.66	.12	-.05	-.06
78	.47	-.01	.34	.55	.04	-.27	-.02	.09
79	.12	.33	.05	.36	-.16	.04	.43	.53
80	.24	.48	.33	.23	-.14	.11	.12	.02
81	-.01	.50	.52	.08	.13	.11	.15	.03
82	-.05	.16	.16	.79	.04	-.12	.15	.05
83	.05	.43	.43	.35	.23	.17	.22	.07

APPENDIX 5

DERIVATION OF Q SORT ITEMS FOR STUDY 2

| ITEM | SOURCE |

1. When it comes to medical treatment, patients should always follow their doctor's advice.

Rewritten from pilot [Item 4]

2. Disease and bodily decay are inevitable aspects of being alive - anyone who tells you different is either a liar or a fool.

Item 5 in pilot

3. Medicine is a science and should be based on rigorous scientific principles.

Item 6 in pilot

4. Many so-called 'mental illnesses' are actually forms of weakness or an inability to face reality.

Item 8 in pilot

5. People are born with a predisposition to be 'sickly', 'robust' or whatever.

Rewritten from pilot [Item 38]

6. Modern theraputic achievements (like heart transplants) are important contributions to progress in health care.

Rewritten from pilot [Item 11]

7. Usually being struck by illness is just a matter of bad luck.

From Health Locus of Control Scale

8. Fringe medicine is a dangerous intrusion on proper health care.

Rewritten from pilot [Item 14]

9. Doctors treat symptoms, not the underlying causes of illness.

Rewritten from pilot [Item 15]

10. Being fit and well depends as much on your state of mind as on the functioning of your body.

From pilot interview

11. We could improve health more in Britain by providing better sports and recreational facilities then by building more and better hospitals.

Rewritten from pilot [Item 17]

12. It is very important to keep yourself and your home clean and hygenic to keep disease at bay.

Rewritten from pilot [Item 20]

13. Many forms of medical treatment today seem to do more harm than good.

Suggested by participant

14. Doctors only recommend surgery when it is really necessary.

Rewritten from pilot [Item 24]

15. When someone is seriously ill, knowing the full truth may not be in their best interests.

Rewritten from pilot [Item 18]

ITEM	SOURCE
16. Many diseases of modern life result from the stressful, polluted, noxious environment in which we live.	Suggested by participant
17. Treating people as 'mentally ill' is often a means by which society controls those who don't conform.	Rewritten from pilot [Item 29]
18. For some people being ill becomes a way of life.	From pilot interview
19. We will only improve the overall health of people in the world when we have found ways to overcome the fundamental injustices between rich and poor.	Rewritten from pilot [Item 30]
20. The ability of the body to heal itself is far greater than most people realise.	Item 31 in pilot
21. Good health is a fundamental human right.	Item 32 in pilot
22. Modern drugs have made a major contribution to fighting disease.	Rewritten from pilot [Item 36]
23. When deciding upon medical treatment it is better to let incurably ill people die with dignity rather than prolong life regardless.	Rewritten from pilot [Item 34]
24. Treatment which uses 'therapy of the mind' (e.g. relaxation or imaging techniques) should be used much more widely.	Suggested by participant
25. Giving birth is a natural process and should not be treated as if it were an illness.	Suggested by participant
26. Often just going to the doctor can make you feel better.	Suggested by participant
27. Being healthy is a lot more than simply not being ill - it has to do with a positive state of wellbeing.	Rewritten from pilot [Item 44]
28. A vegetarian diet is more healthy than one containing meat.	Rewritten from pilot [Item 48]
29. Our experience of 'being ill' is substantially something that we learn.	From Herzlich (1973)

ITEM   SOURCE

30. The 'will to live' can be a   Rewritten from pilot
significant   factor in whether people   [Item 53]
recover from a serious illness or serious
injury.

31. It is quite possible to die of a   Suggested by
'broken heart'.   participant

32. As doctors are commited to preserve   Rewritten from pilot
life, they have a moral duty to support   [Item 49]
Nuclear Disarmament.

33. If people are unpleasant to me, it   From pilot
can have the effect of making me ill.   interview.

34. To be healthy, it is best to live as   From pilot
natural a life as possible.   interview.

35. Doctors don't discover diseases so   From Foucault (1971)
much as invent them.

36. It's a good idea to see illness as a   From Herzlich (1973)
'challenge' - something to be overcome,   'health as an
to fight with all the resources you can   occupation'
muster.

37. I can't help seeing illness as a   Statement made in
'weakness' in myself and in others.   conversation.

38. Basically I define 'health' as an   Suggested by
absence of symptoms. I'm healthy when I   participant
don't have to worry about my body.

39. Health in adulthood depends upon   From pilot
building up a robust constitution when   interview.
you are young.

40. When I'm ill I feel as though in some   Statement made in
way I'm to blame.   TV documentary

41.Many people suffer from illnesses   Rewritten from pilot
caused by their own bad habits.   [Item 9]

42. People who suffer from 'depression'   Rewritten from pilot
are often just responding to the   [Item 52]
intolerable pressures and problems of
their lives.

43. Adequate food, better housing and   From McKeown (1974)
proper drains have done more to improve
our   health   than   all   the   medical
discoveries of the last 100 years.

ITEM	SOURCE

44. We are fortunate to live in a world of medical excellence - skilled surgery, highly trained professional care, etc.

'Converse' of Item 21 in pilot (for balance)

45. Capitalism is inherently anti-health. It puts making profits before the wellbeing and safety of people.

From Navarro (1978)

46. Life is too short and too sweet to spend time worrying over much about what is 'healthy' and what is not.

From pilot interview.

47. Having good health is about the most important thing in life.

Need to see whether salience differs.

48. The worst off in our society have very little choice about the unhealthy lives they lead.

Rewritten from pilot [Item 12]

49. Health is largely a matter of moderation in all things.

From pilot interview

50. Sometimes being struck by illness is a punishment for misdeeds.

From anthropological literature.

51. When I'm ill I don't just feel pain and discomfort, I feel less of a person.

From Herzlich (1973) 'illness-as-destroyer'

52. Lazy people are seldom really healthy.

From pilot interview.

53. Health promotion has become just another fashion - health foods and jogging suits are just more ways to persuade people to spend money.

Suggested by participant

54. A good health service is one which respects people's autonomy even if it puts people at risk.

From Ehrenreich (1978)

55. Being healthy depends a lot on the food you eat.

Suggested by two participants

56. Faith-healing can bring about a cure where conventional medicine fails.

To contrast with Item 24 (ie. spirit vs psyche)

57. I have more important goals in my life than the persuit of optimal health.

Suggested by participant

58. The Government cares more about Tobacco revenues than the health of its people.

Rewritten from pilot [Item 26]

ITEM	SOURCE
59. Recent medical advances (e.g. in contraception and childbirth) have been particularly beneficial to women.	Converse of suggestions by participants (more 'feminist' than pilot Item 43)
60. People should be free to damage their own health (e.g. by smoking).	Suggested by participant
61. People should take responsibility for their own health.	Rewritten from pilot [Item 46]
62. Information about improving our national diet has been suppressed because of lobbying by the Food industry.	Article in newspaper
63. In the future medical science will have eradicated disease.	Converse of statement made in TV documentary
64. The 'work ethic' has a lot to answer for when it comes to people's health.	Comment made in magazine article
65. It is important that all children are given a full set of innoculations.	Suggested by two participants
66. Obesity is an illness and needs to be treated medically.	From pilot interview
67. Dental decay is more a matter of bad luck than poor care of your teeth.	From pilot interview.
68. Too much 'junk food' in childhood can be a serious threat to health.	Suggested by participant
69. Most of the things I enjoy are bad for my health in some way or another.	From pilot interview.
70. For most minor illnesses (like a 'cold') it's better to let nature take its course than seek out medical treatment.	Suggested by participant
71. Medical researchers should be encouraged to look for the underlying causes of so-called spontaneous recovery.	Suggested by participant
72. Drug companies are more concerned with profits than making people well.	Suggested by participant

ITEM	SOURCE
73. Most people have cancer at some time in their life but their body's defences are able to overcome it.	From pilot interview
74. More care about health in adulthood could prevent many of the illnesses of old age.	Statement made in magazine
75. A lot of health problems are caused by people not following their course of treatment properly.	From non-compliance literature
76. I approve of measures like fluoridation of the water supply.	Suggested by participant
77. Far too many drugs are prescribed because people need to feel that their doctor has 'done something' for their illness.	From pilot interview
78. I would prefer to be treated by homeopathy than by conventional medicine.	To tap positive assessment of 'alternative' medicine
79. Technical expertese is far more important in a doctor than personal qualities.	Suggested by participant (converse)
80. We should be doing a lot more about environmental causes of disease (e.g.cancer).	Suggested by participant

APPENDIX 6

EXPERIMENTAL MATERIALS FOR STUDY 2

HEALTH BELIEFS

I am conducting research designed to discover the different kinds of beliefs people have about health and illness. I am trying to find out about a variety of aspects. First, I want to document the range of beliefs held by as many different people as possible. Next I want to see whether there are any systematic differences between the beliefs held by different people who work in the Health Care area, and how these compare with beliefs held by others. And at a later stage in the project I hope to look at the expectations people have about other's beliefs (e.g. what do doctors think their patients believe? What do patients assume their doctor believes?).

Finding the right approach is difficult and my research involves a variety of techniques. I began by interviewing a large number of people (some of you may have been in this group). From these interviews and by reading what other researchers have written about the subject I have derived 80 statements to describe different aspects of health beliefs. What I am asking you to do now is to work on these statements in a variety of ways.

Before I begin setting out what I would like you to do, I need to make clear that my main aim is to get as accurate and as representative an understanding of what people believe as possible. However, some of the tasks are a bit constrained by the way I'm setting about this. Part of your contribution is designed in such a way that I can feed your responses (anonymously) into a data analysis programme on the computer. This will cluster the kinds of statements which seem to go together - the extent to which believing one thing tends, in certain people, to go with another belief. When you work on people's responses like this it inevitably imposes limits upon what they do (you will see later that it forces you sometimes to make quite difficult decisions). Please bear with this. I have done my best to design the rest of the exercise in such a way that it is possible to also make clear why you decide as you do, and what reservations you have had. But if anything worries you or you feel you want to add any comments, please do so, either in writing or by contacting me directly. If you have any problems or want to discuss the research please give me a ring, or send me a note asking me to call you.

Thank you for taking part in the research. I recognise that I am asking busy people to take a fair amount of time to help, and I do appreciate your contribution. Very little research of this kind has been done in Britain, and at the moment what seems to happen is that people assume that certain beliefs are common, or held by particular groups, without any proper basis.

Wendy Stainton Rogers

Wendy Stainton Rogers
Health and Social Welfare Section
The Open University

INSTRUCTIONS FOR TAKING PART IN THE RESEARCH

Please read and follow these instructions carefully. It is important that you complete tasks in the order specified. In pilot tests the whole process was found to take about an hour. Some people found it hard to do with distractions (like small children wanting attention) so you might find it easier to arrange an hour of reasonable peace and quiet before you begin.

Please start with Booklet A. This sets out the 80 statements with a space beside each. You should read through them all and add any comment you like in the spaces. Where there are statements with which you neither agree or disagree, or which present you with problems of any other kind (e.g. you feel ambivalent) please say why. Do feel free to suggest alternative wordings or suggestions for improvements. What you do will depend largely upon the time you have to comment, but do feel completely free to say anything about the items that strikes you as interesting or important.

On the final page are a series of blank spaces. Please use these to add any statements that you feel are left out of my set. That is, if you feel there are any beliefs about health that matter to you and have been left off, this is your opportunity to extend the set for future studies. I would be grateful if you could spend a few moments on this because it is very difficult to cover everything without suggestions from a variety of other people.

Next move on to Booklet B which consists of the materials for completing a Q-sort. This is a technique designed to identify different 'worldviews'. It is an open-ended technique, where different alternative viewpoints are defined by the people participating in the research. Unlike other approaches like attitude scales or questionnaires the researcher with a Q-sort does not define, before the research, what 'types' of people there are, or what particular 'worldviews' are. These emerge by way of the analysis which will take your responses and compare them with others, clustering together people who seem to think alike in terms of the statements which emerge, for them, as most salient. To make this work it is important to fill in the response grid exactly as it is set out for you. Please do conform to the format, even if it is frustrating - otherwise the analysis will not work.

Booklet C is provided for you to fill in after you have completed the Q-sort. It is identical to Booklet A, with statements set out with blank spaces. It is for you to use in two ways. First, there are no "right", or "wrong" interpretations of any of the statements. The Q-sort technique works on the basis of them meanining whatever they 'mean' to you (and allows for this in interpretation). So different people will interpret them in different ways. If one or more of the statements strikes you as having several possible interpretations, please indicate which one you used for the basis of your decision. Next, please add any information you feel is salient to why you put particular statements in particular places in your sort. Don't feel you have to comment on every statement. Just use this booklet to dis-ambiguate or elaborate on anything which you found at all problematic.

When you have completed all three phases of the task, please fill in the participant's information form and send all the booklets back to me. You are welcome to keep the Q-sort items if they are of any use or interest to you.

Thank you once more for your help.

INSTRUCTIONS FOR COMPLETING THE Q SORT

What I'm asking you to do, and why

Enclosed you will find several sheets of paper, on each of which
are numbered statements about health and illness; there are 80
statements in all. These are mostly things that people have said
in interviews, or in comments from a previous Q study, but also
include statements in books, magazines and on TV and radio. Your
task will be to sort them in a way that gives an impression of
how you feel about them. You will also find a further pink
sheet, on which there are numbers marked from -6 through 0 to
+6. To carry out the Q sort you will need to cut all of these
out, so that you have two piles of small bits of paper, one pile
of 54 statements, and one pile of 11 pink numbers. You will also
need a large, clear table or desk - or the floor ! (as the
process takes up a fair bit of space).

Your task will be to sort the statements according to a profile,
from **STRONGEST DISAGREEMENT** (-6) to **STRONGEST AGREEMENT**
(+6). If you look now at the response grid on the back page, you
will see the format of choices. As you will see, the pattern is
such that at the extreme ends you will need to place just three
statements - those with which you feel strongest disagreement at
one end, and those with which you most strongly agree at the
other. In between, you will place increasingly more statements,
in a V shape.

In this way you should be able to give a rough account of your
views about health and illness. I say "rough account" because a
technique like this can only go so far, and cannot represent a
lot of detail, or take account of the "...yes, but..." feelings
we all have about any issue or topic. However, this technique is
is not intended so much to give an accurate picture of just one
person's views, but to be able to compare across people. I use
it to look for patterns of ideas, examining the ways some people
sort in similar ways, and some people sort very differently.

However, two booklets are included to give you the chance to get
your own particular viewpoint across. Booklet A is provided to
enable you to make more personal comments, or explain your
reactions to the statements; and Booklet C provides the
opportunity for you to say why you have put particular
statements in particular places.

Starting to sort

To begin the Q-sort, sort the statements first of all fairly
roughly into three piles like this :

Pile A	Pile B	Pile C
Those statements with which you **disagree**	Don´t know No strong feeling Ambivalent Don´t understand	Those statements with which you **agree**

At this stage it´s probably worth going through the piles a
second time, just to make sure that you are happy with where you
have placed the statements. Include in pile A all of those with
which you disagree, even if only mildly; and in pile C ensure
that there are all the statements with which you agree, even if
your agreement is pretty small. You can go on changing
statements from pile to pile as long as you want, right up to
the end of the sort, but people usually find that the sorting
gets easier later on if they make sure they are fairly happy at
this stage.

Doing the Q sort

When you are satisfied with your three piles, your need for lots
of space arises. Set out the pink numbers in a row in front of
you like this, with plenty of space below :

-6   -5   -4   -3   -2   -1   0   +1   +2   +3   +4   +5   +6

P L E N T Y   O F   S P A C E

Your task from this point on is to sort the statements according
to two considerations. First and foremost, consider the extent
to which you agree or disagree with each one. When a decision
gets hard, however, you should also consider the importance of
the subject matter to your beliefs and opinions - place those
statements that are salient to you before those that are of less
concern.

Now, using the grid on the back page, begin to sort your
statements according to the specified profile. Most people start
by selecting one pile (e.g. Pile A) and chosing from it the
three statements with which they feel strongest disagreement,
placing these under the -5 marker. The object from this point
on is to gradually refine your strength of disagreement by
next selecting four statements to go under -4, then five
statements to go under -3 and so on, working from pile A until
you have used them all up. Then you should move on to pile C,
and in a similar manner first find your three statements of
greatest agreement to put under the +5 marker, moving on in turn
to choices for +4, +3 and so on.

When you have used up all of your statements from piles A and B,
go on to place pile C. Here you should still aim as far as
possible to work from disagreement to agreement. While for some
people the 0 row will be sufficient for all of pile B, for
others you may be using + or   - columns. Some people even find
that their ´agrees´ spread over into the ´disagree´ side or vive
versa. If either of these happens to you, then mark the grid
with lines, to show where your agreement ends, and where your
disagreement starts. But these statements in the middle of the
grid don´t matter so much, and you should not worry over them
for too long. It is the statements at the end that are most
important for comparing your sorting with those of other people.

At the end of your sorting, you should have something in front
of you that looks like this :

Even at this stage if you want to (and have the time) you should
feel free to move the statements around. When, however, you are
reasonably happy with your choices, fill in the grid with the
numbers of the statements. Please note, however, that for the
purposes of the analysis I will carry out on the responses, it
is absolutely crucial that you stick to the format specified by
the grid, with exactly the right number of statements in each
column (i.e. you should not put, say, four statements under the
+5 column, however much you may feel you would like to do so !).

SO PLEASE DO STICK TO THE RIGHT NUMBER OF STATEMENTS IN EACH
COLUMN - OTHERWISE THE COMPUTER WILL SPIT OUT THE DATA, AND I
WILL TEAR MY HAIR OUT !!!

Thankyou very much for helping me with my research, I appreciate
the time and effort required, and your willingness to give me
your support.

Q SORT ABOUT HEALTH AND ILLNESS

NAME ·····················

STRONGEST
DISAGREEMENT <----------- -----------> STRONGEST
AGREEMENT

-6	-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5	+6
(3)	(4)	(5)	(6)	(7)	(9)	(12)	(9)	(7)	(6)	(5)	(4)	(3)
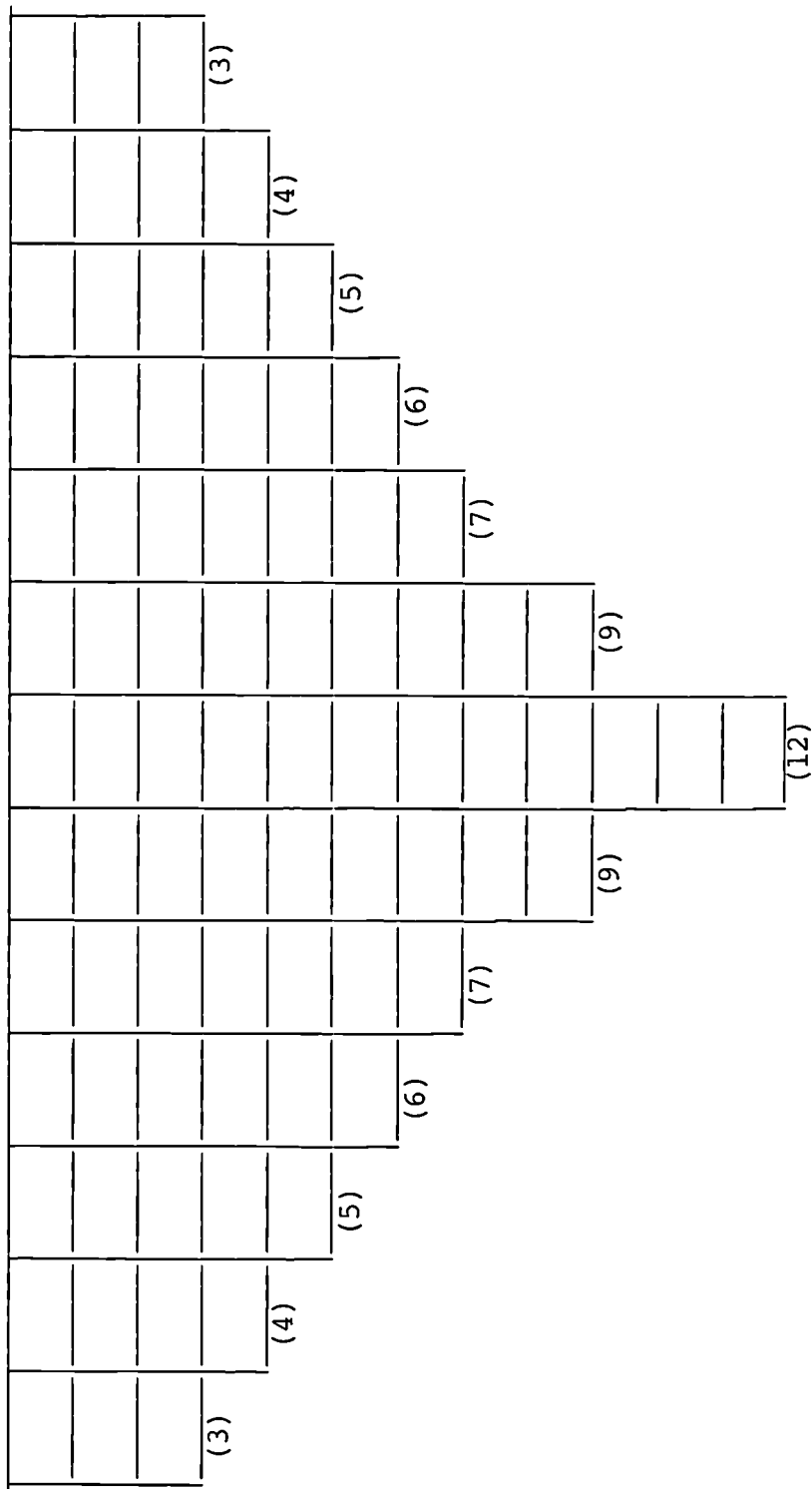
APPENDIX 7

Q EXEMPLAR FEEDBACK MATERIALS USED IN STUDY 2

Q SORT FEEDBACK FORM

NAME..

Please indicate which of the 9 Accounts (derived from the Q sort) is closest to the views you expressed about health and illness in your Q sort. Circle the most appropriate number :

Account 1 2 3 4 5 6 7 8 9

Please say briefly in what ways the description differs from or distorts your viewpoint :

_____

Please add anything here that was left out :

_____

Please comment here about any of the other accounts (e.g. ones with which you feel sympathy, or felt very stongly against :

_____

Please use extra paper if you have a lot to say !
Thankyou once more for your help.

FACTOR ACCOUNTS AS SENT TO PARTICIPANTS FOR COMMENTS

Account 1

Poverty and disadvantage are the most common cause of ill-health, both in our society and in other countries, with the poorest and weakest deprived of the resources to promote health, and forced to live and work in conditions which are unhealthy. Doctors treat symptoms, not the underlying causes of illness. The medical profession is a self-serving hegemony, who place their own professional advancement before the needs of their patients, and who impose their own views, diagnoses and treatments upon people in a patronising and paternalistic manner. Modern medicine makes little contribution to health - more has been achieved by better drains and good housing (in the West) than by any medical discoveries - indeed, many drugs and forms of treatment do more harm than good.

Capitalism is anti-health. Drug companies are more concerned with profits than health; Industry more concerned with production than pollution; the 'Health' Industry more interested in selling expensive food and fashionable jogging suits than actually promoting health itself. Women in particular get the least resources and suffer the most oppression; they have been branded as 'hysterical' and 'weak'; their health problems have been trivialised.

Account 2

Health is to do with the whole person - being ill or well involves mind as well as body, and treatment for illness depends a lot on the warmth, understanding and personal commitment of doctors, most of whom are dedicated to helping others and maintaining high professional standards. The body has tremendous powers to heal itself and function properly; often a doctor's main role is merely to promote this self-healing, letting nature run its course and the body to use its own defences. However, individuals have a lot of control over their own health, and must be encouraged to adopt healthy habits. Anybody can improve their health, given the will to do so.

I object to the notion of applying politics to health - health and politics are quite separate. While it may be true that in countries like Russia mental illness is used as a means of social control that's not true here. Similarly, it is within democratic and free societies like our own that new drugs and improved health care has been made available to all - capitalism promotes health by providing the incentive for new discoveries, and the resources to fund our Health Service.

Account 3

Good health is a fundamental human right; being healthy is a lot more than simply not being ill - it has to do with a positive sense of wellbeing, emotionally and spiritually and well as physically. Good health is extremely important - only when you are healthy can you enjoy what life has to offer. What is more, we each have considerable control over our own health - people can make major improvements in their health by taking sufficient exercise, eating a sensible diet, avoiding too much alcohol, by giving up smoking, and seeking out less stressful lifestyles.

Health education is crucial. The worst off in our society tend to be the least healthy, in part because they have fewer resources (e.g. for good food, adequate housing) in part because poverty is stressful but primarily because they lack knowledge about healthy living and healthy child care. Our Health Service is essentially a good one, though it stresses modern hospital medicine to the detriment of preventive and community care. We need to re-allocate NHS resources, putting less money into unnecessary drugs, high-tech equipment and expensive operations, and more into primary care, education and health promotion.

Account 4

I see the human body rather like a very efficient self-regulating machine which has evolved over millions of years the capacity to mend itself when damaged and fight off attack from invading organisms. Mechanisms like blood clotting, tissue repair and biochemical balance mean that the body continually copes with injury or malfunction, aided by inoculations and other preventive measures. Illness is usually the result of disease organisms or the breakdown of these resources. Modern medicine is able to offer highly effective treatments to fight disease and to repair the body.

I'm suspicious of explanations of illness that attribute personal blame or psychological factors. Often falling ill is a matter of sheer bad luck - being exposed to germs, or accidental damage. We can, though, do a lot to look after ourselves - like having innoculations to support our immune system, or eating wisely to keep the body running smoothly.

Account 5

Health is a product of people's preparedness to look after themselves, take advice, stick to healthy habits and take responsibility for themselves. Although the worst off may not have the opportunities or the education that others have, everyone has a duty to accept responsibility for their own health. Taking responsibility involves being prepared to make an effort to devop healthy habits, and acting in an informed, responsible manner. Doctors must involve their patients, and be much more prepared to explain treatment to them, to ensure co-operation.

We are fortunate to live in a world of medical excellence - skilled surgery, highly trained professional care, effective new drugs and major innovations in treatment. The problem, unfortunately, is that all too often people don't benefit from what modern medical science has to offer because of their subborness, laziness or sheer unwillingness to participate fully in their treatment.

Account 6

Everybody has a right to good health. Unfortunately, our society is one which denies it to many, failing to provide them with the income or the resources to live in a healthy way, and, by a system of private medicine and privilege, offering one standard of health care to the rich, and another to the poor. The worst off must live in housing and work in environments which are unhealthy, and drug companies and the like put profits before the needs of sick people. Illness is the result, more often than not, of disadvantage - people should not be held to blame for being ill, nor see it as a form of weakness.

Modern medicine is something of which we should be proud - it offers the opportunities for people in our society to recieve a high standard of care and treatment when they are ill. The trouble is, particularly now that the NHS is being starved of funds, only a few can benefit from what is available. A far greater proportion of our national resources should go into the NHS, and its system of distribution should be made much more equitable. A good start could be made by spending less on nuclear weapons, and defence in general, and putting the savings into proper health care for all.

Account 7

To understand what constitutes ´health´ and what causes ´illness´ we need to take account of the psychological and social factors involved. Health has as much to do with the mind as the body, and therapies which act upon our psychological side are as likely to be effective as drug treatments or surgical intervention - sometimes better. Indeed, often the reassurance of talking out your symptoms with your doctor can do as much good as any treatment offered; and ´sugar pills´ can work just as well as drugs. Doctors need much more training in psychology and psychotherapy; they also need more contact with the communities in which their patients live, since without this understanding of the social context of illness, the help they can offer is limited.

State of mind has a major impact upon health - depression and worry can lead to illness, whereas a positive outlook can make all the difference to recovery. So yes, we need the support modern medicine can provide; and most medical treatments are useful and effective. But to work best they need to be combined with an understanding of the psychological aspects of illness, and tehniques which muster our psychological resources for recovery and wellbeing.

Account 8

Illness is a function of feeling good about yourself and happy in your relationship with others. Feelings of contentment and happiness promote health and wellbeing; feelings of distress and unhappiness drain the body of its energy and capacity to resist disease, and so lead feelings of ´unwellness´ and, in many cases, actual illness. When people are unpleasant to me, it can have the effect of making me ill; I respond to emotional scenes and rows by feeling unwell, and often actually becoming ill. When I´m ill, I feel less of a person; I also feel, sometimes, in some way to blame - as though I have allowed myself to become ill by being unable to cope with the upsets of life. And yet there is a sense that we can ´want´ to be ill - to get attention, to avoid doing theings we don´t want to do, to ´get a break´ from life and have some time to ourselves.

Account 9

When thinking about health - among other things - my primary consideration is the absolute right of each individual to decide for themselves about matters that affect them. Hence I would want to live in a society in which things like private medicine are available, if that is what somebody wants to buy; where health services are offered, but people are free to refuse them; where people are allowed, if they choose, to take risks with their own health. In fact, I think in Britain we have a very healthy society - much healthier than countries where there may be so called 'egalitarianism' but in fact the opportunities for good health care are less. There people have very little choice, and must accept the treatment the State offers. Here we have the ability to select - to ask for second opinions, to buy whatever expertese we want - and I believe that ability to shop around for the service you want is very desirable. I reject ideas about inequality in health, and deprived people having little choice. We all have a lot of choice about the lives we lead, and many of the worst off in our society could be a lot healthier if they chose to spend their money more wisely, and organise their lives more sensibly.

APPENDIX 8

SAMPLE INTERVIEW FOR STUDY 2

Account 8

<u>Interview with Participant No 53, Study 2</u>   Rose Bentley
(Pseudonym)

<u>Biographical details</u>

Rose was thirty six when I interviewed her, a graduate working part-time as a lecturer in a College of Further Education and a Polytechnic, teaching communication studies and Drama. She was married with two sons of five and seven. She lived ain a large city in the north of England, but had only been there for some three years, although she had also been a student there previously.

<u>Written Comments about Account 8</u>

Rose wrote about this :

Seems to suggest that external factors e.g. viruses are irrelevant - obviously illnesses are frequently caused by external influences. But this description accurately demonstrates my feelings that the <u>way</u> we react to illness can affect the severity of the problem. Add that people have a responsibility to do what they can to look after their health e.g. low chloresterol diet, exercise, not smoking, low alcohol intake, keeping stress levels down. I feel very guilty when I disobey my own rules.

<u>Interview comments</u>

Rose reiterated what she saw as the overemphasis upon emotional factors, and explained her views on emotional aspects thus :

"My feeling is that if there is a cold virus going round you´re probably more susceptible to it if you are in certain conditions, but having said that it´s the cold virus that gives you the snotty nose and the runny eyes etc. ... People, for example, are more likely to catch polio if they have other factors going ... why was it in the old days that some people caught typhoid or cholera from the water supply and some didn´t ?"

However, she gave several graphic descriptions of how emotional upset can make her ill :

"I experience illness in two quite different ways I think. ... Like anybody else, I get the odd cold or cystitis or throat infection, which is mostly, as I said, not a lot more than a matter of catching a bug or being run down, really there´s always going to be a combination of factors involved. And then there are the times when, quite literally, I become ill because of emotion. For example, when I was teaching if I had a class that was being really horrible I would come out and literally throw up. A recent experience of grief literally physically prostrated me - it just laid me out... I´m talking about my father´s funeral where I just collapsed. It was partly physiological in that I´d just had a

double whisky. But it was mainly the fact that I was very distressed and further emotional things on top of that literally prostrated me. There was nothing physically all that wrong with me, I hadn't eaten or drunk more or less than usual.

Interview comments about other accounts

About Account 1, Rose said :

"I have a certain amount of sympathy with that one although I think I actually rated it fairly low because its seems obvious that poverty does cause a lot of illness but the point where I started to diverge from it was that I felt that it was really too strong in that it denies the two things I picked out as being most important which are one's own response to situations and external causes of illness like disease. It's seeing it far too much as external social constructions rather than what actually happens to people themselves. I think that plays a part - that if you tell somebody in a lunatic assylum that they are mad then they are more likely to see themselves as mad, or you go to my doctor and he says 'Oh, I see you are under stress at the moment' that can help to define you as that. But it overemphasises the effect other people can have, and denies the way our own thoughts and feelings are important."

She was also less happy to define the medical profession as an hegemony :

"I have come across some absolute bastards among doctors and among nurses for that matter and some are just power-hungry. But some I have had to do with are superb ... absolutely marvellous with good skills... I think you should not forget that a lot of people that go into medicine do so for very idealistic reasons, they really do believe that they are going to help people ... because they perceive health care as something very valuable, as something very worth doing. I think the danger arises once people get in a position of power - they start to see themselves as others see them, as very important people whose time is very valuable and they stop remembering that they are part of the same human race as their patients... but to lump them all together as all bad is to deny human virtue and medical skills ... I bet somebody like that is actually only too happy to live in a world where they have access to a bit of medical expertise if they broke their leg or had a stomach ulcer ... it's a holier-than-thou sort of opinion, as though they never exploit anybody or take part in power games themselves ... it's naive to think anybody is immune."

About Account 2 she said :

"I remember being absolutely staggered once when I went to the doctor with something recurrent like cystitis and talked about my uniwllingness to have antibiotics again because of the after-effects and he said to me 'Well, it will go away of course by itself'. And that had never occured to me that things could go away by themselves. I'd always considered it as being something that if you have a symptom, then you have to treat it and if you ignore it, it just gets worse. I never thought of it as going away by itself, though I suppose that it does sometimes... but

I'm very frightened of illness, and not very happy to assume that the body will heal itself. But the whole person bit, yes that fits with the way I see health, that there are multiple strands."

She spoke predominantly about psychological and emotional factors, to do with 'willing oneself' well or ill, and suggested a connection between mind and body :

"People can be utterly determined to recover from something and this can - I don't know how it works, but I suspect it triggers chemical impulses or something."

She also spoke of individuals having a lot of control, and linked this to Account 3 :

"Sensible things like not smoking, not drinking too much, taking adequate exercise can actually make a tremendous difference and I think we have a responsibility to ourselves and to our families to do whatever we can to make sure we can stay as healthy as possible ... I feel desperately guilty when I put weight on ... when I don't take as much exercise as I should. I feel very good when I do take exercise ... I mean I feel self-satisfied and good about myself."

Note that even here, emotion slips back into the conversation again :

"Guilt is my central emotion ... I've come to accept that now about myself ... it's guilt to myself, I feel I'm letting myself down."

When asked where the guilt comes from, she replied :

"I think, I'm fairly sure it's from my childhood. It was very strongly instilled that one has strong responsibility, also a religious thing. It goes back to Mother instilling in me at a very early age the principle of service. I did a lot of little services for her as a demonstration of love and it is the single most dangerous thing in my life in that I still see services - cooking, caring for clothes, buying little presents - I see that as my strongest expression of love and it leaves me with the most awful problems with my own life and it means I spend all my time trying to do everything for my family and my friends and even complete stangers and I ... end up doing too much and then I discover I'm not wonderwoman... Only when my mother died did I start to grow up... though I'm still looking, I think, for a replacement for my mother ... I still need to have people who need me... and I still define myself by how much people are nice to me... and within that context, I feel guilty if I don't match up, because if I'm not fit and well, then I need other people to look after me, and I'm not able to look after them ... and so I get frightened."

"... Illness in our family was a sign of weakness... an excuse for not pulling your weight ... Mother got very cross with us when we were ill ... but that was the paradox, and it might explain a lot, if she really really thought you were ill, then of course she waited on you, you got ... all her attention."

She said that she rejected Account 2 predominantly, however,

because of its antagonism to politics :

"Health and politics <u>are</u> quite involved in eachother... politics at the moment in England are making sure that some of the poorest people are getting inadequate health care. Politics mean that people with arthritic hips have to wait three years for an operation ... I think it´s absolutely monstrous."

She said, therefore, that politically her views were best described by Account 6, which she listed as second closest after Account 9. She agreed with its basic approval of modern medicine :

"Having had a lot of experience with the health service over the last ten years I think we are very, very lucky indeed with the kind of care we get ... In the post war period when the health service was set up it had very high ideals to provide proper health care for everybody and I think we are very lucky. We have a very well qualified medical profession in this country who actually practice to very high standards and I think we have a very, very good health service."

And with its stress on inequality of resource allocation :

"I think it´s absolutely scandalous that somebody who is relatively young and articulate can get decent care for their kids and I can, and yet the old and the weak and the frail aren´t able to articulate their needs as well, or who can´t put pressure or who, because theyv´e got a common, low-rated thing like arthritis, they have to wait.... The health service is being sold down the river by the fact that they are not employiong enough surgeons, there are not enough nurses for premature babies, and I think it´s disgusting the waste of resources in this country where qualified nurses are unable to get jobs and acute wards are being shut down because there isn´t the money to pay for the nurses."

Most of the other Accounts received fairly short shrift, and were dismissed with a few words. Account 9 received the most vehement rejection :

"This one struck me as incredibly right wing .. it takes a very narrow view of choice - choice is available to people to the extent that people know there are choices .. if you haven´t got the cash, you havn´t got the choice. People on ´sup ben´ have no choices at all."

Comments on the sources of her views

Rose clearly saw her views as embedded within her biography, as a result of her childhood experiences and upbinging in particular. When I asked her whether she had always seen health in terms of emotion she responded :

"... Yes, it´s always been true. When I was about twelve I can remember a patch when I had dreadful, dreadful headaches ... and it was partly traced to problems with my eyes, but even once I got glasses I was having sort of migraines and headaches and so forth, and it was partly to do with the fact that I was having

problems coming to terms with growing up and sexuality and things, and in the end I had a very thorough talking to by my mother who told me I had to pull myself together and that was it really."

Myself : Did that make a difference ?

Rose :

"I think I - for the first time, I realised that these symptoms I was experiencing were at least in part caused by my attitudes. Before that I thought ´Oh God, I´ve got a headache, I´m ill´. After she said to me ´Now come on, you can´t not go to school every day ´cos you´ve got a headache´ the headache didn´t go away, but I realised that I had to go to school, and of course they eventually wore off."

Myself : Do you get ill if you are angry ?

Rose :

"Oh yes, oh yes. Headaches and feeling sick for days afterwards if I have a row with Alan, my husband. A really stinking row will make me ill for days. My own anger makes me illest ... and it´s not just that way ... I feel really good when I´m happy. I can experience symptoms very similar to being drunk - I can get slightly weepy and lightheaded when I´m really, amazingly happy."

Rose felt she was unusual with the extent to which she experienced emotions as physical symptoma, but commented that she thought most people are "... a lot more like that than they are prepared to accept."

Unlike most of the other interviewees, she said very little about the media even though she read a great deal and saw literature as an important part of her life :

"I suppose that´s it really, I suppose I am most concerned with the individual and how the person constructs the world for themselves ... a concern with ´inner life´."

She did say that her political views were influenced by media including newpapapers (particularly the Guardian) and documentaries, and by her friends who were mostly ´leftwingers´ (she was an active member of the Labour party). But in contrast, say, to Helen (interviewed as a representative of the ´Marxist´ version of Account 1) who placed political analysis first and personal experience a very guarded second source of ideas, Rose spoke of her views as very much determined in the opposite direction - personal experience and feeling as the dominant and most salient, and politics a set of ideas which were ´there´ but a lot less important and ´top of mind´. Indeed she commented that carrying out the Q sort had been instructive in making her think through her ideas :

"It made me think about things I probably havent thought about very much, I´ve articulated things I don´t totally understand about my own thoughts ... I think it demonstrates that I´ve got a sort of rag-bag of ideas that are sometimes in conflict with eachother ... I´ve had the sense, particularly looking at those

descriptions in sort of cold, hard terms of almost sort of 'looking into' my own thinking in a rather objective way so that I can say 'Yes, that makes a lot of sense' or 'That's total crap' and yet I don't have any real understanding of why. "

Perhaps most telling was something said when the interview had officially finished :

"... It also gave me a sense of different situations - I can see myself, say, as I'm getting into a conversation with some bloke at work and arguing about the rip-off of the health service and all that because he's on about, like the description at the end, and well, my feelings about emotion would be irrelevant there, and wouldn't come up... and you could say that I was expressing my opinion, and I would be - they would be things I really did feel... what people's views are differs according to the situation ... what this did was make me able to see my views at the same time, almost as if they were spread out in front of me like a big montage ... and it was a bit disturbing, because all the paradoxes show up by contrast that you keep hidden from yourself ... I have the experience in a way I've never had before that some of the things I think are directly contradictory ... and yet I think them, in all truth, I cannot deny them ... and I find that a bit disturbing."

.

APPENDIX 9

PILOT QUESTIONNAIRE USED FOR STUDY 3

Dear

After what seems like an awful long time finishing off my course production work, I'm now on study leave and able to devote all my energies to my research. I have taken up where I left off, and am now devising a new Q sort questionaire which focusses on people's beliefs about the causes of health and illness - what do they think keeps them well; and what do they think makes them ill ? My aim is to design an instrument that is better than the ones that exist at the moment, and will be useful to people like Health Educators and theorists.

Now that I'm able to concentrate fully, I'm doing the job properly and carrying out a pilot study of the items I intend to use. You will find a list of 48 statements enclosed, and I would be grateful if you would give me some feedback about them. There are four main aspects about which I would appreciate your advice :

1. 'Balance'

With a Q sort questionaire it's important that different people feel able to agree with about half of the items, and disagree with about half, with some in the middle. Could you just say for each statement whether you broadly agree or disagree with it, so that I can get the balance right.

2. Wording

Next, it is obviously essential to make sure the wording of the statements is clear, feels 'right', and the spelling is correct ! Please use the 'comments' space for telling me about any lack of clarity or other problem with the wording. Do feel free to suggest alternative wording if you feel that the idea could be expressed better.

3. Duplication

If you have carried out a Q sort you will know that it gets very difficult when several statements seem to say much the same thing. Would you therefore please say (in the box provided) whether you think any statement is too similar to any other. By and large I have grouped statements together to make this easier for you to do (obviously in the study proper I will mix them all up).

4. Comprehensiveness

It is crucial to cover as many different viewpoints as possible. I have used several other scales and feedback from my last study to do my best to include as wide a variety of different ideas as I can. But it would help a great deal if you could add some more. I have suggested you think up about three extra items - it would help me a lot if you could spend a few minutes doing this at the end.

The statements are set out to make these tasks as easy as possible, and as fast to do as I can make them. Of course I would be delighted if you could give me a bit of your time - but will understand if you cannot. If not, would you be kind enough to return the materials to me in the SEA provided. Many thanks.

Yours sincerely,

HEALTH BELIEFS QUESTIONAIRE : PILOT STUDY

---

1. I feel that when I became ill there are a lot of things I can do to
speed my recovery.

Agree [ ]   Disagree [ ]   . Ambivalent/ Don't know [ ]

Is this item too similar to any others ? Yes - state nos: [   ]

                                           No [ ]
Comments :

---

2. I feel directly responsible for my own health.

Agree [ ]   Disagree [ ]   Ambivalent/ Don't know [ ]

Is this item too similar to any others ? Yes - state nos: [   ]

                                           No [ ]
Comments :

---

3. When I became ill, I'm prone to feel that I'm in some way to blame.

Agree [ ]   Disagree [ ]   Ambivalent/ Don't know [ ]

Is this item too similar to any others ? Yes - state nos: [   ]

                                           No [ ]
Comments :

To save space I have just listed here all of the items in the questionnaire. They were listed three to a page, set out as the first page shown. At the wnd of the questionnaire, additional items were requested.

1. I feel that when I become ill there are a lot of things I can do to speed my recovery.

2. I feel directly responsible for my own health.

3. When I become ill, I'm prone to feel that I'm in some way to blame.

4. My physical wellbeing largely depends on how effectively I take care of myself.

5. The way I live my life now is likely to determine how healthy I will be in the future.

6. My body is my responsibility; in the long run only I can look after it and keep it healthy.

7. I believe that my health is largely the result of the constitution with which I was born.

8. I have a lot of faith in my body's own natural defences against disease.

9. I believe that when I'm ill I can "think myself well again".

10. When I'm ill I see it as a challenge - it's up to me to make up my mind to overcome the illness.

11. I feel I have a lot of power to control my body; wellbeing is largely a state of mind.

12. I tend to see illness as a weakness in myself.

13. My health has a lot to do with my state of spiritual wellbeing.

14. An important way for me to avoid serious illness is to see my doctor regularly.

15. I believe I should consult my doctor regularly whenever I feel ill.

16. I regard my health as dependent on receiving good professional medical care.

17. When I'm ill I seek out the best medical advice and treatment I can get.

18. I feel I should follow my doctor's advice regarding my health.

19. I am grateful for the advice I get from medical experts to help me live a healthy life.

20. Often just going to the doctor can make me feel better.

21. I feel that I have to battle to be healthy within the polluted, competitive and stressful world that others have created.

22. I am wary of seeking treatment or advice from medical professionals who often serve their own needs rather than mine.

23. My health is partly a product of my economic and social position.

24. I believe that if I'm going to get ill, then I will get ill, no matter what I do.

25. Most of the times when I'm ill it's to do with things that happen by chance.

26. When I'm healthy, it's not really to do with anything I do, it's just my good fortune.

27. Like everybody else I have to accept that disease and decay are inevitable aspects of being alive.

28. I believe that whan I'm ill, then this is a punishment for my misdeeds.

29. If it is God's will, then I will stay healthy; if he wills it, I may become ill.

30. For minor illnesses I would rather use an 'over the counter' remedy than go to my doctor for a prescription.

31. To me keeping healthy involves listening to what my body is trying to tell me.

32. I think that living as natural a life as possible is the best way for me to stay healthy.

33. I believe that I could become ill because of a 'curse' or ill-wishing on the part of another person.

34. I believe that faith healing could work for me.

35. I feel there is still a great deal that I don't know about the mysteries of illness and disease which affect my health.

36. I think being unhappy or upset can lead to me becoming ill.

37. Overall I feel that I have the state of health I deserve.

38. A lot of the minor illnesses and pains I suffer are the result of my own bad habits or fail.ure to take care of myself.

39. I feel as though in some ways nature is malevolent -

39. I feel as though in some ways nature is malevolent - disease organsism seem to be able to attack me, no matter what medical treatment I get.

40. I am wary of seeking medical treatment because I don´t like to feel I´m giving up control of my body to someone else. ·

41. Many illnesses are out of my control, or the control of medical treatment - they cannot be ´cured´ or prevented.

42. By maintaining a good state of overall health, I feel that I can help my body fight off disease.

43. I think I have certain inbuilt weaknesses. No matter what I do, there will always be ´weak spots´ which may lead eventually to illness or disability.

44. I believe that when I´m under stress I´m much more vulnerable to becoming ill.

45. I recognise that there are times when I ´use´ illness as an excuse to avoid doing things I don´t want to do.

46. When I´m ill, it´s the care and support I get from my family and friends that helps me get better.

47. My state of health is affected by the way other people look after me.

48. Whether or not I stay healthy depends a lot on what other people do.

APPENDIX 10

Q SORT STRUCTURE AND QUESTIONNAIRE USED TO FURTHER PILOT STUDY 3

HEALTH ATTRIBUTION Q-SORT : PILOT STUDY

The purpose of this questionnaire is simply to test out a series of statements to be used in a Q sort study. In other words, I´m far less interested in your responses themselves at this stage, than getting feedback on the following :

A : BALANCE

Your agree/disagree responses are needed to make sure that the Q statements are reasonably balanced (i.e. people will in general be able to agree with about half, and disagree with about half). My hunch is that there are too many "agrees" at the moment, so I will need to change some items into the converse (e.g. X is not a factor......). But I need some responses from different people to check which ones need to be changed.

B : ENGLISH/COMPREHENSION

This is a structured Q sort (i.e. based upon a matrix of different causes versus different situations). Some slots on the matrix were difficult to fill, and I´m worried that in consequence my expression has been poor. Could you mark any statements that are unclear, or where the English needs improving - where possible, do suggest better alternatives. I enclose a copy of the matrix to help show what I´m trying to do (the items are roughly in order).

Thankyou for your help.

STRUCTURE FOR HEALTH ATTRIBUTION Q-SORT

SITUATIONS/HEALTH STATUS

POSSIBLE FACTORS AFFECTING :-		State of Health	Health Promotion	Becoming ill	Recovery from illness
Self	Body				
	Mind				
	Action				
Chance	Fate				
	Probability				
Agents	Persons				
	God				
	Organisms				
	Environment				
	Circumstances				
	Events				
	Substances				

My present state of health is influenced by the constitution with which I was born.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

I see my body as rather like a machine - how well or badly it is running determines my state of health.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

My physical health and wellbeing are affected by my state of mind.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

Emotional distress can upset my general health.

Agree [ ]   Disagree [.]   Ambivalent/don't know [ ]

My overall state of health has a lot to do with my own actions - how well or badly I take care of myself.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

When my state of health is poor, it is often my own bad habits that are to blame.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

How well or ill I am is largely a matter of luck.

Agree [ ]   Disagree [ ]   Ambivalent/don't know [ ]

Once more I have saved space by simply listing all the items in this questionnaire. They were all set out as the previous page.

My present state of health is influenced by the constitution with which I was born.

I see my body as rather like a machine - how well or badly it is running determines my state of health.

My physical health and wellbeing are affected by my state of mind.

Emotional distress can upset my general health.

My overall state of health has a lot to do with my own actions - how well or badly I take care of myself.

When my state of health is poor, it is often my own bad habits that are to blame.

How well or ill I am is largely a matter of luck.

Some of the time I´m likely to be healthy, some of the time ill. At any point in my life, my state of health is often just a matter of how the probabilities stack up.

The state of my relationships with others - how well or badly I´m getting on with those close to me at a particular point in time - has a significant impact on my state of health.

The care and support I receive from others has an influence on my overall health.

I believe that God watches over my health.

My state of health is considerably influenced by whether or not I´m exposed to infectious or cantagious disease organisms.

The physical conditions of my life (e.g. my working environment, my housing situation) affect my general state of health.

My health and wellbeing are affected by my economic situation.

My state of health at any point in time reflects what is going on in my life - some of the things that happen will improve it, some make it worse.

I believe certain chemicals (e.g. additives in food, pollution in the air) affect my general state of health.

In order to become healthier, I would need to marshall my body´s own natural capacities.

State of mind is a crucial part of my achieving better health - by promoting positive feelings of contentment and fulfillment in myself, I can enhance my state of physical health.

My own actions are crucial to achieving better health - it is something I have to work for.

It's a matter of luck whether or not my health will improve.

Improving my health can never be certain. The best I can do is to change the odds to give myself a greater chance of becoming more healthy.

Whether or not I can achieve better health will be influenced by the quality of advice and support I receive from others.

God has given me the means by which to improve my own health.

When I am exposed to infection, my capacity to achieve better health is impaired.

To improve my health would require improvements in the environment in which I live.

My ability to achieve a better standard of health is affected by whether my life circumstances are helpful or a hinderance.

Being able to improve my health will depend, in part, upon what is going on in my life at the time.

I may improve my health by, say, taking vitamins or changing to a more balanced diet.

I believe I may have certain inbuilt weaknesses which make me vulnerable to particular illnesses or disorders.

When I feel unhappy or under pressure, I'm more likely to become ill.

My falling ill can be a weakness of will - I don't always have the power of mind to fight off disease.

There are times I become ill because of my own bad habits, or failiure to take care of myself properly.

If I'm going to get ill, then I will get ill - it's just the luck of the draw.

Illness is a fact of life - I cannot expect to go through life without ever becoming ill, or without risk of disability.

I believe I could become ill as a result of a curse or ill-wishing on the part of another person.

When others are unpleasant to me, or I get into conflicts with them, it can have the effect of making me ill.

Sometimes the stupid or thoughtless actions of others can lead to me becoming unwell.

There may be times when God sends me ill health for reasons I may not be able to understand.

Illness is often a simple matter of being attacked by disease - nothing more complicated than that.

Crowded conditions (e.g. public transport) can increase the risk of me catching disease.

I can become ill due to an adverse environment - being somewhere that is cold and damp, for example.

Sudden stressful life events (e.g. bereavement, moving house, losing my job) can have the effect of making me ill.

On-going adverse life circumstances (e.g. being poor, or frustrated with my lot) could lead to my becoming ill.

I believe I could become unwell as a result of exposure to noxious substances in the day-to-day environment (e.g. food additives, pollution, industrial waste).

When I'm ill, I have faith in my body's mechanisms to promote recovery, and restore good health.

I see illness as a challenge to be overcome - a determined attitude on my part can speed my recovery.

When I'm ill, there are things I can do for myself which will help me to get better faster.

By taking good care of myself when I'm ill I can help my self get better.

When I'm ill, how rapidly I recover is a matter of chance.

Recovery from illness is, as much as anything, a matter of odds - there's a certain probability I'll get better sooner or later, and a certain probability that I won't.

The 'tender loving care' I get from others has a strong influence on my recovery when I am ill.

When I'm ill, my recovery depends a lot on the quality of medical treatment I may receive.

Where illness is concerned, I believe I should follow medical advice - my recovery will be faster if I comply properly with the treatment I am given.

When I'm ill, sometimes just a chance to talk to the doctor will make me feel better.

I believe that when I am ill, prayer can help my recovery.

The speed of my recovery from an infection depends a lot on the virulence of the disease organisms causing the it.

When I'm ill, my recovery is influenced by the comfort and peacefulness of my surroundings.

My recovery from illness depends a lot on the circumstances in which I'm ill - some would help my recovery, others would make it more difficult.

When I'm ill, my ability to recover will depend in part upon other events in my life (e.g. whether there are other stresses like trouble at work).

When I'm ill, I usually expect to take medicine to help me recover.

APPENDIX 11

EXPERIMENTAL MATERIALS USED IN STUDY 3

THE OPEN UNIVERSITY

June 4th 1986

Dear Participant,

I enclose some materials which you (or somebody on your behalf !) have agreed to complete, to help me with my research into people's beliefs about health and illness. There are basically two questionnaires - one short, one rather long - and a Q sort, which is similar to a questionnaire, but involves sorting statements into a grid (full instructions are given).

I recognise that these are fairly time-consuming, and do appreciate your willingness to help. I am able to offer you a payment of £5.00 in recognition of your time - not a lot, I'm afraid, but all our Departmental Research Budget will stand. Please indicate on the form provided in what way you would like this sent (Book token etc.). Please would you return the following to me :
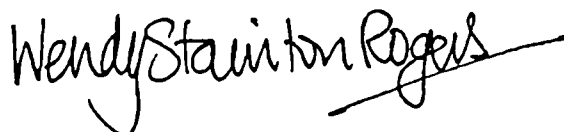
1. The Control of Health Questionnaire
2. The Influences on Health and Illnesses Questionnaire
3. The two Q sort response forms
4. The participant's details form

I am working to a very tight schedule, and so would appreciate their return by Tuesday June 23rd. A stamped addressed envelope is enclosed. I intend to have the study written up by the end of July, and will be pleased to send you a report of the findings then, if you would like it.

On each questionnaire I say rather grovellingly "Thank you very much" for all your time and effort. These thanks are genuinely heartfelt; the kind of research I do would be completely impossible without the help of people like you, and a willingness to find time in a busy life to contribute to another person's work (it's always the busy people who have the most interesting views, and so get asked to help !). I hope you feel that your time is well spent. My hope is that by documenting the vast variation in beliefs and perspectives, I can make some impact upon our understanding of an important topic - and even possibly offer some contribution to the

training of professionals, and an improvement in health care. Just a final point, for those of you who don't really approve of questionnaires, and feel they are attempts to pigeon hole people. The way that the data is analysed is one which does not do that - it separates out different viewpoints, but does <u>not</u> try to categorise you (or anybody else); and the results that arise are used in conjunction with other methods (such as interviews and group discussions) to give a more rounded picture.

Yours sincerely

Wendy Stainton Rogers
Lecturer in Health and Social Welfare

1. I believe I may have certain inbuilt weaknesses which make me vulnerable to particular illnesses or disorders.

9. I have little faith that the advice I may get from the medical profession can help very much in improving my health.

2. When I'm ill enough to consult a doctor, my recovery will be faster if I comply properly with the advice and treatment I get.

10. When I'm ill, I usually feel as though I'm in some way to blame.

3. My becoming ill is seldom, if ever, the result of exposure to noxious substances in the day-to-day environment (e.g. food additives, pollution, industrial waste).

11. If I were ever seriously ill, I would have a lot of faith in the ability of doctors to find a cure.

4. To improve my health would require improvements in the environment in which I live.

12. My state of health at any time is considerably influenced by whether or not I've been exposed to infectious or contagious disease organisms.

5. I see my body as rather like a machine; how well or badly it is running determines my state of health.

13. I believe I could become ill through a curse or ill-wishing on the part of another person.

6. When I'm ill, my recovery is influenced by the quality and comfort of my surroundings.

14. State of mind is a crucial part of my achieving better health – by promoting positive feelings of contentment and fulfillment in myself, I can enhance my state of physical health.

7. Some of the time I'm likely to be healthy, some of the time ill. At any point in my life, my state of health is often just a matter of how the probabilities stack up.

15. When I'm ill, whether I get better quickly or slowly is largely a matter of luck.

8. I usually expect to take medicine to help me recover from illness.

16. The physical conditions of my life (e.g. my working environment, my housing situation) do not affect my general state of health.

17. Try as I may, there is nothing I can do that I can be certain will improve my health. The best I can do is to change the odds to give myself a greater chance of becoming more healthy.

25. In order to become healthier, I would need to marshal my body's own natural capacities.

18. The state of my relationships with others - how well or badly I'm getting on with those close to me at a particular point in time - has a significant impact on my state of health.

26. My falling ill can be a weakness of will - I don't always have the power of mind to fight off disease.

19. God has given me the means by which to improve my health.

27. I cannot improve my health by 'tonics' or taking extra vitamins.

20. When I'm exposed to infection, my capacity to achieve better health is impaired.

28. If I'm going to get ill, then I will get ill - it's just the luck of the draw.

21. How well or badly I look after myself generally has an influence on my overall health.

29. Illness is a fact of life - I cannot expect to go through life without ever becoming ill, or without risk of disability.

22. My ability to achieve a better standard of health is affected by whether my life circumstances are helpful or unhelpful.

30. When others are unpleasant to me, or I get into conflicts with them, it can have the effect of making me ill.

23. When I feel unhappy, I'm more likely to become ill.

31. The speed of my recovery from an infection depends a lot on the virulence of the disease organisms causing it.

24. My state of overall health is in part a product of my economic resources - how "well off" or "badly off" I am.

32. It's a matter of luck whether or not my health will improve.

33. Being exposed to crowded conditions (e.g. public transport) can lead to me catching disease.

41. Emotional distress can upset my general health.

34. The constitution with which I was born has little if any influence on my day to day state of health.

42. When my state of health is poor, it is often my own bad habits that are to blame.

35. I believe that God watches over my health.

43. When I'm ill, sometimes just a chance to talk to the doctor will make me feel better.

36. Sometimes when I get ill, it's a result of long-term pressures in the circumstances of my life.

44. Recovery from illness is, as much as anything, a matter of odds - there's a certain probability I'll get better sooner or later, and a certain probability that I won't.

37. When I'm ill, I have faith in my body's mechanisms to promote recovery, and restore good health.

45. Illness is often a simple matter of being attacked by a disease - nothing more complicated than that.

38. Sudden stressful life events (e.g. bereavement, moving house, losing my job) can sometimes have the effect of making me ill.

46. My overall state of health has a lot to do with my own day to day actions - I can allow myself to get run down, or take steps to keep healthy.

39. I see illness as a challenge to be overcome - a determined attitude on my part can speed my recovery.

47. My recovery from illness depends a lot on the circumstances in which I'm ill - some would help my recovery, others would make it more difficult.

40. When I'm ill, there is very little that I can do for myself which will help me to get better faster.

48. My state of health at any point in time reflects what is going on in my life - some of the things that happen will improve it, some make it worse.

49. Maintaining my health is somewhat of an uphill struggle, given the polluted, stressful, exploitative society in which we live.

57. I don't believe that my health is very much affected by chemicals such as additives in food, or pollution.

50. I feel I have the state of overall health I deserve.

58. My own actions are crucial to achieving better health - it is something I have to work for.

51. Sometimes I get ill because of my own stupid behaviour.

59. Sometimes the stupid or thoughtless actions of others can lead to me becoming unwell.

52. When I'm ill, my recovery depends a lot on the quality of medical treatment I may receive.

60. How well or ill I am is seldom, if ever just a matter of chance.

53. My physical health and wellbeing are affected by my state of mind.

61. The 'tender loving care' I get from others when I'm ill can make all the difference to whether I make a full recovery or not.

54. Being able to achieve a better standard of health is not really influenced at all by what is going on in my life at the time.

62. Often for me, feeling truly fit and well, and feeling truly happy are much the same thing.

55. There may be times when God sends me ill health for reasons I may not be able to understand.

63. There are times when I think I become ill because of deep-seated worries of which I am not consciously aware.

56. The care and support I receive from others has an influence on my overall health.

64. I believe that there are people with the powers of a "healer", who could cure me were I to become ill.

65. With minor illnesses, I think that I will do far better to let 'nature take its course' than seek out medical treatment.

73. Illness can be caused by the external environment - my being somewhere that is cold and damp, for example.

66. My health is my own responsibility.

74. A lot of the time when I am ill, I use my own common sense to work out what to do to treat it.

67. Major stresses in my childhood have shown up as illness in my adult life.

75. I think good health has more to do with living a satisfying and fulfilling life than being obsessive over things like exercise and diet.

68. I feel I have a right to chose whether or not to act in ways that harm my health (e.g. work too hard, or smoke).

76. I believe that faith healing could work for me.

69. Stress only makes me ill when I'm "down"; when I'm feeling full of energy and/or content, I can ride it out with no ill effects.

77. By attuning myself to nature itself - to the "power for good" in the Universe, I can improve my health.

70. Where certain forms of illness are concerned, I would seek help from competent practitioners in 'alternative' medicine.

78. Being healthy is a product of lifestyle as a whole - only by living a healthy lifestyle can I ensure that I'm fit and well.

71. No amount of praying on my part could physically affect my recovery, if I was ill.

79. For me illness can sometimes be a way of withdrawing from life or my responsibilities.

72. When I'm ill, my ability to recover will depend very little upon other events in my life (e.g. whether there are other stresses like trouble at work).

80. When I'm ill, I believe I should seek deep within myself for the reason - by tackling the inner motivations and pressures, I can find ways to get better.

−5 3 statements	**+5** 3 statements
−4 5 statements	**+4** 5 statements
−3 7 statements	**+3** 7 statements
−2 9 statements	**+2** 9 statements
−1 10 statements	**+1** 10 statements
0 12 statements	

PARTICIPANT'S DETAILS FORM

The following information is useful, but not essential. You may simply insert a pseudonym and any address to which your token can be sent if you prefer. However, all personal details will be strictly seen by me alone, and no published report will mention names, or tie your responses to you personally.

NAME...

Male [ ]   Female [ ]

OCCUPATION (if applicable)...

Under   [ ]   [ ]   [ ]   [ ]   [ ]

ADDRESS...

....

....

Any information which you consider to be important to your views - from membership of a particular professional group, to deep religious faith.

Have you suffered from any serious
illnesses, or disability ? If so,
please give details.

Would you consider yourself
generally in good health at
the present ? If not, please
give details.

WOULD YOU LIKE YOUR £5 IN THE FORM OF :

Book Token [ ]   Record Token [ ]   Boots Voucher [ ]

Q SORT RESPONSE FORM - EXPLANATIONS

It is very helpful when interpreting the different viewpoints to know why somebody feels strongly about a particular statement. Therefore would you be kind enough just to write a few words about your three choices for the STRONGEST DISAGREE and STRONGEST AGREE placements. If you want to make any comments about any other statements (e.g. if you found the wording ambiguous, or didn't feel you understood what it was getting at) please use the back of this page. Please don't forget to give the statement number for reference.

-5 STRONGEST DISAGREEMENT

Statement
number...................

-5 STRONGEST DISAGREEMENT

Statement
number...................

-5 STRONGEST DISAGREEMENT

Statement
number...................

+5 STRONGEST AGREEMENT

Statement

number...................

+5 STRONGEST AGREEMENT

Statement
number...................

+5 STRONGEST AGREEMENT

Statement
number...................

YOUR NAME ....

Q SORT RESPONSE FORM

Name ....

Now please complete the matrix, inserting the statement numbers of the choices you have made in each column. Please ensure you have the right number of statements in each. Thankyou.

<--- STRONGEST DISAGREEMENT ------------------ STRONGEST AGREEMENT --->

-5	-4	-3	-2	-1	0	+1	+2	+3	+4	+5

CONTROL OF HEALTH QUESTIONNAIRE

This questionnaire has been designed to discover people's views about what controls their health and illness. It consists of 36 statements, and all you have to do is tick just <u>one</u> of the boxes on the scale for each item, indicating your views. For example :

	STRONGLY DISAGREE				STRONGLY AGREE	
1. If I get ill, it is my own behaviour which determines how soon I get well again.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

If you **strongly agreed** with this statement you would put a tick in the far right hand side box like this :

	STRONGLY DISAGREE				STRONGLY AGREE	
1. If I get ill, it is my own behaviour which determines how soon I get well again.	[ ]	[ ]	[ ]	[ ]	[ ]	[✓]

If you, however, strongly disagree you would tick the far left hand side box like this :

	STRONGLY DISAGREE				STRONGLY AGREE	
1. If I get ill, it is my own behaviour which determines how soon I get well again.	[✓]	[ ]	[ ]	[ ]	[ ]	[ ]

However, if your disagreement was mild, you should tick a middling box like this :

	STRONGLY DISAGREE				STRONGLY AGREE	
1. If I get ill, it is my own behaviour which determines how soon I get well again.	[ ]	[ ]	[✓]	[ ]	[ ]	[ ]

That's all there is to it. Please just make sure of three things. First, don't confuse the agree/disagree - make sure that your tick says what it is meant to say (it's all too easy to get them the wrong way round). Second, make sure all your ticks <u>are in the boxes</u> not between them; otherwise it is difficult to compare responses between people. Finally, do try as far as possible to use the full range - include the extremes as well as the middling boxes, to discriminate well between your feelings about the different statements. Thanks for your help.

	STRONGLY DISAGREE					STRONGLY AGREE

1. If I get ill, it is my own behaviour which determines how soon I get well again.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

2. Following doctor's orders to the letter is the best way for me to stay healthy.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

3. When I become ill, it's a matter of fate.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

4. I can pretty much stay healthy by taking good care of myself.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

5. Whenever I don't feel well, I should consult a medically trained professional.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

6. My family has a lot to do with my becoming ill or staying healthy.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

7. Luck plays a big part in determining how soon I will recover from an illness.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

8. Having regular contact with my doctor is the best way for me to avoid illness.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

9. Even when I take care of myself, it's easy to get ill.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

10. The type of care I receive from other people is what is responsible for how well I recover from an illness.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

11. My good health is largely a matter of good fortune.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

12. When I feel ill, I know it is because I have not been taking care of myself properly.   [ ]   [ ]   [ ]   [ ]   [ ]   [ ]

	STRONGLY DISAGREE				STRONGLY AGREE	
13.If I take care of myself, I can avoid illness.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
14.I can only maintain my health by consulting health professionals.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
15.No matter what I do, I'm likely to get ill.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
16.If I take the right actions, I can stay healthy.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
17.Health professionals help keep me healthy.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
18.No matter what I do, if I'm going to get ill, I will get ill.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
19. My physical well-being depends on how well I take care of myself.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
20.When I'm ill, I just have to let nature run its course.	[ ]	[ ]	[ ].	[ ]	[ ]	[ ]
21.Most things that affect my health happen to me by accident.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
22.Whatever goes wrong with my health is my own fault.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
23.I am in control of my health.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
24.Other people play a big part in whether I stay healthy or become ill.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

	STRONGLY DISAGREE					STRONGLY AGREE
25.When I get ill, I´m to blame.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
26.I am directly responsible for my own health.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
27.Health professionals control my health.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
28.If it´s meant to be, I will stay healthy.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
29.The main thing which affects my health is what I do myself.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
30.It seems that my health is greatly influenced by accidental happenings.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
31.When I recover from an illness, it´s usually because other people (for example, doctors, nurses, family,friends) have been taking good care of me.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
32.When I stay healthy, I´m just plain lucky.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
33.If I see an excellent doctor regularly, I am less likely to have health problems.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
34.Often I feel that no matter what I do, If I´m going to get ill, I will get ill.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
35.Regarding my health, I can only do what my doctor tells me to do.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
36.If I became ill, I have the power to make myself well again.	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

YOUR NAME ....

INFLUENCES ON HEALTH AND ILLNESS QUESTIONNAIRE

This questionnaire is designed to discover your views about whether or not a variety of things influence four main aspects of health and illness :

* Your current state of health
* Your capacity to become healthier in the future
* Whether or not you become ill
* When you do become ill, how quickly and effectively you recover

These four aspects are set out in order, with a list of many different thing that might or might not exert and influence. For example :

MY CURRENT STATE OF HEALTH	EXERTS NO INFLUENCE AT ALL						EXERTS A STRONG INFLUENCE
The constitution with which I was born	0 +1 +2 +3 +4 +5 +6 +7						

All you have to do is circle one of the numbers from 0 to +7 to indicate whether or not you think, in this case, your present state of health is influenced by the constitution with which you were born. If you think it has no influence at all, you would circle the 0. A small influence might be +1 or +2; a strong influence +5 or +6. If you think constitution is a crucial determining factor, you would circle +7. There are 124 statements like this to go through, and you should circle just one number for each one. Work through fairly quickly - usually with questionnaires like this first thoughts are fine - and anyway, with so many, you would become utterly frustrated if you pondered too long over them. Do write comments if you want to explain or qualify your answer - though don't feel you have to do so unless you want to.

One or two of the categories need some explanation. Environment, which comes up several times, is to do with simple physical conditions - things like heating, lighting, physical space, dampness. Circumstances are to do with a broader range of more complex things - from how well off or poor you are to the organisational pressures of your job. Note that relationships are dealt with separately. On a couple of occasions a separation is made between home and work. If you are currently not in paid employment, make a brief note beside the 'work' questions, and answer in terms of the impact upon you of not having paid work (e.g. of the demands of your job of homemaking or child care; or the impact of unemployment). 'Just probability' is a difficult one to explain. It is intended to draw a distinction between the aspects of "chance" that have to do with luck and fortune (dealt with separately) and "chance" in terms of finite odds - the idea that we all run risks in the hurly burly of life (of accidents, contact with somebody suffering from a highly contagious disease) and 'just probability' indicates this aspect of chance.

With questionnaires like this, the responses people make are much more helpful and meaningful if all of the categories are used some of the time (i.e. 0 and +7 as well as the middling responses). So please do try

to work across the scale as a whole, and spread your responses right over the full range.

Just finally, this questionnaire is a genuine attempt to find out what different people think - there are no "right answers" and no "trick questions". Please feel free to respond just how you see things, and don't worry about what other people might think, or whether you are "getting the responses right". The research is based upon the notion that there are a wide variety of <u>different</u> but <u>equally valid</u> viewpoints about the influences on health and illness, and is designed to try to document each of these viewpoints as accurately and sympathetically as possible.

Thankyou for your help. The time and effort you put into this questionnaire is genuinely appreciated, and will contribute - I hope - to a better understanding of this important topic.

MY CURRENT STATE OF HEALTH	EXERTS NO INFLUENCE AT ALL						EXERTS A STRONG INFLUENCE
1.The constitution with which I was born	0	+1	+2 +3 +4 +5	+6 +7			
2. My body's natural defences	0	+1	+2 +3 +4 +5	+6 +7			
3.My state of mind	0	+1	+2 +3 +4 +5	+6 +7			
4.My emotions	0	+1	+2 +3 +4 +5	+6 +7			
5. 'Inner forces' of my psyche	0	+1	+2 +3 +4 +5	+6 +7			
6.Whether I feel 'on top' of my life, or pressured by it	0	+1	+2 +3 +4 +5	+6 +7			
7.Everyday behaviour (e.g. getting enough sleep; eating spasmodically)	0	+1	+2 +3 +4 +5	+6 +7			
8.My overall life-style	0	+1	+2 +3 +4 +5	+6 +7			
9. 'Taking good care of myself'	0	+1	+2 +3 +4 +5	+6 +7			
10.Whether or not I'm actively taking action to be healthy (e.g. monitoring my diet, exercise etc.)	0	+1	+2 +3 +4 +5	+6 +7			
11.Good or bad luck	0	+1	+2 +3 +4 +5	+6 +7			
12.Simple probability	0	+1	+2 +3 +4 +5	+6 +7			
13.The society in which we live in Britain	0	+1	+2 +3 +4 +5	+6 +7			
14.The culture within which I live	0	+1	+2 +3 +4 +5	+6 +7			
15. The weather	0	+1	+2 +3 +4 +5	+6 +7			

MY CURRENT STATE OF HEALTH	EXERTS NO INFLUENCE AT ALL							EXERTS A STRONG INFLUENCE
16. My relationships with family and friends	0	+1	+2	+3	+4	+5	+6	+7
17. The care of medical professionals	0	+1	+2	+3	+4	+5	+6	+7
18. Whether there is somebody 'ill wishing' me or not	0	+1	+2	+3	+4	+5	+6	+7
19. God, or some other supernatural power	0	+1	+2	+3	+4	+5	+6	+7
20. Whether or not I have been exposed to infectious organisms	0	+1	+2	+3	+4	+5	+6	+7
21. My home environment	0	+1	+2	+3	+4	+5	+6	+7
22. My working environment	0	+1	+2	+3	+4	+5	+6	+7
23. The circumstances of my home-life	0	+1	+2	+3	+4	+5	+6	+7
24. The current circumstances at work	0	+1	+2	+3	+4	+5	+6	+7
25. Particular events in my life at this time	0	+1	+2	+3	+4	+5	+6	+7
26. Whether or not I am being exposed at present to certain substances (e.g. pollution;additives in food)	0	+1	+2	+3	+4	+5	+6	+7
27. My age	0	+1	+2	+3	+4	+5	+6	+7

MY CAPACITY TO BECOME HEALTHIER IN THE FUTURE	WOULD EXERT NO INFLUENCE AT ALL						WOULD EXERT A STRONG INFLUENCE
28.The constitution with which I was born	0	+1	+2	+3	+4	+5	+6	+7
29.My current state of health	0	+1	+2	+3	+4	+5	+6	+7
30.Marshalling my body's own strengths	0	+1	+2	+3	+4	+5	+6	+7
31.Promoting a positive attitude	0	+1	+2	+3	+4	+5	+6	+7
32.Actively seeking out things that make me happy	0	+1	+2	+3	+4	+5	+6	+7
33.Tackling any unresolved inner conflicts	0	+1	+2	+3	+4	+5	+6	+7
34.Taking charge of, and responsibility for my own life	0	+1	+2	+3	+4	+5	+6	+7
35.Changing my day to day behaviour	0	+1	+2	+3	+4	+5	+6	+7
36.Actively changing to a more healthy lifestyle	0	+1	+2	+3	+4	+5	+6	+7
37.Giving up unhealthy habits (e.g. smoking)	0	+1	+2	+3	+4	+5	+6	+7
38. The weather	0	+1	+2	+3	+4	+5	+6	+7
39.Good or bad luck	0	+1	+2	+3	+4	+5	+6	+7
40.Simple probability	0	+1	+2	+3	+4	+5	+6	+7

MY CAPACITY TO BECOME HEALTHIER IN THE FUTURE	WOULD EXERT NO INFLUENCE AT ALL						WOULD EXERT A STRONG INFLUENCE
41. Improvements in my relationships with family and friends	0	+1	+2 +3 +4 +5	+6	+7		
42. Getting advice from friends and family	0	+1	+2 +3 +4 +5	+6	+7		
43. Getting advice from books or leaflets	0	+1	+2 +3 +4 +5	+6	+7		
44. Seeking out preventitive medical services (e.g. getting blood tests, going to a "Well Person" clinic	0	+1	+2 +3 +4 +5	+6	+7		
45. Getting advice from my doctor or health visitor	0	+1	+2 +3 +4 +5	+6	+7		
46. Getting advice from a practitioner of alternative medicine	0	+1	+2 +3 +4 +5	+6	+7		
47. Getting medical treatment	0	+1	+2 +3 +4 +5	+6	+7		
48. My age	0	+1	+2 +3 +4 +5	+6	+7		
49. God's power or influence	0	+1	+2 +3 +4 +5	+6	+7		
50. Any other supernatural influence	0	+1	+2 +3 +4 +5	+6	+7		
51. Whether or not I am exposed to infectious organisms	0	+1	+2 +3 +4 +5	+6	+7		
52. Improvements in my home environment	0	+1	+2 +3 +4 +5	+6	+7		

MY CAPACITY TO IMPROVE MY HEALTH IN THE FUTURE	WOULD EXERT NO INFLUENCE AT ALL						WOULD EXERT A STRONG INFLUENCE
53. Improvements in my working environment	0	+1	+2 +3 +4 +5				+6 +7
54. Improvements in my circumstances at home	0	+1	+2 +3 +4 +5				+6 +7
55. Improvements in the circumstances in which I work	0	+1	+2 +3 +4 +5				+6 +7
56. Particular events - what happens in the future	0	+1	+2 +3 +4 +5				+6 +7
57. Whether or not I'm exposed to certain substances (e.g. pollution)	0	+1	+2 +3 +4 +5				+6 +7
58. Taking vitamins or a tonic	0	+1	+2 +3 +4 +5				+6 +7

WHETHER OR NOT I BECOME ILL

59. The constitution with which I was born	0	+1	+2 +3 +4 +5				+6 +7
60. If my body's own natural defences become weakened or break down	0	+1	+2 +3 +4 +5				+6 +7
61. If my state of mind becomes negative, feelings of powerlessness	0	+1	+2 +3 +4 +5				+6 +7
62. Feeling unhappy	0	+1	+2 +3 +4 +5				+6 +7
63. Inner conflicts of my psyche making themselves felt	0	+1	+2 +3 +4 +5				+6 +7
64. Behaving in stupid ways (e.g. not getting enough sleep, working too hard)	0	+1	+2 +3 +4 +5				+6 +7

WHETHER OR NOT I BECOME ILL	WOULD EXERT NO INFLUENCE AT ALL					WOULD EXERT A STRONG INFLUENCE		
78.Living in a poor environment (e.g. damp or crowded housing)	0	+1	+2	+3	+4	+5	+6	+7
79.Working in a poor environment (e.g. bad lighting or with noxious chemicals)	0	+1	+2	+3	+4	+5	+6	+7
80.Stressful conditions at home (e.g. bad conflicts between other members of the household)	0	+1	+2	+3	+4	+5	+6	+7
81.Stressful conditions at work (e.g. too much work, threats of redundency)	0	+1	+2	+3	+4	+5	+6	+7
82.Stressful, nasty or unsettling events in my life	0	+1	+2	+3	+4	+5	+6	+7
83.Major pleasant life changes (e.g. getting married, being promoted)	0	+1	+2	+3	+4	+5	+6	+7
84.Exposure to harmful chemicals (anything from pollution to other people's cigarette smoke)	0	+1	+2	+3	+4	+5	+6	+7
85.Other people's stupid actions (e.g. visiting me with a bad cold).	0	+1	+2	+3	+4	+5	+6	+7
86.Inbuilt weaknesses or susceptibility to particular diseases (e.g. Having a 'weak chest')	0	+1	+2	+3	+4	+5	+6	+7
87.The virulence of the infective organism	0	+1	+2	+3	+4	+5	+6	+7
88. The weather	0	+1	+2	+3	+4	+5	+6	+7
89. My age	0	+1	+2	+3	+4	+5	+6	+7

WHETHER OR NOT I BECOME ILL	WOULD EXERT NO INFLUENCE AT ALL						WOULD EXERT A STRONG INFLUENCE
65.Adopting a life-style that is unhealthy	0	+1	+2	+3	+4	+5	+6	+7
66.Bad luck	0	+1	+2	+3	+4	+5	+6	+7
67.Simple probability	0	+1	+2	+3	+4	+5	+6	+7
68.Rows or conflicts with family or friends	0	+1	+2	+3	+4	+5	+6	+7
69.Rows with people at work	0	+1	+2	+3	+4	+5	+6	+7
70.Lack of proper medical care	0	+1	+2	+3	+4	+5	+6	+7
71.The ill-effects of poor medical treatment	0	+1	+2	+3	+4	+5	+6	+7
72.Uncaring or unsympathetic treatment by my doctor	0	+1	+2	+3	+4	+5	+6	+7
73.God's will	0	+1	+2	+3	+4	+5	+6	+7
74.Other supernatural influences	0	+1	+2	+3	+4	+5	+6	+7
75.A curse or ill-wishing	0	+1	+2	+3	+4	+5	+6	+7
76.Something at home or work that I can avoid by being ill	0	+1	+2	+3	+4	+5	+6	+7
77.Whether or not I have been exposed to infectious organisms	0	+1	+2	+3	+4	+5	+6	+7

WHEN I AM ILL, HOW QUICKLY AND EFFECTIVELY I RECOVER	WOULD EXERT NO INFLUENCE AT ALL					WOULD EXERT A STRONG INFLUENCE		
90. Getting 'back to normal' as soon as possible	0	+1	+2	+3	+4	+5	+6	+7
91. Finding ways to make myself feel happier	0	+1	+2	+3	+4	+5	+6	+7
92. Finding ways to resolve any inner conflicts	0	+1	+2	+3	+4	+5	+6	+7
93. Taking responsibility for myself, and doing all I can to get better	0	+1	+2	+3	+4	+5	+6	+7
94. Looking after myself and taking things easy	0	+1	+2	+3	+4	+5	+6	+7
95. Being careful about my day to day behaviour (e.g. getting sufficient sleep and a nourishing diet)	0	+1	+2	+3	+4	+5	+6	+7
96. Actively taking steps to make my life-style more healthy	0	+1	+2	+3	+4	+5	+6	+7
97. Giving up unhealthy habits (e.g. drinking too much)	0	+1	+2	+3	+4	+5	+6	+7
98. Good luck	0	+1	+2	+3	+4	+5	+6	+7
99. Simple probability	0	+1	+2	+3	+4	+5	+6	+7
100. The care I got from my family and friends	0	+1	+2	+3	+4	+5	+6	+7
101. The quality of medical treatment I received	0	+1	+2	+3	+4	+5	+6	+7
102. The sympathy and understanding of my nurse/doctor	0	+1	+2	+3	+4	+5	+6	+7

WHEN I AM ILL, HOW QUICKLY AND EFFECTIVELY I RECOVER	WOULD EXERT NO INFLUENCE AT ALL							WOULD EXERT A STRONG INFLUENCE
103.The quality of any conventional medical treatment	0	+1	+2	+3	+4	+5	+6	+7
104.A curse or ill-wishing	0	+1	+2	+3	+4	+5	+6	+7
105.The intervention of a spiritual healer or healers	0	+1	+2	+3	+4	+5	+6	+7
106.Prayers said for me	0	+1	+2	+3	+4	+5	+6	+7
107.God's will	0	+1	+2	+3	+4	+5	+6	+7
108.Some other supernatural power	0	+1	+2	+3	+4	+5	+6	+7
109.The virulence of the disease itself	0	+1	+2	+3	+4	+5	+6	+7
110.An environment which is conducive to recovery (whether at home, at work or in hospital)	0	+1	+2	+3	+4	+5	+6	+7
111.Circumstances which are conducive to recovery	0	+1	+2	+3	+4	+5	+6	+7
112.Particular events in my life at the time	0	+1	+2	+3	+4	+5	+6	+7
113.Taking drugs or medicines that are effective	0	+1	+2	+3	+4	+5	+6	+7
114.Treatments (e.g. surgery, radiotherapy) that are effective	0	+1	+2	+3	+4	+5	+6	+7

WHEN I AM ILL, HOW QUICKLY AND EFFECTIVELY I RECOVER	WOULD EXERT NO INFLUENCE AT ALL					WOULD EXERT A STRONG INFLUENCE		
115. 'Alternative' therapies, if I sought them out	0	+1	+2	+3	+4	+5	+6	+7
116. The constitution with which I was born	0	+1	+2	+3	+4	+5	+6	+7
117. My body's own natural defences.	0	+1	+2	+3	+4	+5	+6	+7
118. Thinking positively and seeing the illness as a challenge	0	+1	+2	+3	+4	+5	+6	+7
119. Following 'doctors orders' - complying properly with the treatment I am given	0	+1	+2	+3	+4	+5	+6	+7
120. Letting nature take its course	0	+1	+2	+3	+4	+5	+6	+7
121. Seeking medical advice soon enough - not waiting until the illness becomes too serious before I go to the doctor	0	+1	+2	+3	+4	+5	+6	+7
122. Just the chance to talk things over with the doctor without any treatment	0	+1	+2	+3	+4	+5	+6	+7
123. The weather	0	+1	+2	+3	+4	+5	+6	+7
124. My age	0	+1	+2	+3	+4	+5	+6	+7

YOUR NAME ....

ON THIS PAGE I HAVE LEFT SPACES FOR YOU TO ADD IN ANY INFLUENCES ON HEALTH AND ILLNESS THAT YOU CONSIDER IMPORTANT, AND HAVE BEEN LEFT OUT OF THE QUESTIONNAIRE. PLEASE SAY WHICH ONE YOU ARE REFERING TO (Present state of health, ability to improve health, causes of illness, factors affecting recovery) :

Your assessment of its influence :

0   +1   +2   +3 ,+4   +5   +6   +7

Your assessment of its influence :

0   +1   +2   +3   +4   +5   +6   +7

Your assessment of its influence :

0   +1   +2   +3   +4   +5   +6   +7

Your assessment of its influence :

0   +1   +2   +3   +4   +5   +6   +7

Your assessment of its influence :

0   +1   +2   +3   +4   +5   +6   +7

YOUR NAME ....