

# Mental ill health in the elderly: medical students' social representations in the United Kingdom\*

A DOENÇA MENTAL NO IDOSO: REPRESENTAÇÕES SOCIAIS DE ESTUDANTES DE MEDICINA NO REINO UNIDO

LA ENFERMEDAD MENTAL EN EL ANCIANO: REPRESENTACIONES SOCIALES DE LOS ESTUDIANTES DE MEDICINA EM EL REINO UNIDO

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## ABSTRACT

**Objective:** This study aims to explore medical students' social representations of mental ill health in older adults. **Method:** it comprises an exploratory and qualitative investigation based on the theory of social representations. Two focus groups with pre-clinical medics (group 1, N=4; group 2, N=4) and 10 individual interviews with clinical medical students were conducted. **Thematic analysis** at a latent level explored meanings and differences between groups. **Results:** three overarching themes reflect participants' representations of mental health problems in later life – mental ill health in old age, polarisation of care, and challenges to care. Primary health care appears as an important strategy to overcome barriers to mental health care in the community. Nevertheless, disqualifying representations, stigma and organization of services constitute the main challenges to quality mental health care in later life. **Conclusion:** this paper highlights the need to address cultural and organizational barriers to promote quality care.

## DESCRIPTORS

Mental health  
Primary health care  
Geriatrics  
Culture

## RESUMO

**Objetivo:** o estudo propõe investigar as representações sociais de estudantes de medicina sobre a doença mental entre idosos. **Método:** a pesquisa qualitativa e exploratória foi baseada na teoria das representações sociais. Os principais métodos utilizados foram dois grupos focais com estudantes pré-clínicos (grupo 1, N=4; grupo 2, N=4) e dez entrevistas individuais com estudantes em prática clínica. A análise temática explorou os significados e diferenças entre os grupos. **Resultados:** três principais temas refletem as representações dos participantes sobre a doença mental na velhice: doença mental na velhice, polarização do cuidado, desafios ao cuidado. A atenção primária à saúde constitui uma estratégia importante para ultrapassar barreiras ao cuidado em saúde mental na comunidade. Contudo, crenças depreciativas, estigma e organização de serviços se apresentam como os principais desafios. **Conclusão:** esse estudo aponta para a necessidade de profissionais de saúde responderem aos desafios culturais e organizacionais ao cuidado em saúde mental do idoso.

## DESCRITORES

Saúde mental  
Atenção primária à saúde  
Geriatria  
Cultura

## RESUMEN

**Objetivo:** Este estudio tiene como propósito explorar la representaciones sociales de los estudiantes de medicina acerca de las enfermedades mentales en adultos en edad madura. **Método:** abarca una investigación exploratoria y cualitativa basada en la teoría de representaciones sociales. Se realizan entrevistas a dos grupos de interés, médicos pre-clínica (grupo 1, N=4, grupo 2, N=4) así como 10 entrevistas individuales a estudiantes de medicina clínica. **Resultados:** tres temas generales reflejan las representaciones de los participantes sobre los problemas mentales en el futuro - enfermedades mentales a edades avanzadas, polarización de la atención, y desafíos de la atención. La atención primaria en salud aparece como una estrategia importante para hacer frente a los obstáculos a la atención de la salud mental en la comunidad. No obstante, representaciones descalificadoras, estigmas y la organización de servicios constituyen los retos principales al cuidado de la salud mental en la madurez. **Conclusión:** este artículo destaca la necesidad de hacer frente a los obstáculos culturales y organizativos para promover la calidad en la atención.

## DESCRIPTORES

Salud mental  
Atención primaria de salud  
Geriatría  
Cultura

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## INTRODUCTION

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Living longer has brought challenges to health care in the United Kingdom. Currently, about 10 million people are 65 years old and over and official reports predict this number will increase to 19 million by 2050<sup>(1)</sup>. Moreover, there are more than 3 million older adults above 80 years of age who require specialised services due to physical, psychological, and social problems<sup>(1,2)</sup>. Thus, ageing population has challenged hospital management and community-based care for the elderly by the National Health Service<sup>(1)</sup>.

One of the main concerns in an ageing society is mental health care in the community. The increasing number of older adults in need of psychological care underlines the importance of re-evaluating mental health care for the elderly. In the former mental health care system, psychiatric institutions constituted the space of care for the elderly with mental health problems<sup>(3)</sup>. Nevertheless, de-institutionalisation has enhanced mental health support for the elderly in the community<sup>(4)</sup>. Despite these changes, cultural and organisational aspects of mental health care in later life present some of the main barriers to quality services.

In this context, primary care is one of the main strategies to enhance mental health promotion in later life. In the United Kingdom, it not only fills the gap between generalist and specialist health care, but also includes the management of enduring mental health problems in older adults<sup>(4,5)</sup>. Primary care constitutes the first point for seeking help for mental health problems<sup>(6)</sup>. This setting is particularly relevant in the management of mental health problems in later life for two reasons: older adults express more willingness to reveal mental health problems in primary care; secondly, primary care facilitates service provision to marginalised and “difficult-to-reach” groups such as older adults with depression<sup>(7,8)</sup>.

Community mental health care in the UK has shifted from “mental illness prevention” to “promotion of mental health”<sup>(4)</sup>. This new orientation of care deal with the environmental conditions that have an impact on population’s mental health (e.g. employment, involvement of social and voluntary organisations, etc.). Furthermore, it focus on primary health care rather than specialist mental health services. In this perspective, service provision is located in the context where mental health problems are manifested<sup>(4)</sup>. On the other hand, the cultural inheritance of beliefs about and practices toward older adults with mental health problems constitutes one of the main barriers to implementing community-based care for this group<sup>(4)</sup>. Health professionals might hold established social norms regarding mental illness in later life, and practice discriminatorily toward older adults<sup>(9)</sup>. Furthermore, stigma constitutes a barrier to seeking mental health care<sup>(7,10)</sup>. The literature has

pointed to a common form of *therapeutic nihilism* in medical practice; that is, medics tend to hold negative views about health progression in later life<sup>(4,11)</sup>. Stigma associated with mental health problems might also affect how different older adults accept and engage with care<sup>(7)</sup>. Thus, socio-psychological research should address multiple stigma (in this case, age and mental health) in the investigation of health conceptions/practice<sup>(10)</sup>. On the other hand, societal conceptions do not only reflect negative representations of mental health in later life. Current trends in psychosocial management of mental health and public policies focusing on *active ageing* represent ideological attempts to present positive theory and praxis in health services<sup>(12,13)</sup>.

Ageing societies and the increasing demand for adequate mental health provision require in-depth investigation of how groups directly involved with health care understand their challenges and possibilities. Within primary care, general practitioners constitute key professionals in translating (mental) health policies into daily practice. Medical students, whose training is preparing them to deal with a senior clientele, also share conceptions and beliefs about management of mental health problems in their clinical practice<sup>(14)</sup>. Therefore, this study explore trainee medics’ perspectives on mental health problems in later life. Moreover, it investigates their beliefs on the inclusion of primary care in the services’ agenda<sup>(15)</sup>. In so doing, this paper draws on the theory of social representations to explore how medical students make sense of mental health care in later life. This theory is a socio-psychological approach that considers how social groups understand unfamiliar and significant phenomena in their everyday lives<sup>(16)</sup>. Social representations are theorized as systems of beliefs and ideas with two main functions: firstly, to provide a common ground for understanding relevant phenomena, and secondly, to provide consensual codes for communication and interaction in relation to different aspects of reality<sup>(16)</sup>.

Health and illness are relevant dimensions in social representations research due to their influence in orienting health-related attitudes<sup>(17)</sup>. In this context, mental health constitutes a contentious area of research in social representations. Previous findings show that social groups still perceive the “mentally ill” as different and dangerous<sup>(18-20)</sup>. Mental health professionals also tend to share these representations<sup>(12)</sup>. Disqualifying representations of ageing and mental illness might constitute some of the barriers to promoting social and political changes in mental health care<sup>(9)</sup>. Given the importance of health professionals to the translation of policy into practice, this study aims to answer this question: “How do those training to be doctors perceive mental health problems in older adults from the UK?”

## METHOD

This exploratory and qualitative study explores medical students' understandings of mental health problems in later life. The theory of social representations informed the selection of methods. Furthermore, a qualitative design was appropriate, given that the aim was to capture meanings and beliefs constructed by different groups.

Medical students (N=18) enrolled in the pre-clinical and clinical school at a university in the United Kingdom participated in this study. Research on social representations on mental health has identified them as an "intermediate group", positioned between "expert" and "lay" systems of knowledge<sup>(12)</sup>. Progression in medical clinical school has been associated with more contact with expert knowledge and less stigmatizing ideas and practices on mental health<sup>(21)</sup>. Therefore, these students were segmented into two groups: pre-clinical students (N=8, age range 18 to 28 years old, Mean=22,7) not yet involved with institutionalised practices in medicine and clinical students (N=10, age range 22 to 34 years old, Mean=24,3) who are positioned in a more "expert" field. It was therefore hypothesised that clinical students would share less stigmatising views than those at the beginning of medical training.

Two focus groups (group 1, N=4; group 2, N=4) were conducted with pre-clinical students. This method is an important strategy to access the micro-genetic level of representations; that is, how groups generate representations in social interaction<sup>(22)</sup>. A topic guide with three short stories helped students to debate. The first story covered the theme of therapeutic nihilism<sup>(4)</sup>, the second, stigma and ideas of strangeness<sup>(10)</sup>. The third one comprised a brief discussion on older adults living with mental illness from the National Health Service's website as part of a campaign about mental health issues in later life. The researcher read these three stories respectively, and asked the participants to discuss their main issues.

Clinical students participated in individual semi-structured interviews (N=10). This method covered issues related to conceptions of mental health in later life, problems in society, barriers to promoting quality practice etc. Time pressures made attendance at focus groups difficult for clinical students. Moreover, distinct training stages called for the researcher to approach these students individually. Theoretical saturation was the criterion for stopping data collection with clinical students<sup>(23)</sup>. Thus, the researcher recruited different participants until the insertion of new ones not anymore brought new representations. Additionally, a socio-demographic questionnaire described contextual aspects in both groups.

The University Research Ethics committee approved the project. The first author contacted the School of Medicine to introduce the research project and ask for an e-mail advertisement to be circulated. All respondents

were contacted to arrange a focus group or interview. Focus groups and interviews lasted 20-30 minutes and took place at the sites around a university campus. Each participant was given an information sheet and signed a consent form. The researcher conducted, recorded and transcribed verbatim all interviews between April and May 2012.

Thematic analysis constituted the main analytical approach to actively identify, analyse and report patterns of beliefs between groups<sup>(24)</sup>. The search for common themes corroborates the shared nature of social representations<sup>(16)</sup>. Thematic analysis at a latent level<sup>(24)</sup> was also employed; that is, underlying concepts and beliefs that shaped the semantic content of the data were examined. From this perspective, description of codes and analysis are a joint process. The following steps characterised the analytical work: familiarisation with data, generation of initial codes, searching for themes across data, review of themes, naming or re-defining themes, and reporting analysis. The qualitative data analysis package Atlas-ti program supported data management.

## RESULTS AND DISCUSSION

Three overarching themes describe participants' understandings of mental health in old age: mental ill health in old age, polarization of care and challenges to care.

### 1. Mental ill health in old age

The first theme describes how medical students make sense of mental health problems in old age, their challenges, and how society sees the elderly. Four sub-themes emerged: mental health problems as a stigmatising issue, the burden attached to being considered old and mentally ill, mental health difficulties as natural outcomes of old age, and older adults' lack of competence to manage their care.

#### 1.1 Stigmatising issue

Both groups of students depict older adults with mental health problems as objects of stigma. The lack of clear understandings about the nature and consequences of mental illnesses also contribute to discriminatory practices in the general population<sup>(12,19)</sup>.

*"(...) there is a lot of stigma associated with it (...) there is still quite a lot of associated negative connotations with whether it is mad depression or (...) schizophrenia, personality disorders (...)"* (P. 01, pre-clinical student, Focus Group 01)

*"Well, probably it is an issue of great stigma, (...) because mental health in general is quite, hmm, a difficult concept to deal with in society. I mean, certainly in Britain (...)"* (P.04, clinical student)

Stigma might also affect compliance to medical care as stated in the following quote:

*(...) they're not following the treatments and stuff (...) they don't believe they've got these issues and they don't really want to (...) if they do comply with the treatments then they are acknowledging they are mentally ill and then there's a stigma attached to that (...).*" (P.04, pre-clinical student, FG 02)

Participants are concerned that multiple stigma – in this case, “being old” and “mentally ill” – might constitute barriers to seeking care<sup>(10)</sup>. They state that older adults tend to resist medical classifications and treatment in order to protect their identity from discriminatory practices<sup>(25)</sup>. Illness may affect one's sense of self and the way one interacts with the social world<sup>(8)</sup>. In this case, the experience of being diagnosed and complying with mental health care is seen as threatening an older person's identity and social relationships.

### 1.2 Burden

For these participants, older people (with mental health problems) lack economic and social value in society, hence “they are invisible” and “not looked after”.

*(...) I think they're pretty invisible. I think people don't really think about it (...)*" (P. 01, pre-clinical student, FG 2)

*(...) there is a large proportion of people who will say, shit, this is a burden. How am I going to deal with this burden without compromising my life? (...) I cannot leave all that to care for the elderly person that is next to me (...)*" (P. 10, PhD medical student)

The replacement of long-stay residential forms of care with primary and informal care (family, voluntary organisations, friends etc.) might pose challenges<sup>(26,27)</sup>. Moreover, negative views on mental illness and later life might promote social exclusion despite current trends in community care<sup>(9,18,19)</sup>.

### 1.3 Natural outcome

Clinical students describe mental health problems as a natural consequence of the ageing process. They repeatedly define mental health problems as a “deteriorating condition”, “problems overall” or “general senescence”.

*(...) most elderly people are in a state that, hmm, they progressively get worse (...).*" (P.01, clinical student)

They frame the unfamiliar aspects of mental illness in later life as natural process of ageing, hence ‘understandable’ and less threatening than mental health at other points in one's life. Furthermore, they try to normalise mental health problems in later life by relying on epidemiological sources (medical reports and academic journals) and clinical observations. They also seem to express a form of therapeutic nihilism when describing prognostic of care.

*(...) they have so many different diseases on top of their mental health problems so, hmm, probably the one thing that I told you before it is the fact that most of these is going to be chronic and you can't solve it (...).*" (P. 10, clinical student)

However, the pre-clinical group resists this representation. The stigma of being old lies behind these conceptions and impacts on identification and management of mental health problems.

*(...) that is considered a normal process and that is why people don't go to doctor, that is why they don't get treatment, and that is why they present when the dementia is in the late stages (...).*" (P.03 and P. 01, pre-clinical students, FG 01)

### 1.4 Lack of competence

Medical students conceive of older adults with mental health problems as lacking mental capacities to handle their life activities and health: “they don't have insight into their problems” (P.01 clinical student), “patients who are (...) not able to care for themselves” (P.10 PhD medical student), or they “can't make that decision” of care (P.02 clinical student). Clinical students were the only group who presented these ideas. This might be related to their experiences in managing and observing vulnerable older adults. Consequently, they understand that the main responsibility for managing care lies with a patient's family, due to an assumed lack of competence on the patient's part in decision making. In so doing, participants also parallel lay conceptions of the ‘mentally ill’ as unintelligible, passive and lacking insight into their condition<sup>(4)</sup>.

## 2. Polarisation of care

This theme refers to opposite views on mental health care for the elderly. It comprises two sub-themes: alternatives to institutionalisation and institutionalisation of care.

### 2.1 Alternatives to institutionalisation

Medics from both groups raised the need for alternatives to hospitalisation and medicalization of care.

*(...) It is not just drugs, perhaps it could be an element of psychotherapy, group therapy. If they are in a care home, then the sense of isolation might be reduced with some sort of alternative complementary stuff. It is not just about 'oh, let's just give them Prozac and see how it goes (...).*" (P. 01, pre-clinical student, FG 01)

Participants understand mental health care as a multidisciplinary task, involving different professional teams, family support and living in the community. This eclecticism of care might reveal attempts to incorporate a psychosocial framework into traditional forms of care<sup>(9,12)</sup>.

They also see changes in community-based care as positive for undermining stigma and promoting quality care.

P. 02- *I get the general impression that everybody is really quite enamoured with the shift to de-institutionalising the care of mental health, and I think it's been quite successful at fixing a lot of problems of institutionalization (...).*"

P. 01 – *I think the fact that a lot of the older mental health institutions don't exist anymore is really helpful in terms of*



persuading people it's ok to talk about mental health problems." (P. 01 and P. 02, pre-clinical students, FG 02).

### 2.1 Institutionalisation of care

Institutions are not absent from participants' discourse, and are even sometimes seen as necessary to deal with the disabling aspects of mental illnesses in later life.

*"But then again, on the flip side, I've seen one of my uncles. He's got really, really serious dementia, and he wouldn't be able to just be in sort of community care (...). He actually needs to be. He should be in an institution really because he needs professional care and stuff (...)"* (P. 04, pre-clinical student, FG 02).

Both groups of students mentioned that economic and political neglect are the main problems in implementing community care. Thus, participants fear an increasing tendency towards institutionalisation aimed at addressing the burden of "being old", "mentally ill" and "non-productive".

*"(...). I suppose it will happen probably because the world is getting you know, more and more work, less and less time that facilities for elderly people with mental health problems will become bigger and more equipped and much more people will actually opt to send, hmm, the elderly person to that sort of facility (...)"* (P. 10, PhD medical student)

### 3. Challenges to care

This theme shows students' social representations of challenges to medical practice in later life. It includes two sub-themes: 1) challenges to fulfilling patients' needs and 2) primary care support.

#### 3.1 Challenges to fulfil patients' needs

As suggested above (see sub-theme alternatives to institutionalisation), participants suggest a holistic approach to mental health care in later life. This care design involves different working teams, combined therapies, family participation, and community support. Ideals of rehabilitation, recovery and social support results in person-centred care, and contrasts with a more individualistic and segregated practice in medicine<sup>(9,28)</sup>.

*"(...). I think the role of the doctor is to find a specific need for a specific person, and you deal with that need (...)"* (P. 03, clinical student)

*"(...). not just caring for that particular person but the health care system is providing a sort of care team that is looking after these particular person's problems and then also helping with family (...)"* (R. 03, pre-clinical student, FG 01)

However, students mentioned two main challenges to implementing such a framework in medical practice: efficient communication with patients and time constraints in clinical practice. Thus, lack of proper communication of symptoms, managing undifferentiated symptoms and medical-patient relationships are the main problems in promoting quality care.

*"(...). when you try to communicate with them [elderly people], say, describe their disease and explain the necessity of the treatment, so you may spend more time, you know, to win their trust and to explain everything (...)"* (P. 06, clinical student).

*"(...). in this case when you have elderly patients coming in with certain sort of symptoms (...) for most often this particular group of people are under diagnosed or misdiagnosed (...)"* (P. 03, pre-clinical student, FG 01).

Time constraints in general medicine practices constitute another main problem to promote integral mental health care.

*"(...). in terms of consultation, hmm, we don't have enough time to in, you know, everything that needs to be done, and (...), trying meaningfully deal with a mental health issue you need, you know, good slot in you consultation time (...), possibly that's one reason why things might go ignored (...)"* (P. 04, clinical student)

The lack of a precise diagnostic results not only from beliefs about health progression in later life, but also from organisational practices and the political agenda in health services<sup>(29)</sup>. In this case, time constraints might affect one's health evaluation. Thus, students call for structural rearrangements in general practice. In spite of these challenges, medics regard primary care as a promising area of medicine to enhance service provision in later life.

#### 3.2 Primary care support

Medical students mention primary care as a relevant area to manage mental health problems in later life. Thus, it has the potential to overcome challenges and promote centred-person mental health care in later life.

*"Hum, I think on the one hand, it might be a little bit easier because elderly people tend to be a lot of more in contact with their primary care services or is going to GPs to check their prescription and these things (...)"* (P. 04, clinical student).

They also understand primary care as the first strategy to promote mental health. Indeed, older adults tend to feel less stigmatised sharing their mental health problems with general practitioners than with specialised mental health professionals<sup>(7)</sup>. This might constitute an opportunity to enhance compliance access to health services. Nevertheless, participants state that further professional training in geriatrics is necessary.

*"(...). I don't think with the type of training that most of us get, that we actually have an adequate training to deal with, hmm, health problems of the elderly, (...) but as far as it becomes part of the GP training to do care of the elderly work, then, that would be, that would be very useful because obviously for any health thing your GP is the first port of call (...)"* (P. 02, clinical student).

The increasing number of older adults presenting

mental health problems calls for further formation in geriatrics. Thus, this paper might point to four intertwined challenges in promoting quality mental health care in later life. First, the tendency to respond to bio psychosocial problems through adhering to institutionalisation; second, the multiple stigma associated with ageing and mental ill health; third, the presence of disqualifying representations of mental health in later life; and fourth, current organisational arrangements of primary care<sup>(15)</sup>.

## CONCLUSION

This investigation provided knowledge on medical students' representations of mental health in later life. This study gave voice to medics, whose training encompasses not only expert knowledge but also daily life experiences.

## REFERENCES

1. Cracknell R. The ageing population. Key issues for the New Parliament 2010. House of Commons Library Research. [Internet]. 2010 [Cited 2014 Sept 24]; p. 44-45. Available from: [http://www.parliament.uk/documents/commons/lib/research/key\\_issues/Key-Issues-The-ageing-population2007.pdf](http://www.parliament.uk/documents/commons/lib/research/key_issues/Key-Issues-The-ageing-population2007.pdf).
2. Age-UK. Improving later life: understanding the oldest old. London; 2013.
3. Rogers A, Pilgrim P. Mental health policy in Britain. Basingstoke: Macmillan Press; 2001.
4. Rogers A, Pilgrim D. A sociology of mental health and illness. 3rd ed. Maidenhead: Open University Press; 2010.
5. Cohen A. Primary care and mental health. In Bell A, Peter L, editores. The Sainsbury centre for mental health. London: 2005, p. 83-101.
6. Lynch JM, Askew D, Mitchell GK, Hegarty KL. Beyond symptoms: defining primary care mental health clinical assessment priorities, content and process. *Soc Sci Med*. 2012;74(2):143-149.
7. Bartels SJ. Improving the United States' system of care for older adults with mental illness: findings and recommendations for the President's New Freedom Commission on Mental Health. *Am J Geriatr Psychiatry*. 2003; 11:486-97.
8. Lamb JD, Bower P, Rogers A, et al. Access to mental health in primary care: a qualitative meta-synthesis of evidence from the experience of people from 'hard-to-reach groups.' *Health (London)*. 2011;(16):76-104.
9. Dallaire B, McCubbin M, Carpentier N, Clément M. Social work in mental health representations of elderly with mental health problems held by psychosocial practitioners from community and institutional settings. *Social Work Mental Health*. 2009;7(1):139-152.
10. Conner KO, Lee B, Mayers V, et al. Attitudes and beliefs about mental health among African American older adults suffering from depression. *J Aging Stud*. 2010;24:266-77. doi:10.1016/j.jaging.2010.05.007
11. Burroughs H, Lovell K, Morley M, et al. 'Justifiable depression': how primary care professionals and patients view late-life depression? A qualitative study. *Fam Pract*. 2006;23(3):369-77.
12. Morant N. Social representations and professional knowledge: the representation of mental illness among mental health practitioners. *Br J Soc Psychol*. 2006;45(4):817-38.
13. World Health Organisation. Active ageing: a policy framework. Madrid; 2002.
14. Economou M, Peppou LE, Louki E, Stefanis CN. Medical students' beliefs and attitudes towards schizophrenia before and after undergraduate psychiatric training in Greece. *Psychiatry and Clin Neurosci*. 2012;66:17-25.
15. Medeiros B, Foster J. Social representations of mental of mental health problems in later life: medical students' perspectives in the United Kingdom. In: Costa AP, Reis LP, Souza FN, Luengo R, editors. *Artigos de saúde. CIAIQ 2014: Proceedings of the 3º Ibero-American Congress on Qualitative Research; 2014 Jul 14-16; Universidad de Extermadura, Badajoz, Spain: CIAIQ; 2014. p. 209-14.*
16. Moscovici S, Duveen G. Social representations: explorations in social psychology. Cambridge: Polity Press; 2000.
17. Jovchelovitch S, Gervais MC. Social representations of health and illness: the case of the Chinese community in England. *J Community Appl Soc Psychol*. 1999;(9):247-60.

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18. Zani B. The mentally ill person and the others: social representations and interactive strategies. In: Marková I, Farr RM, editores. Representations of health illness and handicap. Chur: Harwood Academic Publishers; 1995, p. 145-162.
  19. Jodelet D. Madness and social representations. Hemel Hempstead: Harvester Wheatsheaf; 1991.
  20. Dixit S. Meaning and explanations of mental illness: a social representations approach. *Psychology & Developing Societies*. 2005;17(1):1-18.
  21. Kassam G, Glozier N, Leese M, Loughran J, Thornicroft G, A controlled trial of mental illness related stigma training for medical students. *BMC Med Edu*. 2011;(11):51.
  22. Duveen D, Lloyd B. Social representation and the development of knowledge. Cambridge: Cambridge University Press; 1990.
  23. Bauer MW, Aarts B. Corpus construction: a principle for qualitative data collection. In Bauer M, Gaskell G, editores. *Qualitative researching with text, image and sound*. London: SAGE Publications; 2000, p. 19-37.
  24. Braun V, Clark V. Using thematic analysis in psychology, *Qualitative Research in Psychology*. 2006;(3):77-101.
  25. Pilgrim D. Key concepts in mental health. London: SAGE Publications; 2009.
  26. Pickard L. Substitution between formal and informal care: a 'natural experiment' in social policy in Britain between 1985 and 2000. *Ageing Soc*. 2012; 32(7):1147-175.
  27. Brown K. Community vulnerable adults. 2nd ed. Exeter: Learning Matters; 2010.
  28. Desviat M. International overview of psychiatric reform. *Cien Saude Colet*. 2011;16(12):4615-621.
  29. Jones S, Howard L, Thornicroft G. Diagnostic overshadowing: worse physical health care for people with mental illness. *Acta Psychiatr Scand*. 2008;118;169-71.