GENDERING AND SCHIZOPHRENIA: NEGOTIATING POWER RELATIONS, GENDER UNDERSTANDINGS AND EXPERIENCE IN PSYCHIATRIC/PATIENT INTERACTIONS

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by

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Abstract

This thesis uses a discursive approach to examine psychiatric understandings of gender and schizophrenia in clinical encounters between professionals and patients. Chief reasons for undertaking the research were an unease about the concept of schizophrenia and a lack of attention to interactive psychiatric contexts in feminist work on gender and madness. This study attempts to move beyond explanations of schizophrenia as a label or social product to analyse the intersections between femininity, masculinity, and schizophrenia accomplished within psychiatric/patient interactions. Drawing on case conference discussions in a British psychiatric unit, I argue that the interplay between locally accomplished power and the broader mandate of community care produces co-existing relations of benevolent psychiatry/responsible patient, and supervisory psychiatry/ untrustworthy patient, and considerable professional persuasion and patient resistance at this local level. Within these relations, understandings of femininity and (masculine) personhood produce a plurality of meanings of emotion, activity, and (in)dependence. The experiences of patients and their significant others are fluid and complex resources (re)configured in gendered relational terms to inform the restoration of lives and definitions of trouble.

The central argument is that schizophrenia is not applied as a label but operates largely as a background understanding. Professional assumptions about schizophrenia, not gender, inform discourses of responsibility, consumerism and supervision, whereas professional discourses of femininity and (masculine) personhood intersect with understandings of schizophrenia to differentiate and delimit restoration to purpose and autonomy. But professionals' understandings of femininity and masculinity, not schizophrenia, inform definitions of trouble: negative understandings of femininity are associated with blame and change; those of masculinity with excusing and unchangeability. Contemporary psychiatry is more concerned with encouraging self-regulation and restoring lives than straightforward social control and gender conformity. But gender understandings remain salient to contemporary psychiatry and, in relation to schizophrenia, gender differentiations in local interactions run counter to schizophrenia's distributional gloss of gender neutrality.

Contents

Introduction

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Introduction

Standard psychiatric histories of schizophrenia suggest that Kraepelin's concept of "dementia pracox" marked the initial recognition of schizophrenia at the end of the nineteenth century, although it is often claimed to have existed throughout history, and the term schizophrenia itself was introduced by Bleuler in 1911 (Kendell 1975; Wing 1978; Andreasen & Carpenter 1993; Bleuler 1991). Today schizophrenia is regarded as the core concept of modern psychiatry (Marshall 1990), a "disturbance" characterised by "positive" symptoms such as delusions and hallucinations and "negative" symptoms such as affective flattening and avolition (American Psychiatric Association (APA) 1994: 273-5). While a range of statistical imbalances between women and men in the area of mental disorder are well established (Chesler 1974; Allen 1986; DoH 1995; Busfield 1996), schizophrenia is said to affect women and men in fairly equal numbers (APA 1987; 1994; Kohen 2000; Scott 2000; Ussher 2000),[1] giving it a gloss of gender neutrality. However, differences between women and men are not necessarily ones of "magnitude" (Smith 1975a: 109) and gender effects may be hidden beneath statistical associations (Holstein 1987). In the last two decades mainstream psychiatric research on schizophrenia has shown a growing interest in sex/gender differences (Bardenstein & McGlashen 1990; Torrey et al 1991; Lewis 1992; Takei et al 1992; Zolese 2000). This research produces something of a paradox whereby psychiatric research and classification (APA 1987; 1994) is replete with gender differentiations while schizophrenia retains its gloss of gender neutrality and the relevance of gender to schizophrenia at the level of clinical practice remains largely unknown.

My interest in the relationship between gender and schizophrenia was initially aroused by Chesler's (1974) classic study of women and madness and her thesis that psychiatry holds a double standard of mental health for women and men whereby the female sex-role is viewed as inherently deviant. In this account, schizophrenia is a label applied by psychiatry to women who reject their female role and men who act out "feminine" behaviours. A range of research provides support for Chesler's contention that clinicians hold different conceptions of female and male mental health (Broverman et al 1970;

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[1] It has recently been suggested that the incidence of schizophrenia for women could be lower than for men or decreasing (Castle et al 1993; Kendler & Walsh 1995) although this could be an artefact of who comes to psychiatric attention, or differential responses to treatment (Prior 1999; Zolese 2000).

Abramowitz et al 1973; Brodsky & Holroyd 1981; Jones & Cochrane 1981; Swenson & Ragucci 1984; Waisberg & Paige 1988), and that women and men who deviate from their gender-roles may be diagnosed as schizophrenic (Cheek 1964; McClelland & Watt 1968).

But there appears to be some unease about the status of the concept of schizophrenia in Chesler's work producing conceptual problems and contradictions which are echoed in later feminist literature on women and schizophrenia (Al-Issa 1980; Barnes & Maple 1992), and perhaps played out in a tendency within the feminist literature to make general claims about an association between women and madness while seldom including schizophrenia in the analyses (e.g. Stephenson & Walker 1981; Gorman 1992; Prior 1999). In effect, schizophrenia appears to be a problematic presence in feminist analyses (what is madness, who is mad?) and a convenient absence (labelling is on firmer ground when associated with depression, anxiety and general unhappiness). Moreover, it is not clear whether Chesler's account holds good for contemporary psychiatry in the era of community care (Allen 1986; Busfield 1989; 1996). The unease or disquiet about the status of schizophrenia in feminist writings, and the claim by some writers that schizophrenia is not particularly relevant for a feminist analysis (Busfield 1988; Pugliesi 1992; Russell 1995), increased rather than diminished my interest.

At the same time I was becoming increasingly interested in discursive approaches to researching social and psychological phenomena, particularly discourse analysis (DA) developed within the social study of science and social psychology (Gilbert & Mulkay 1980; 1984; Woolgar 1980; Potter & Wetherell 1987; Edwards & Potter 1992; Wetherell & Potter 1992). Rather than language being the means for describing, labelling, or reflecting a real world, discursive approaches[2] reconceptualise language as constitutive of social realities. The interest here lay in the way discursive approaches offer a different focus and open up different kinds of questions. On this basis, what schizophrenia and gender mean will be constituted and negotiated within discourses and according to the contexts of their production. A small but growing body of literature has taken this approach (broadly understood) to explore discourses of gender and madness (e.g. Allen

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[2] Discourse analysis is a term used for a range of approaches including Foucauldian archaeology/genealogy (Foucault 1971; 1972; 1973; 1990), and conversation analysis (Sacks 1972; 1974; Atkinson & Heritage 1984; Schegloff 1987; 1997), as well as the approach above. There are some common assumptions about language and knowledge shared by these approaches but also some important differences.

1987; Showalter 1987; Hepworth & Griffin 1990; 1995; Ussher 1991; Malson 1995; 1998) but there is largely a focus on categories where women predominate (such as hysteria and anorexia nervosa)[3] and on textual materials.[4] My interest at the outset, therefore, was to use a discursive approach to investigate psychiatric discourses of gender and schizophrenia and in an interactive psychiatric context.

In the 1980s Chesler's thesis of a sexist psychiatry lost ground to the alternative explanation that mental distress is the product of the stress and oppression women experience in patriarchal society (e.g. Smart 1976; Lipshitz 1978; Oakley 1982; Belle 1990; Mind 1995; Bostock 1997; Holmshaw & Hillier 2000). This explanation was influenced by early feminist writings on the stress and anxiety experienced by women in their roles as housewives and mothers (Friedan 1963; Bernard 1972), and is underpinned by a large body of epidemiological research (e.g. Gove & Tudor 1972; Gove & Geerkin 1977; Kessler & McRae 1981; 1982; Thoits 1986; Prior 1999; Thorbjornsson 2000). However, as with the literature on sexist psychiatry, the argument that mental distress is the social product of stress and oppression in a sexist society makes a general claim about the association between women and madness largely based on milder disorders, implicitly replicating the unease about what madness is and who is mad. In turn, the small feminist literature that has focused explicitly on schizophrenia (Al-Issa 1980; Warren 1987; Barnes & Maple 1992) adds little to the general explanations and fails to illuminate why the same kinds of experiences produce different kinds of distress.

Broader issues of gender, power and language traverse these fields of feminist literature where there has been a focus chiefly on women, rather than femininity and masculinity, and the assumption of a stable identity underlying characterisations of "women". Reliance on the concept of patriarchy and gender as a "role" has produced an oversimplified picture of male villains and female victims (Stacey & Thorne 1985; Busfield 1996). These concepts of gender and power are underpinned by conceptualisations of language in terms of labelling and/or realism. As a result, on the one hand, notions of characteristics associated with femininity (such as dependence and emotion) are assumed to have

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[3] Notable exceptions are Allen's (1987) focus on psychiatric court reports and Lunbeck's (1994) analysis of psychiatric case records.

[4] However Malson (1995) and Hepworth & Griffin (1995) interviewed women with anorexia and healthcare professionals respectively.

singular meanings and, on the other hand, the diversity of women's experiences tend to be reduced to fit the stress-oppression-patriarchy equation (Busfield 1988). Furthermore, there is a tendency to "switch" (Hacking 1995: 67) between explanations of schizophrenia as social product or social construction[5] producing conceptual confusions (Sedgwick 1982), and often a failure to clarify the relationship between labelling and oppression.

In terms of our understanding of the relationship between gender and schizophrenia, the potential complexity and diversity of psychiatric understandings of characteristics such as dependency, emotion, and activity in relation to schizophrenia are underplayed and not well understood. There is little consideration of how patients' experiences are formulated, negotiated, and gendered within language in general and in clinical contexts in particular. We have little idea how psychiatric understandings of femininity may be produced in relation to understandings of masculinity and schizophrenia. And it is not clear how psychiatric power unfolds within clinical encounters in this era of community care.

The relevance of gender and conceptualisation of language in anti-psychiatric and societal reaction accounts of schizophrenia raise further issues. These accounts contest the meaningfulness of schizophrenia as a mental disorder: it is "problems in living" (Szasz 1973: 21; 1974; 1976); a label for residual rule-breaking (Scheff 1966; Rosenhan 1973); the understandable response to contradictory family interaction (Laing & Esterson 1964); or reaction to a mad society (Laing 1967). In general terms, schizophrenia is viewed as behaviour that breaks social rules with mainstream psychiatry acting as agents of social control through their conceptualisation and treatment of such behaviours. The writings of Szasz (1976) in particular are suggestive of the potential salience of gender to psychiatric understandings of schizophrenia, in terms of dependence, incompetence, employability and femininity. But gender is underdeveloped in Szasz' account and it is not apparent how these understandings might be constituted by psychiatrists in interactive contexts with patients. Moreover these accounts are not very informative about the factors and processes underlying psychiatric control.[6] Rosenhan (1973) suggests that the past and

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[5] The notion of social construction has been applied to a wide number of diverse approaches from labelling theory to discursive approaches such as Foucault (1971; 1972; 1973; 1990) and Potter & Wetherell (1987; 1992).

[6] This is not to say that more informative accounts are not available. For example, Goffman (1968) charts in detail the "moral career" of the mental patient. But neither gender nor schizophrenia are the focus of his account and he specifically excludes those treated outside the asylum. Similarly, Emerson & Messinger

present experiences of patients will be interpreted in the light of psychiatric understandings of schizophrenia but we have little idea how understandings of femininity and masculinity might inform such interpretations. In effect, it is not clear how psychiatry names and labels certain behaviours as schizophrenia or whether they even do apply labels such as schizophrenia within clinical encounters in the way anti-psychiatric theories suggest.

A discursive approach offers a productive avenue for investigating the issues raised in the feminist and sociological literatures. Language is reconceptualised as constitutive of schizophrenia in a broader and more complex way than the social construction/labelling approaches above. What schizophrenia means is socially produced within discourses that vary across time and place. Thus the focus changes to the ways that different understandings of schizophrenia are constituted in particular contexts and there is no "switch" between language as constructing and reflecting the "real". Such a conceptualisation of language facilitates a reconceptualisation of gender as a relational and contextual discursive production; gender is conceived as a fluid category created through social interaction in specific contexts, rather than having an essential or stable meaning. Such a conception can incorporate the assumption that gender is interrelated and interdependent, that is, "through gender relations two types of persons are created: men and women" but what gender means will be produced in specific social contexts (Flax 1987: 628). As such gender becomes a doing rather than a being (Davies 1996).[7] This reconceptualisation overcomes problems associated with concentrating solely on women and focuses attention on the contexts in which psychiatry produces meanings of femininity and masculinity in relation to schizophrenia. This conceptualisation of language also provides the basis for reconceptualising experience as a "linguistic event", constituted and negotiated, interactively and inter-subjectively, within language (Scott 1992: 34; Weedon 1997). Reconceptualising experience in this way enables consideration of how patients' experiences are formulated and negotiated in relation to schizophrenia, and to femininity and masculinity, during psychiatric interactions.

(1977) provide a general but detailed framework for understanding how relational troubles are defined and responded to by troubleshooters.

[7] This conceptualisation of gender has theoretical affinities with some postmodern/postructuralist feminism (Nicholson 1990; Butler 1990; 1994; Butler & Scott 1992; Hekman 1990; Weedon 1997).

However, questions related to gender and experience in psychiatric interactions should also attend to the power relations within which they are constituted: gender relations are an effect of power (Flax 1987; Davies 1996) and what comes to count as a valid experience will be determined by the power relations between psychiatric professionals and patients (Scott 1992; Weedon 1997). Differing conceptions of contemporary psychiatric power have implications for whether formulations of gender and experience will be imposed, encouraged, negotiated or contested in clinical interactions. If contemporary psychiatric power is conceived as a top-down, hierarchical power (Chesler 1974; Szasz 1976), relations will be those of powerful psychiatrists and subjugated patients; psychiatric professionals will have the authority to impose their understandings of femininity, masculinity, and experience, and patients' attempts to contest these definitions are likely to be met with imputations of pathology (Goffman 1968).

Alternatively, Foucault (1979; 1982; 1984; 1990) conceives power as mainly productive rather than repressive, and as relational so that resistance is present in every power relation. On this basis psychiatry is viewed as a "persuasive discipline" (Lunbeck 1994) which aims to restore patients to purpose, autonomy, choice and responsibility (Miller 1986; Rose 1986a; 1989). However, we do not know whether psychiatric notions of purpose and autonomy may be shot through with gender differentiated understandings, nor is it clear how a rearranged professional power is managed within clinical encounters and where points of resistance may occur (Kitzinger 2000). This also has implications for understanding how individuals' histories and current experiences may be shaped and played out in terms of understandings of gender and schizophrenia and notions of "care" (Banton et al 1985; Ussher 1991; Gorman 1992; Fisher 1997; Graham 1997). Moreover an increasing concern for and legislation towards patients' rights may constrain psychiatric actions and interactions (Gostin 1975; 1983; Jones 1980; 1993), producing a greater potential for negotiation and contestation of meanings of schizophrenia, gender and experiences. As such, negotiation, resistance, and contestation can become opaque in Foucauldian analyses (Kitzinger 2000).

However, these frameworks of psychiatric power are based on theoretical/textual analyses rather than "the encounters of treatment, the power relations that are displayed" (Banton et al 1985: 191). Conversation analysis (CA) focuses on the way social order is produced and managed as an interactional accomplishment (Sacks 1972; 1974; Atkinson & Drew 1979; Atkinson & Heritage 1984; Schegloff 1987; 1997). From this perspective, psychiatric power and patient resistance are "micropolitical achievements...produced in and through actual turns of talk" (Mellinger 1995: 394) rather than structured or determined by broad discourses. However the CA notion of external factors as interactional resources can underplay the extent to which broader discourses may come into play at the local level.

Therefore I have situated my methodological approach within DA (Potter & Wetherell 1987; Edwards & Potter 1992; Wetherell & Potter 1992; Widdicombe 1995; Potter 1996a; 1996b; Edwards 1998).[8] I combine a Foucauldian understanding of power at the micro-level with attention to the interactive context of language-in-use. I focus on a "naturally" occurring psychiatric/patient interactive context: that is, a context in which interactions occur whether a researcher is present or not. I attend to the way broader discourses and institutional practices come into play at the local level, and how locally produced social order and meanings are accomplished and resisted. This analytic approach enables consideration of the power relations displayed in clinical encounters and the implications for structuring gender relations and experiences in relation to schizophrenia. Underlying this approach are feminist aims, based on a concern for women's lives and a desire to elucidate the conditions of those lives (Wilkinson 1988; Gill 1995; Busfield 1996).

An important tenet of CA is that analysts should stay within the bounds of what is relevant to interactional participants (Schegloff 1992; 1997; 1998). Taking participants' relevance seriously, particularly in relation to gender understandings, has generated considerable debate in CA and DA in recent years (e.g. Schegloff 1997; 1998; Frith 1998; Stokoe 1998; 2000; Wetherell 1998; Billig 1999; Kitzinger 2000; Speer & Potter 2000; Speer 2001; Edley 2001; Stokoe & Smithson 2001), and has a number of advantages for a feminist analysis of gender and schizophrenia in a psychiatric context. It can demonstrate the way professionals' understandings of femininity, masculinity and schizophrenia are

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[8] It should be noted that within DA incudes various orientations ranging from Foucauldian inspired analyses (e.g. Parker 1992) through to analyses close to CA (e.g. Widdicombe 1993; 1995). Moreover, Potter (1996a; 1996b) and Edwards (1998) have moved closer to a CA approach whereas Wetherell (1998) has remained largely within the DA approach outlined in Wetherell & Potter 1992.

produced within the talk, rather than having essential meanings, ground the analysis in participants' own understandings, and thus provide an effective political critique (Widdicombe 1995; Kitzinger 2000). However, gender understandings (and schizophrenia) may operate as background relevancies (Garfinkel 1967; Zimmerman 1998) without being explicitly named within psychiatric talk (West & Zimmerman 1987; Ochs 1992; Schegloff 1997; Frith 1998; Hopper & LeBaron 1998; Kitzinger 2000). Therefore I attend to instances where gender and schizophrenia are explicitly oriented to within interactions and I take account of instances where they are relevant in non-obvious ways.

The site for the research is a psychiatric unit in South East England and the materials for analysis are audiotaped talk and notes of discussions between psychiatric professionals, patients with a diagnosis of schizophrenia, and their significant others in a type of case conference called the "Care Programme Approach" (CPA). As I discuss more fully in chapter two, the "ever-present" issue of access (Rachel 1996: 124) and the way it is interwoven with ethics in this setting sets constraints on the research and analytic processes and also raises questions about how relevance and micro/macro notions of power are framed when participants define the extent of context for the researcher. However, in comparison with large bodies of CA/DA work on medical encounters (e.g. Cicourel 1987; Silverman 1987; West 1990; ten Have 1991; Coupland et al 1994; Gill & Maynard 1995) and (psycho)therapeutic interactions (e.g. Labov & Fanshel 1977; Davis 1986; Buttny 1990; 1996; Burman 1995; Edwards 1998), relatively little research has been undertaken on psychiatric/patient interactions (Scheff 1968; Wootton 1977; Barrett 1988; Mehan 1990; Bergmann 1992; Hak 1992; Soyland 1994; Hak & de Boer 1995; Mellinger 1995),[9] particularly in Britain and since the 1983 Mental Health Act.

Therefore my aim is to use the discursive approach outlined to analyse contemporary psychiatric/patient interactions in a British psychiatric unit with a specific focus on discussions with and about patients with a diagnosis of schizophrenia. The feminist literature on gender and madness, and the sociological literature on schizophrenia and contemporary psychiatric power leave a number of questions unaddressed. The research

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[9] With the exception of Wootton (1977), all of the cited research was conducted in America, The Netherlands, Australia or Germany.

presented here represents a small contribution to filling some of these gaps and towards the discursive literature on psychiatric/patient interactions. My specific aims are:

1. To investigate how understandings of femininity and masculinity are constituted and negotiated in relation to schizophrenia during psychiatric professionals' interactions with patients in case conferences. Focusing on interactions in psychiatric case conferences provides an opportunity to explore discussions about treatment, discharge and on-going care in the community, and enables consideration of the way gender is made relevant as an accomplishment within interactions. A focus on femininity and masculinity overcomes problems with concentrating on women, and enables investigation of the interrelationships between femininity and masculinity, and their intersection with understandings of schizophrenia.
2. To explore how psychiatric/patient relations unfold within clinical encounters with a dual focus on power and resistance as local interactional accomplishments and the way broader discourses and institutional practices come into play at the local level. This dual focus will enable me to consider how contemporary psychiatric power works at the level of local encounters and the implications for structuring gender understandings and experiences: in particular, whether professionals enforce gender conformity or restore lives to purpose and autonomy, and who has the authority to determine what counts as a valid experience.
3. To analyse experience as an interactional resource and accomplishment. Focusing on the way experiences are formulated interactively allows consideration of how patients' biographies and current experiences, and experiences between patients and significant others, including notions of "care", are negotiated and contested during professional/patient interactions, and in relation to understandings of gender.
4. To explore how schizophrenia is made relevant in professional/patient discussions about treatment, future care and activities, and relationships between patients and significant others. The focus here is on the extent to which schizophrenia is named and applied as a label, or operates as a background understanding which organises professionals' understandings of patients and their experiences

My main objective is to fashion a discursive analysis of the intersections between femininity, masculinity and schizophrenia produced within contemporary psychiatric/patient relations at the local level of clinical encounters. Within CPA interactions, how do professional discourses of governance and control, and the management of locally accomplished power and broader mandates structure the intersections between gender and schizophrenia? How do professional understandings of gender and schizophrenia intersect with discourses of responsibility, choice and supervision, plans for restoring patients' lives, and definitions of trouble, blame and change?

The thesis is organised as follows:

In Chapter One, I provide a literature review of feminist approaches to gender/women and schizophrenia, and psychiatric and critical accounts of schizophrenia, with a focus on issues of gender, power and language. I explore problems with feminist accounts of labelling and/or oppression in terms of their focus largely on women, a top-down theory of power and a conceptualisation of language as labelling or reflecting the "real". I outline the mainstream psychiatric account of schizophrenia, and alternative understandings provided by anti-psychiatric and societal reaction theory focusing on the relevance of gender and conceptualisations of schizophrenia within these accounts. I draw on discursive approaches to gender and madness to reconceptualise language, gender and experience.

Chapter Two outlines the methodological approach I will use. The first half of the chapter is organised around questions of how to approach the analysis of power and gender. I consider how gender relations and experience are implicated in power relations and explore three approaches to contemporary psychiatric power, drawing on insights from Foucauldian, conversation (CA), and discourse (DA) analytic approaches. I discuss the CA criterion of participants' relevance, particularly in relation to gender, and draw out the implications for the research. From these discussions I delineate a discourse analytic scheme for investigating the research questions. The second half of the chapter examines the constraints of access and ethics which occur when researching a psychiatric context and the implications for the research and analytic process.

Chapter Three initiates the analytic core of the thesis and is concerned with the discursive constitution of psychiatric practices and professional/patient relations in CPA meetings, providing a framework for the chapters that follow. I investigate discourses which constitute power relations between psychiatric professionals and patients, considering the extent to which contemporary psychiatric power is concerned with governmentality or social control. I discuss the interplay between practices and relations as situational accomplishments and the incorporation of broader legislative concerns within interactions. And I examine the intersections between professionals' understandings of schizophrenia, and discourses of responsibility, choice and supervision.

In Chapter Four, I continue the focus on power with an investigation of patients' resistance and professionals' reassertions of psychiatric power at the local level. I discuss how patients appropriate and reformulate psychiatric discourses to resist the plans and assessments of the professionals. I assess the extent to which psychiatric control of decision-making and assessment is disrupted, and the effect in terms of practical outcomes for patients. I continue the exploration of power and resistance as interactional accomplishments and the impact of wider legislative and rights discourses. I go on to examine points of reassertion of psychiatric power, in response to patient resistance, focusing on the intra-professional post-meeting, and the extent to which professionals' understandings of schizophrenia and gender are resources for reasserting authority.

Chapter Five focuses more closely on professionals' gender understandings through consideration of professional/patient discussions about restoring patients' lives. I investigate the discourses deployed to position patients as insufficiently purposeful, drawing out how professionals' gender understandings inform their problematisations and solutions. I explore how patients' experiences are shaped and gendered within clinical encounters according to the activity of restoring lives. I assess whether contemporary psychiatry is more concerned with restoring lives than gender conformity, and the extent to which professionals' gender understandings inform notions of purposes and autonomies. And I consider the intersections between professionals' assumptions about schizophrenia, gender understandings and the restoration of patients' lives.

Chapter Six examines gender understandings and experiences as interactional accomplishments through investigating how discourses of "care" and experiences between patients and significant others are negotiated within meetings. I consider how carers experiences of care are shaped, interrelated with those of patients and gendered within interactions. I explore what care means in this setting and whether professionals reinscribe notions of caring as a traditionally feminine activity. In particular, I focus on professionals' definitions of trouble, blame and change, tracing configurations through the course of meetings. I examine how patients and significant others, and the experiences between them, are configured in gender relational terms to give sense to definitions of trouble and to accomplish blamings, excusings and decisions regarding who should change. And I weigh up whether understandings of femininity and masculinity or schizophrenia are the major resource informing professionals' definitions.

In the conclusion, I summarise and draw together the main arguments of the thesis. I include a feminist comment on the findings and suggest some future directions in which the research could be taken

Chapter One

Locating the Gender/Schizophrenia Relationship within Accounts of Madness: Issues of Gender, Power, and Language

Introduction

This chapter considers the academic literature concerned with the relationship between psychiatric understandings of gender and schizophrenia. Statistical imbalances between women and men in the area of mental disorder are well-established: more women than men are admitted and readmitted to psychiatric hospitals (DoH 1995); more women receive treatment for psychological problems from General Practitioners and health centres; and women are more often treated with psychotropic drugs (Chesler 1974; Allen 1986; Busfield 1996).[1] There are also diagnostic differences: women are more likely to be diagnosed as suffering from depression, affective psychoses, and neuroses, whereas more men are diagnosed as alcoholic, or as having drug related disorders (DoH 1995; Prior 1999; Kohen 2000). However, this is not the case for schizophrenia which is said to affect women and men in fairly equal numbers (American Psychiatric Association 1987; 1994; Kohen 2000; Scott 2000; Ussher 2000), giving it a gloss of gender neutrality.

In the first part of the chapter, I outline two interrelated feminist approaches to gender/women and schizophrenia which focus on labelling and oppression in the form of "sexism" within psychiatry and/or "sexism" within "patriarchal society". I raise problems about the concepts of power, gender and language underpinning this work, and the focus largely on women. Power is conceived in terms of a monolithic patriarchy producing a simplified power relation of male villains and female victims which does not consider how power relations may be more differentiated and complex. In turn, gender is mainly conceptualised as "women" leaving exploration of the interrelations between femininity, masculinity, and schizophrenia largely unexplored. I argue that the conceptualisation of language in terms of labelling and/or as reflecting the real world produces conceptual difficulties over what madness is and who is mad, exemplified by schizophrenia, and a "switching" between labelling and realism in explanations. Furthermore, there is a separation between language and experience which precludes consideration of the ways

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[1] However, changing definitions of mental disorder may mean that the claim that women "always dominate psychiatric statistics is...no longer accurate" (Prior 1999: 2)

experiences are given meanings within language and interactions. This literature does not focus on clinical contexts, nor is it evident how relevant gender understandings continue to be for a contemporary psychiatry which is largely concerned with community care.

The second part considers psychiatric and critical accounts of schizophrenia. I argue that despite very different and polarised explanations, neither approach is entirely gender-blind and both are suggestive that gender is potentially salient to psychiatric understandings of schizophrenia in clinical contexts, despite its distributional gloss of gender neutrality. However, in psychiatric accounts power is absented, gender is assumed to be an obvious difference and language simply describes a real world. In contrast, in anti-psychiatric and societal reaction theories power is once again conceptualised in terms of powerful psychiatrists and powerless patients, gender is underdeveloped and language becomes a relatively straightforward means of labelling and thus constructing schizophrenia. I suggest that these forms of social construction[2] are not particularly enlightening about the ways in which this occurs.

In the final section I draw on discursive approaches to gender and madness, and schizophrenia to provide reconceptualisations of language and gender, and to raise further questions regarding experience. I argue that discursive approaches afford a more complex analysis of psychiatric understandings and enable a reconceptualisation of language as constitutive of social reality in a broader and more comprehensive way than earlier notions of social construction. This conception of language refuses the "switch" between language as constructive and reflective. It also facilitates a reconceptualisation of gender as a contextual and discursive (re)production. I emphasise that gender should be understood as relational, consisting of two interdependent and interrelated parts, women and men. The separation between language and experience, discussed in the first section, re-emerges here and I argue for an approach which dissolves this separation; experiences should be understood as constituted within interactive and inter-subjective contexts. I conclude with the main question for my thesis: How are gender understandings negotiated in relation to schizophrenia during psychiatric interactions with patients?

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[2] A wide range of work in the social sciences has been termed "constructionism", from labelling theory and anti-psychiatry through to Foucauldian and other discursive approaches. Thus the term can mean very different things in different approaches (Potter 1996b). Some of these differences will be discussed through the course of the chapter.

1. Gender/Women and Schizophrenia: Sexist Psychiatry or Sexist Society?

Distributional anomalies have informed work in the field of gender/women and madness, where the primary focus has been on women and on categories where women predominate. In contrast, there is only a small body of literature explicitly focusing on gender/women and schizophrenia. In this section I discuss two major approaches in this field, contrasting explanations of sexist psychiatry, or madness as social construct, with those of sexist society, or madness as social product.

1.1 Sexist Psychiatry

The higher incidence of mental distress in women is viewed as primarily due to sexism within psychiatry where there is a double standard of mental health for women and men. There is a basic asymmetry in the way female and male sex-roles are conceived and responded to by psychiatry (Chesler 1974). The female sex-role is viewed as inherently deviant so that women may be regarded as mentally disturbed whether they conform to or deviate from the female stereotype, whereas men are only viewed as deviant if they behave in feminine ways. Women who reject the female role are usually diagnosed as schizophrenic, as are men who act out feminine behaviours such as dependency or passivity. Schizophrenia, it is argued therefore, is a label applied to women and men who deviate from their conditioned gender-roles (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992), although these writers are primarily concerned with women. This double standard is said to dominate psychiatric theories and treatments. In particular psychoanalytic theorists and therapists are said to present marriage and motherhood as necessary for women's happiness and mental health. In therapy, women are in an unequal relationship where they are dominated by a (usually) male authority figure who "helps" them to come to terms with their female role (Chesler 1974).[3]

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[3] Chesler's indictment of psychoanalytic theories and therapies has become increasingly problematic during the last two decades. Some writers have condemned traditional psychoanalytic therapy as an unequal power relationship with oppressive aims and outcomes (Rubin 1975; Ussher 1991). But since the 1970s, feminist revisions of psychoanalytic theory and practice have produced a much more complex view (Smith 1975b; Lipshitz 1978; Hare-Mustin 1981; Eichenbaum & Orbach 1983; Penfold & Walker 1983; Irigaray 1985; Elliot 1992; Gorman 1992). The success of feminist therapy in achieving its aims has been questioned (Lipshitz 1978; Allen 1986) but the argument is that therapy does not necessarily have to oppress women.

This account stresses the role of psychiatry in mediating the sexism in wider society through its evaluation and treatment of women, and the part that schizophrenia plays in enforcing sex-role conformity. A range of feminist writers have broadly supported Chesler's thesis,[4] although many writers do not include schizophrenia in their analyses even though their claims are for a general association between women and madness. This raises the question of what kinds of madness writers are talking about, and who is mad. According to Chesler there are very few mad women in Western cultures: they may be unhappy, powerless and self-destructive, but they are not mad. Only a small number of women experience "genuine states of madness" (Chesler 1974: xx). However, the distinction between "genuine" madness and unhappiness, and the role of psychiatry in producing this difference, is not clearly drawn (Chamberlin 1994). It would seem that schizophrenic women are truly mad but this differentiation does not sit easily with the tenor of Chesler's general thesis. Is psychiatry "genuinely" labelling these particular women? And why should rejecting the female role produce real madness while conformity does not (Russell 1995)? In attempting to delineate between the "real" and the "not real", Chesler produces an uneasy synthesis of labelling theory and surveys of extant mental disorder.

As such there appears to be an underlying unease about what madness is and who is mad, as exemplified by schizophrenia. It then becomes questionable that *general* explanations of labelling hold good for all kinds of madness (Sedgwick 1982). When schizophrenia is included, as in Chesler's case, it leads to conceptual problems and contradictions. It would seem that schizophrenia is irrelevant[5] or inconvenient for a feminist analysis: a problematic presence (what is madness, who is mad?) and a convenient absence (labelling is on firmer ground when associated with depression, anxiety and general unhappiness).

In addition, feminist analyses have been chiefly or wholly focused on women, raising two further problems. Firstly, conceptual underpinnings in terms of "women" have become

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[4] Psychiatry individualises, internalises and pathologises women's protests at their social situation (Smith 1975b: Stephenson & Walker 1981; Barnes & Maple 1992; Russell 1995). Psychiatrists over-medicalise women's lives obscuring issues of oppression and unhappiness (Prior 1999). And male experts in the nineteenth century viewed femininity and madness as synonymous (Ehrenreich & English 1979), a view that continues today (Gorman 1992). Masculine-biased assumptions are also encoded into diagnostic criteria of disorders such as Self-Defeating Personality Disorder and Premenstural Dysphoric Disorder, which could be applied to virtually all women, illustrating the difficulty of being a normal woman (Caplan 1987; 1995).

[5] For example, Russell (1995) makes this argument.

increasingly problematic for feminist/gender theorising. Analyses which focus on "women" as their subject(s) tend to assume: an essential, stable subject lying beneath different characterisations; a common identity that can provide a universal basis for a feminist project; and often a universal structure of oppression that produces a common (subjugated) experience. However, if we take seriously the idea that sex and gender are socially constituted, there is no "doer behind the deed" (Butler 1990: 25; Foucault 1980a; 1990; Riley 1988; Jacobus et al 1990; Bailey 1993; Hood-Williams 1996; Kitzinger 1999), then woman as a category and subject of feminism becomes highly problematic.[6] Furthermore, woman as a category and signifier has not remained stable over time (Riley 1988). If women's needs and sufferings are therefore not based on a common essence to being a woman, but emerge from the ways women are discursively positioned as women, then this raises the paradox that in taking the category of women as a stable subject, feminism has unintentionally reified the very gender relations it seeks to undermine.

Secondly, feminist analyses focusing largely or wholly on women leave the interrelationships between femininity/masculinity and schizophrenia largely unexplored.[7] However, at the same time, writers often rely upon an implicit comparison with, or assumed knowledge about, men (Busfield 1996). Thus gender as relational is assumed in many analyses, that is, that gender consists of two interdependent and interrelated parts, women and men (Flax 1987; Davies 1996). But these interrelations are not explicated nor fully analysed.

Research provides some support for the contention that women and men who deviate from their gender-roles will be diagnosed as schizophrenic.[8] Women with schizophrenia

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[6] The problem of assuming that there is a universal category of women is highlighted by the resistance encountered by white middle-class feminists from many of those who "should" be part of this category, for example women of colour, lesbian women and women from developing countries (Bailey: 1993).

[7] However some feminist writers have focused on gender and general accounts of madness. They suggest that symptoms and behaviours associated with depression and anxiety (where women predominate) are viewed as illnesses by health professionals, whereas alcoholism, drug abuse and personality disorder (where men predominate) have been perceived as wrong-doing rather than illness and still have an ambiguous status. As a result more women have been channelled towards the psychiatric system, men towards the penal system (Prior 1999; Holmshaw & Hillier 2000). However, definitions of mental disorder appear to be changing to include behaviours associated with men that used to be viewed as bad rather than mad, and may be related to the move to community care and concerns regarding dangerousness and risk to the public (Prior 1999).

[8] Sex-role non-conformity in general is likely to be viewed as mentally disordered or similar behaviours meet differential responses from health professionals. Women were viewed as more seriously disordered than men when they showed "masculine" symptoms such as alcoholism and anti-social behaviour, as were

may be more active, aggressive and dominant than normal women while men with schizophrenia may be more withdrawn and less active than women with schizophrenia and normal men (Cheek 1964). In addition, women with schizophrenia were more assertive than normal women, and men with schizophrenia more "sensitive" than normal men on self-image tests suggesting gender-role "alienation" (McClelland & Watt 1968: 226). However, it is possible that overactive women and passive men are simply more likely to be hospitalised. Moreover, while people with schizophrenia may have disturbed self-images, "role reversal" is not significant when the normal women for comparison are career women rather than housewives (McClelland & Watt 1968: 226). But reliance on the language of roles here, and in the feminist literature, is also problematic. It reinforces assumptions of consensus, continuity and complementarity (Stacey & Thorne 1985; West & Zimmerman 1987; Busfield 1996). Gender is far more basic and pervasive than can be captured in the term role or even roles[9] (Busfield 1996). Furthermore, the concept of roles makes it too easy to underplay or over-simplify issues of power (Stacey & Thorne 1985; West & Zimmerman 1987).[10]

Feminist literature, however, adds power to the notion of gender-roles through using the concept of patriarchy. But the term patriarchy directly attributes women's oppression to men and their actions so that all men everywhere have more power than women and use it to oppress them. In this sense it is both reductionist and circular (Pollert 1996). It over-emphasises the similarities and irons out all the differences between men, and between women based on race, socio-economic class etc. (Bailey 1993; Busfield 1996; Pollert 1996). The concept of patriarchy as explanation makes it difficult to accommodate the possibility that power may be exercised by some women over other women, or some men over other men (Ramazanoglu 1993). While patriarchy may still be useful as a descriptive rather than explanatory term (Busfield 1996), [11] Pollert (1996) argues that it is a reductive and confusing term which should be replaced by the concept of gender

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men with "feminine" symptoms of depression or anxiety (Waisberg & Paige 1988). And a similar pattern was found in psychiatric emergency room decisions on whether to hospitalise (Rosenfield 1982). However, clinicians may only fall back on gender understandings when the mental disorder category is less deviant or the symptoms are vague (Billingsley 1977; Dixon et al 1995).

[9] Although roles may be assigned to persons on the basis of gender.

[10] These problems are particularly germane to the functionalist notion of roles. The concept does not have to be functionalist; in the 1960s interactionists reformulated the notion to make roles more dynamic and socially negotiated. However, both conceptualisations underplay issues of power.

[11] It continues to be used by many feminists including some poststructuralist feminists (e.g. Weedon 1997).

relations.[12]

Thus the feminist account of sexist psychiatry relies upon a top-down hierarchical notion of power in which patriarchal male psychiatrists (in theory, if not always in practice) have substantial power over passive female patients and use it to pathologise them as a means of enforcing gender conformity. Recourse to an overarching concept of patriarchy leaves the possibility of complex and differential power relations unexplored and (re)produces an over-simplified relation of (female) victims and (male) villains. It is not clear how men with schizophrenia would fit into this conception of power relations. Chesler (1974: 38) does suggest that "white, wealthy and older men" who show severely disturbed behaviour may escape hospitalisation, implying that there may be differentiations between men, particularly in terms of class and race. However, such differentiations are not explored in relation to men or women. Moreover, power relations between psychiatric professionals and patients may have changed along with the move to community care, encapsulated in the move from the language of "doctors" and "patients" to that of "providers" and "clients"/"users" (Elliott 1997).[13]

However, there is evidence that clinicians do have a double standard of mental health. Clinicians' conceptions of male mental health were close to those for adult mental health whereas conceptions of female mental health differed markedly. Mentally healthy women were thought to be less independent, aggressive and competitive, and more emotional, submissive, passive and subjective than mentally healthy men or adults. Moreover, characteristics ascribed to mentally healthy men were seen as more socially desirable suggesting "a powerful, negative assessment of women." (Broverman et al 1970: 4). A number of studies in a similar vein continue to support the notion of a double standard of mental health (Abramowitz et al 1973; Brodsky & Holroyd 1981; Jones & Cochrane 1981; Swenson & Ragucci 1984; Waisberg & Paige 1988).[14] However, gender

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[12] However, Pollert (1996) proposes a Marxist feminist version of gender relations which is not consistent with the "poststructuralist" approach to gender, which will be outlined in the final section.

[13] In my own research I shall continue with the terms "doctor", "professional" and "patient", reflecting the terms used within the research context. This will be explained in more detail in the following methodology chapter.

[14] There is also the question of whether clinicians' gender makes any difference. Labelling theory predicts that evaluations will be more severe the greater the social distance between agent of social control and rule-breaker (Scheff 1966; Horwitz 1982). However the evidence is equivocal (Broverman et al 1970; Abramowitz et al 1973; Billingsley 1977; Stricker 1977; Swenson & Ragucci 1984; Smyth & McFarlane 1985; Loring & Powell 1988; Miles 1988; Dixon et al 1995). On balance, female clinicians may have the

understandings may have shifted over time. Whilst psychiatrists and psychologists continue to view adults as more masculine, and adults and men as less emotional than women, gender differentiation in terms of aggression and competence may have declined (Smyth & McFarlane 1985).

But it is not clear what characteristics such as (in)dependence mean to clinicians in this body of research. For example, the criteria for Dependent Personality Disorder in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, (DSM-III) focus on the ways women are likely to express dependency, such as lack of self-reliance and self-responsibility. The criteria do not include ways in which men may be dependent, for example reliance on others for housework and childcare. Thus women's dependency is pathologised whereas men's is not (Kaplan 1983a; 1983b). Or to put it another way, it is possible that clinicians have differential understandings of what it means to be (in)dependent which are in turn informed by gender understandings, although Kaplan lacks empirical evidence for her claim (Kass et al 1983; Williams & Spitzer 1983).

This points to a deeper problem in terms of the conceptualisation of language underpinning the literature on gender/women, schizophrenia and sexist psychiatry. In Chesler's thesis, language is the means for labelling and thus the means through which mental illness in general, and schizophrenia in particular, is constructed. In this conceptualisation, there is no straightforward correspondence between the experiences and actions of women and the language used to describe them. However this notion of labelling/social construction is not particularly informative (Hacking 1995; Potter 1996b; Rose 1999):

> ...the language of social construction is actually rather weak. It is not very enlightening to be told repeatedly that something claimed as "objective" is in fact "socially constructed". Objects of thought are constructed in thought: what else could they be? So the interesting questions concern the *ways* in which they are constructed. (Rose 1999: x, emphasis added) [15]

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potential to treat other women in a less biased way but this will not necessarily be the case, given their (largely male-controlled) training and shared understandings of gender characteristics and behaviours (Lipshitz 1978; Gorman 1992).

[15] While Rose (1999) is referring largely to studies of science and technology, this criticism applies equally to labelling approaches.

Such a conceptualisation of language has methodological and theoretical implications. When language is conceived as the means for labelling, feminist writers tend to draw on research focusing on hypothetical rating scales and case histories, questionnaires and, occasionally, interviews. The influential and extensively cited study by Broverman et al (1970), outlined above, provides a good example. Firstly, their bipolar scale of characteristics such as independent, emotional, aggressive, submissive etc. dichotomises differences that may only be a matter of degree (Stricker 1977; Swenson & Ragucci 1984; Russell 1995). Secondly, their rating scale is tapping into clinicians' attitudes rather than practices and it is unknown whether and how such attitudes may be translated into clinical practices (Billingsley 1977; Stricker 1977). Thirdly it assumes a stable attitude towards, and a common understanding of the meaning of the object(s) in question (Potter & Wetherell 1987). It relies upon such characteristics as independent and emotional having relatively simple and singular meanings rather than a complex of meanings.

At the theoretical level, this conceptualisation of language as (socially) constructing madness/schizophrenia tends to sit in an uneasy alliance with an understanding of language as describing or reflecting a real world. This leads to conceptual confusions and separations between real madness/unhappiness, schizophrenia/mild disorders, sex/gender, which tend to undermine arguments regarding the socially constituted character of schizophrenia and gender and conceal the potential diversity and complexity of psychiatric understandings.

One final question in this section concerns whether Chesler's account holds good for contemporary psychiatry in this era of community care. Allen (1986) claims that contemporary psychiatry simply does not operate in the way Chesler describes. Since psychiatry has extended out of the hospital into the community, psychiatrists are increasingly refusing to use deviance from gender-roles as grounds for psychiatric intervention; social coping does not necessitate adjustment to gender-role. In opposition to this, Busfield (1989; 1996) contends that the person being assessed is "always a gendered subject" (Busfield 1996: 114) and the judgment of performance on gendered tasks is likely to be salient.[16] However, writers are drawing on textual evidence; there is a

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[16] Busfield's analysis appears to be aimed at disorders such as depression, phobias and eating disorders, even though her claims are general and her analysis of gendered tasks operates at a relatively superficial level only. Nevertheless she provides strong support for the argument that gender understandings permeate

distinct lack of data from *actual* encounters between psychiatric professionals and patients throughout this literature.

Despite the problems associated with this literature, in broad terms and on balance it does suggest that clinicians hold a negative conception of femininity and are likely to pathologise gender deviation in both women and men. Schizophrenia is a key psychiatric label in this account, applied to women who are perceived as over-active and assertive, and to men who are dependent and passive. The research is also suggestive that psychiatric treatment, in terms of restoring patients to their "correct" gender, will be oriented towards notions of masculinity in terms of independence, activity and low emotionality, and femininity in terms of dependence, emotion and passivity, along with concerns related to marriage and motherhood. However we have little idea how psychiatric understandings of femininity and masculinity are articulated in relation to schizophrenia, particularly during interactions with patients, and in relation to community care. Nor what kinds of professional/patient relations are constituted.

In the following section I discuss an alternative, or additional, approach which argues that schizophrenia is the result of the oppression women experience in patriarchal society. I suggest that similar problems in terms of conceptualisations of gender, power and language arise in this body of literature.

1.2 Sexist Society

In the 1980s approaches which argued that sexism within psychiatry is central to any explanation of women's madness, lost ground to the claim that the major factor is the oppression of women in patriarchal society. This is not only due to empirical support for the latter explanation but also to the decline in support for labelling theory. Such an explanation is also less threatening to psychiatry and acknowledges women's suffering and misery in their daily lives (Busfield 1989). The argument that women's mental distress is a product of the oppression they experience in their daily lives is grounded largely in concepts of stress and based mainly on epidemiological research.[17] Early

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contemporary psychiatry.

[17] An early study of this sort was conducted by Gove & Tudor (1972). They suggested that there were higher levels of mental illness in married women than married men, whilst there were lower rates among unmarried women than unmarried men. They linked this with women's position in modern industrial societies which was said to have a negative effect on their mental health. The asymmetry in mental disorder statistics was

epidemiological work was influenced by feminist writings which highlighted "the problem that has no name" (Friedan 1963: 29): the frustration, dissatisfaction, stress and anxiety experienced by married women trapped in the housewife role (Bernard 1972).

A small number of feminist writers have explored the possibility that schizophrenia is the result of traumatic events or the stress and oppression associated with the female role (Al-Issa 1980; Warren 1987; Barnes & Maple 1992). For example, Al-Issa (1980) argues that the stressful life situations women encounter can produce schizophrenia, and Barnes and Maple (1992) suggest that schizophrenia is an understandable response to an intolerable situation; they cite a case study of a woman diagnosed with schizophrenia whose husband killed their three children and then committed suicide. Some of these analyses contain interesting insights regarding women and schizophrenia[18] but at a broader level, these analyses of women and schizophrenia add little to the general claims regarding women, madness and stress/oppression.

A large body of feminist work has drawn on epidemiological research to argue that the oppression of women in patriarchal society causes misery, suffering and mental disorder.[19] A range of epidemiological research provides some support for feminists' arguments that mental distress is the (social) product of stresses in women's lives, but the findings are mixed and somewhat contradictory[20] and there are a number of difficulties associated with this body of research.[21] However, while the small literature on women and schizophrenia

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due to the social situation of women and the nature of the feminine role, particularly within marriage

[18] Women may be more likely to have sexual fantasies than men as an escape from the harsh realities of life (Al-Issa 1980). Or women may be more likely to experience thoughts of rage as not their own (Barnes & Maple 1992).

[19] For example, women's mental distress is caused by their social and economic oppression (Oakley 1982), and the strains of marriage and family life (Lipshitz 1978), particularly if they are working-class women (Smart 1976). In terms of psychology, madness is construed as the unconscious expression of women's anger and desperation about the roles, activities and limited sexuality prescribed for them (Eichenbaum & Orbach 1983; Baker Miller 1986). More recently feminists suggest a more differentiated understanding in which ethnicity, age, sexuality and even parental status will affect the degree of stress women experience (Belle 1990; McBride 1990; Gorman 1992; Mind 1995; Bostock 1997; Holmshaw & Hillier 2000).

[20] For example, differential findings on effects of and interactions between marital status, employment, childcare responsibilities, age and ethnicity (Gove & Geerken 1977; Fox 1980; Kessler & McRae 1981; 1982; Warr & Parry 1982; Reskin & Coverman 1985; Thoits 1986; Prior 1999; Thorbjornsson 2000).

[21] Standard criticisms include employing concepts of mental disorder which exclude personality disorders where men predominate and taking insufficient account of the ways concepts of mental disorders and categories change over time (Dohrenwend & Dohrenwend 1976); sampling and combining different characteristics whilst ignoring others and operationalising these concepts in differing and often problematic ways (Warr & Parry 1982; Thorbjornsson 2000); sampling different populations (Cochrane 1983); and working with standard indices of stressful life events, excluding experiences that may be particularly salient for women (Busfield 1996).

adds little to general explanations, feminist analyses of women and general mental disorder seldom include schizophrenia, although their claims are for a general association between stress/oppression and women's madness. Thus a similar problem to the literature on sexist psychiatry occurs with the argument that women's madness is a social product. The vast majority of epidemiological studies are based on schedules which focus on symptoms related to depression and/or anxiety, or "mild emotional problems", where women have tended to predominate, rather than schizophrenia (Thorbjornsson 2000). Furthermore, it appears that feminist writers either have made general claims about oppression largely on the basis of research on milder disorders, or they have considered only the milder, or "female", disorders as relevant[22] (with the notable exceptions of Al-Issa 1980 and Barnes & Maple 1992).

In either case the unease about what madness is and who is mad, identified in the literature on sexist psychiatry, is replicated here. A problem which was overt in Chesler's analysis, is implicit in much of the work on oppression. It can be argued that claims regarding stress and oppression are on firmer ground when relating to depression, misery and unhappiness rather than the strange thoughts and behaviours associated with schizophrenia. This point is acknowledged by Al-Issa who warns that schizophrenia is considered to be "an extreme state of madness" (Al-Issa 1980: 71). Therefore, whilst connections can be made between the difficulties women experience in their lives and depression, anxiety and so forth, it is far less clear whether the same kinds of experiences can be linked with schizophrenia, and if so, why the same kinds of experiences should produce different kinds of distress.

This problem is particularly pertinent in Warren's (1987) detailed study of "mad wives" in 1950's America. She provides a re-analysis of Sampson et al's (1964) interviews with husbands of women hospitalised for schizophrenia, and the women themselves. She argues that the strain of the female housewife role at that time, the dependency, subjugation and isolation, precipitated mental distress which was re-framed within the psychiatric hospital as an individual problem. Psychiatric control supplemented and reinforced husbands' control of their wives through the focus on the marital relationship and the housewife role as key criteria for assessment and discharge.

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[22] Busfield (1988) and Pugliesi (1992) make this argument.

However, there are a number of major problems with Warren's account as a serious rendering of the relationship between gender and schizophrenia. Firstly, when the case histories of these women were rediagnosed in 1972, most of the women were either probably, or definitely not schizophrenic, illustrating the way schizophrenia has been an evolving category (Hacking 1995). Secondly, the changes to women's position in Western societies since the 1950's (de Ridder 2000), throw doubts on the continuing relevance of Warren's account. More importantly, Warren illuminates nothing specific to schizophrenia; that is, why were these women diagnosed as schizophrenic rather than, say, depressive? Her analysis implies that the same kinds of experiences can produce different kinds of distress but we have no idea why. In contrast, Brown & Harris (1978) suggest that ongoing difficulties such as three or more young children and lack of paid employment are linked with depression in women whereas more immediately disturbing events, such as marriage, moving house or bereavement, are linked with the onset, relapse or exacerbation of schizophrenia for women and men (Brown & Birley 1968).[23]

If certain experiences of stress are linked with schizophrenia for both women and men, as Brown & Birley (1968) suggest, then this highlights further the problem, throughout the feminist literature, of focusing only on women.[24] Firstly, it is possible that women and men experience the same levels of stress, but respond differently. For example, it has been suggested that women may be more likely than men to report psychological symptoms and to ask for help,[25] or women and men may have different coping strategies[26] and/or a differential vulnerability to the same levels of stress.[27] These alternative explanations are not without their flaws,[28] and are unlikely to be especially illuminating for schizophrenia

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[23] However neither of these studies focuses specifically on gender.

[24] Zlotnick et al (1996) provide similar evidence in relation to depression. They suggest that stressful life events and the lack of social support, particularly close friendship, affected depressive symptoms similarly for both women and men.

[25] For example, Phillips & Segal 1969; Horwitz 1977; Cooperstock 1981; Jenkins 1985.

[26] The suggestion is that women are socialised into "learned helplessness"; they are less able to cope with stress because they have less control over their environment and their lives than men (Radloff 1975; Cochrane 1983). Men are more likely to engage in distracting active behaviours whereas women are more likely to brood, thus amplifying their feelings (Nolen-Hoeksema 1987).

[27] Women may be more psychologically vulnerable and therefore less able to withstand emotional disturbances (Kessler 1979; Cochrane 1983). Feminist psychologists provide some support for this view (e.g. Eichenbaum & Orbach 1983; Baker Miller 1987). The "vulnerablity-stress model" suggests that women's gender-role leads to their greater vulnerability *and* more stress (Holmshaw & Hillier 2000).

[28] Community surveys of people who had not sought treatment have found no difference between women and men in their self-assessment of ill-health (Weissman & Klerman 1981; Jenkins 1985), suggesting that

given that it is said to affect women and men in equal numbers. But it is not clear whether women experience more stress than men (Alegria & Canino 2000), pointing to one of the limitations of feminists' analyses which focus solely on women. Following on from this, if the relationship between women and schizophrenia is associated with the stress and oppression of the female role, what is the relationship between men and schizophrenia? Once again, the interrelations between femininity/masculinity and schizophrenia are left unexplored, this time in relation to experiences of stress.

Furthermore, in focusing on women and the feminine role, this area of literature is drawing on the same concepts of sex/gender, roles and the category of women as the literature on sexist psychiatry, with the same attendant problems. The notion of patriarchy plays a central explanatory role here. The argument that schizophrenia is the product of the oppression women experience in patriarchal society involves moving from women's experiences to stress, from stress to oppression, and from oppression to patriarchy (Busfield 1988). Diverse experiences are equated with stress and in turn a straightforward association is presumed between stress and oppression which is not always warranted by the data.[29] Moreover, the meaning of oppression and its association with patriarchy is mostly assumed rather than defined (Busfield 1988). Thus not only are men's experiences largely absented from this approach, but the diversity and complexity of women's experiences also tend to be reduced in order to fit within the stress-oppression-patriarchy equation.[30] In addition, feminist accounts of sexist society rely on a top-down concept of power in which patriarchal men (husbands, psychiatrists, employers etc.) have power over women and use it to oppress them. Once again, we are left with the somewhat reductive picture of subjugated women and dominant men and the possibility of more differentiated power relations is left unexplored.

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women's help-seeking behaviour is only likely to provide, at best, a partial explanation. And, whilst theories of vulnerability posit mediating factors between stress and mental distress, they are either largely untested (Nolen-Hoeksema 1987) or suggest that all women everywhere (in patriarchal societies) will develop the same psychological structures regardless of socio-economic class, ethnicity, or sexuality. Also, as women's position in Western societies is changing, they may be becoming more assertive and independent and therefore better able to deploy problem-solving strategies when faced with stressful life events (de Ridder 2000).

[29] Warren's (1987) is a notable exception.

[30] This is particularly the case in general analyses of women and madness where multifaceted experiences are collapsed into aggregate measures of stress (Busfield 1988).

However, the explanation that schizophrenia is the (social) product of the oppression that women experience in society, is informed by a very different conceptualisation of language from that of sexist psychiatry. Here language is assumed to be a straightforward medium that describes or reflects a real world of stress and oppression which produces schizophrenia. But this understanding of language produces further conceptual confusions and separations for feminist researchers. Many writers move between the two explanations, even though both approaches appear to be mutually exclusive and contradictory: one views women's madness as a social construct, the other as a social product (Busfield 1988; 1989). For example, in the case cited by Barnes & Maple (1992), (in which they document the traumatic events which led to a woman being diagnosed with schizophrenia), they then go on to describe the same woman's difficult and challenging behaviour suggesting that women who defy social conventions are more likely to be labelled and hospitalised than women who do not.

Sedgwick (1982) claims that feminist explanations cannot have it both ways: they cannot argue that psychiatry is merely labelling women (who are really sane) *and* that the stresses and strains of life as a woman cause madness/schizophrenia. However, whilst these two approaches are superficially contradictory, some writers argue that they can be regarded as two complementary levels of analysis (Busfield 1988; Pugliesi 1992). Women suffer oppression in Western societies due to their structural position and the related identities and tasks assigned to them, and psychiatry mediates this sexism by reflecting these images of women and enforcing their conformity.[31] But Sedgwick is right to the extent that feminist writers have often failed to clarify the relationship between psychiatric labelling and experiences of stress and oppression. In many analyses it is not made clear whether psychiatry is pathologising women's reasonable actions and behaviours or whether it is contributing towards the stresses and strains that drive them mad. In this way, feminist analyses often move between a realist and constructionist stance "without noticing the switch" (Hacking 1995: 67). In "switching" between realism and constructionism, therefore, a further conceptual confusion is produced to add to those discussed earlier: oppression/labelling or social production/social construction.

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[31] Ripa's (1990) examination of nineteenth century case records at the Salpetriere asylum in Paris, and Penfold and Walker's (1983) Marxist-feminist analysis provide examples of this kind of synthesis.

Further, in conceiving language as a means of directly reflecting experiences another conceptual separation occurs, this time between language and experience. This separation precludes consideration of the ways the meanings of experiences (of stress, oppression, schizophrenia etc.) are formulated, interactively and inter-subjectively, within language in general and in psychiatric/clinical contexts in particular. And it precludes consideration of who has the authority to determine what experiences are valid or invalid and thus the ways that formulations of what counts as valid experience may be enmeshed within power relations (Scott 1992). Al-Issa's (1980) discussion of women with schizophrenia and their fantasies is suggestive here. While Al-Issa argues that fantasies are a form of escape for women, she goes on to state that such fantasies are viewed as delusions and hallucinations by psychiatrists. Thus experiences do not have predefined singular meanings but rather what an experience means is played out within a variety of linguistic and interactive contexts. And within a psychiatric context professionals may have the authority to reformulate the meaning of patients' experiences, as in the Al-Issa example. A top-down concept of power and patriarchy would predict that this would be the case. However, if power relations are conceived as more complex and differentiated, then the meanings of experiences become open to the possibilities of negotiation and contestation.

Therefore there may be connections between schizophrenia and the difficulties or traumas women experience in their daily lives which, in turn, are related to understandings of femininity. But, given feminist writers' sole focus on women, the extent to which men may be similarly affected by experiences associated with notions of masculinity is not clear. Further, if the "switch" between constructionism and realism, experience and language, is dissolved, the research is suggestive that experiences may be formulated and negotiated within interactive contexts which are enmeshed within power relations. However, we do not know how experiences are formulated in relation to understandings of femininity and masculinity, and articulations of schizophrenia during psychiatric interactions with patients. Nor the extent to which the meanings of experiences are negotiated and contested within professional/patient relations.

In summary, the literature on women/gender and schizophrenia has focused on labelling by a sexist psychiatry and/or stress and oppression in a sexist society. However, this literature is small in comparison with the large body of feminist work on women and madness, despite many of the claims being for a general association between the two. I have suggested that schizophrenia is a problematic presence and a convenient absence, reflecting an unease about what madness is and who is mad. Writers' recourse to notions of roles and patriarchy results in a top-down hierarchical understanding of power where women become victims, men villains, and any sense of more complex and differentiated relations is lost. Their focus, largely or solely on women, creates two further problems. Reliance on the category of "women" tends to assume a stable, common identity of "women" which is difficult to maintain if both sex and gender are viewed as socially constituted. Moreover, the focus on women leaves the interrelationships between femininity, masculinity and schizophrenia largely unexplored.

I have argued that these problems are, in turn, underpinned by particular conceptualisations of language as constructing or simply describing the world. As writers "switch" between the two, conceptual confusions occur which undermine notions of schizophrenia and gender as socially constituted, and underplay the potential complexity and diversity of psychiatric understandings of characteristics and behaviours such as dependency, emotion and activity, and issues of marriage and parenthood. Furthermore, in conceiving a separation between language and experience, writers do not consider how patients' experiences are formulated and negotiated within language, and power relations. In this respect, the literature reviewed has not focused on interactive contexts between psychiatric professionals and patients. Nor is it clear what continuing relevance psychiatric gender understandings have in the era of community care.

Therefore the feminist literature on women/gender and schizophrenia leaves a number of questions unaddressed. How are understandings of femininity and masculinity negotiated in relation to schizophrenia during contemporary psychiatric interactions with patients? What kinds of professional/patient relations are constituted? And how are experiences negotiated and gendered during professional/patient interactions?

In this section, I have discussed explanations of the relationship between gender and schizophrenia in the feminist literature on women/gender and madness. In the next section I turn to the question of gender's relevance to schizophrenia in the existing psychiatric and sociological literatures on schizophrenia.

2. Psychiatric and Critical Understandings of Schizophrenia

In this section, I summarise the mainstream psychiatric explanation of schizophrenia and alternative understandings provided by anti-psychiatry and societal reaction theory. The aim is to provide a brief outline of these differing understandings focusing in particular on how schizophrenia is conceived and the relevance of gender within these accounts.

2.1 Mainstream Psychiatry

According to the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV, American Psychiatric Association, APA, 1994) schizophrenia is a "disturbance" (pg. 273) which is characterised by "positive" symptoms of delusions, hallucinations, disorganised speech and grossly disorganised or catatonic behaviour, and "negative" symptoms of affective flattening, alogia and avolition (APA 1994: 274-5). Schizophrenia is most likely to appear between late teens and mid-thirties, although it can also begin at a later age (after forty-five years old), and varies in its course with some people having acute episodes followed by remission while others remain "chronically ill" (APA 1994: 282). But complete recovery is "probably not common" (APA 1994: 282).

The validity of schizophrenia is underpinned for mainstream psychiatry by research establishing a biological basis for the disorder. The strongest evidence is said to come from twin, adoption and familial linkage studies which point to a genetic predisposition to schizophrenia (Kohn 1972; Townsend 1980; Gottesman & Shields 1982; Metcalfe 1992; Andreasen & Carpenter 1993; Cockerham 1996). There is also evidence of biochemical changes in the neurotransmitter dopamine (Townsend 1980; Metcalfe 1992; Cockerham 1996), and structural brain abnormalities believed to be caused either by genetic factors or early neurological damage such as birth complications (Townsend 1980; Lewis 1992; Metcalfe 1992; Andreasen & Carpenter 1993; Cockerham 1996). But biological and genetic factors cannot provide a complete explanation (Bentall et al 1988; Metcalfe 1992) and schizophrenia is therefore viewed as occurring within people who are biologically predisposed towards it and who are exposed to stressful life events which trigger the disorder (Kohn 1972; Metcalfe 1992; Cockerham 1996). However, this should not be taken to mean that mainstream psychiatry maintains a simple adherence to a medical model of schizophrenia.[32]

Psychiatric researchers have incorporated sex differences into genetic studies for many years,[33] but in the last two decades psychiatric researchers' interest in sex/gender and schizophrenia has grown considerably and sex/gender difference makes its first appearance in the American classificatory system in the 1987 edition (APA 1987). Recent psychiatric research suggests that there are sex/gender differences in age of onset (Lewis 1992; Takei et al 1992), course and outcome (Angermeyer et al 1990; Childers & Harding 1990; Haas et al 1990), premorbid function (McGlashen & Bardenstein 1990; Foerster et al 1991; Torrey et al 1991), non-nuclear symptoms (Bardenstein & McGlashen 1990), neuropsychology (Addington & Addington 1991; Haas et al 1990), familial risk (Goldstein et al 1990) and brain structure (Castle & Murray (1991). Women with schizophrenia are said to have a later onset, a better response to drug and family treatments, less problems prior to developing schizophrenia and more likelihood of having dysphoric and depressive symptoms (Zolese 2000). In addition, high oestrogen levels are said to delay onset and improve response to drug treatment and conversely low levels exacerbate symptoms (Seeman & Lang 1990). Men may be particularly likely to suffer from severe schizophrenia with early onset, negative symptoms and a poor outcome which may be due to early neurological damage rather than genetic factors (Castle & Murray 1991). Men with schizophrenia are also more commonly involved in substance abuse and anti-social behaviour (Lewis 1992).[34]

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[32] Psychiatrists do not hold a unitary view; for example, Andreasen & Carpenter (1993) outline three different conceptual models of schizophrenia. And psychiatrists have long incorporated psycho-social factors into their theories and practices (Clare 1976; Wing 1978; 1988; Rose 1986a; Allen 1986; Prior 1999). Such "eclecticism" suggests that clinicians do not "accept the medical model in a simple and straightforward way" (Baruch & Treacher 1978: 227) although some psychiatrists suggest that this eclecticism is declining, influenced by the "biological transformation" in the U.S.A. (Thomas 1997: 147).

[33] For example, Kendler and Walsh (1995) cite genetic studies as far back as 1928 which reported results differentiated by sex.

[34] A pertinent question here might be how issues of social class and race interact with gender and schizophrenia. I am aware that there is an extensive body of literature on social class and schizophrenia (e.g. Hollingshead & Redlich 1958; Goldberg & Morrison 1963; Turner & Wagenfeld 1967; Dohrenwend & Dohrenwend 1969; Kohn 1972; Brenner 1973; Cochrane 1983); and on race and schizophrenia (e.g. Fanon 1963; Rack 1982; Mercer 1986; Littlewood & Lipsedge 1997). However these literatures are beyond the scope of this review. Nevertheless it should be pointed out, firstly, that African/African-Caribbean people in Britain are over-represented in the psychiatric patient population in general, are more likely to be formally detained under the mental health act and are over-represented in the diagnostic category of schizophrenia in particular (Mercer 1986; Littlewood & Lipsedge 1997). Secondly, there is very little discussion of gender in the work on social class (Busfield 1996) and gender is "conspicuous by its absence" in transcultural psychiatry (Mercer 1986: 292). Thirdly, some writers (e.g. Littlewood & Lipsedge 1997) seem to fall into a similar trap to feminist analyses of gender and schizophrenia: it is both stress and psychiatric labelling.

The explicit way that recent psychiatric research and diagnostic manuals incorporate sex/gender into their delineations of schizophrenia suggests that gender has become increasingly relevant to psychiatric understandings of schizophrenia at the definitional/research level, but we do not know, from this literature, what relevance gender understandings may have for psychiatric practices. This produces something of a paradox. While psychiatric research and classification is replete with gender differentiations, the widespread belief that schizophrenia affects women and men equally, retains its gloss of gender neutrality. However, Smith (1975a: 109) warns that differences between women and men are not necessarily ones of "magnitude", and Holstein's (1987) study of involuntary psychiatric commitment hearings demonstrates the way gender effects may be hidden beneath statistical associations.

Furthermore, psychiatric research on sex/gender and schizophrenia adheres to a standard experimental-scientific approach in which sex/gender is conceived as a straightforward, visible, dichotomous difference which makes a useful variable in schizophrenia research. As such it is a common sense commonplace category which does not require definition. Language here is assumed to be and deployed as a transparent medium, used as the pathway to the study of sex/gender and schizophrenia. And consonant with this approach, power relations between psychiatrists and patients, psychiatric researchers and their subjects are absented. What we are left with, as Haraway (1991) points out, is a "gaze from nowhere" (pg. 188). Therefore, we can say that gender understandings are relevant to psychiatric researchers' understandings of schizophrenia at the definitional/research level but in a largely unknown way, and certainly unknown in relation to clinical practices.

In the following section I turn to the salience of gender in alternative explanations of schizophrenia.

2.2 Anti-Psychiatry and Societal Reaction Theory

The most well-known alternative explanations of schizophrenia were provided in the 1960s and early 1970s by the anti-psychiatry movement and societal reaction theorists. They contested the meaningfulness of schizophrenia as a mental disorder arguing, in general terms, that schizophrenia is a social construct; it is behaviour that breaks social rules. Mainstream psychiatry is criticised for conceptualising and treating such behaviours in physiological terms and thus acting as agents of social control. For the purposes of this discussion I am particularly interested in drawing out the gender relevancies within these accounts, although they are underdeveloped, and to explore the conception of schizophrenia, in some accounts, as a label or diagnostic category which organises professionals' (and patients') perceptions of patients' experiences and behaviours.

For example, Szasz (1973; 1974; 1997) argues that people who are termed mentally ill have "problems in living" (1973: 21) which are very different from medical/bodily diseases. Schizophrenia is the sacred symbol of psychiatry, invented to control (almost any) behaviour which is unacceptable and disturbing to others (Szasz 1976). In particular he compares the psychiatrist/schizophrenic patient relation within institutional psychiatry to the husband/wife relation within marriage,, with schizophrenia as the child and/or incompetency and femininity. While he suggests that madness and the asylum became an alternative "career" for women in patriarchal society, the schizophrenic/wife is a way of life for both women and men. What characterises both relations is that "power is distributed and secured in a tight vertical network" (Szasz 1976: 161); a power relation which Szasz argues is strengthened, not weakened, by deinstitutionalisation. However, the powerlessness and subordination of women in patriarchal society, and madness as a potential "career" for women, are only pursued insofar as they further his comparison of psychiatry with marriage. The symptoms of schizophrenia are said to be the primary symptoms of femininity; incompetence outside the home, dependence on authority and family, and unemployability (Szasz 1976: 158). Szasz suggests that both women and men can become "wives" to institutional psychiatry, and he raises some interesting questions regarding the "femininity" of psychiatric understandings of schizophrenia in terms of notions of home, dependence and employability, although these ideas are not developed.

Labelling or societal reaction theorists (Scheff 1966; Rosenhan 1973) take a rather different approach. Schizophrenia is a label applied by agents of social control to residual rule-breakers. Through their understanding of general stereotypes of mental illness within society, and through the reactions of others, people who have been labelled "mentally ill" accept and eventually internalise the social role of a mentally ill person (Scheff 1966). In particular, Rosenhan's (1973) pseudo-patient study suggests that once the label of schizophrenia has been applied it becomes a self-fulfilling prophecy; past and present behaviours and experiences are interpreted in the light of and reinforce the label. However, gender is not thematic in the work of Scheff or Rosenhan.[35]

While Szasz and societal reaction theorists were not exclusively concerned with schizophrenia, Laing focused his critique on schizophrenia. In his early work Laing (1960) argued that schizophrenia should be understood as a reaction to relations and interactions within the family, in particular a dominant mother and an emotionally withdrawn father. He questioned the unintelligibility but not reality of schizophrenia at that stage, but by 1964 he was arguing that schizophrenia was a social creation, a diagnosis given to people trying to make sense of the senseless situations in which they were living (Laing & Esterson 1964). Explanation remained focused upon the family and their interactions; schizophrenia was the reaction to contradictory and incomprehensible family interactions. In his later work schizophrenia becomes "a successful attempt not to adapt to pseudo social realities" (Laing 1967: 57), a strategy for living in the "protection racket" of the family and an insane world (pg. 55).

Throughout his career, the subjects of Laing's work are largely women and girls (Smart 1976). For the purposes of this discussion, gender issues are omnipresent in this body of work: Mrs D's anger towards her husband, the conflicting messages about femininity received by daughters from their families, and Mary Barnes' relationship with her (male) therapist. Many critics argue that these issues are not developed nor even acknowledged so that ultimately Laing reaffirms the power of the male therapist over the passive and pathologised female patient while also recirculating the idea that mothers are the main cause of their children's problems (e.g. Sedgwick 1982; Showalter 1987; Ussher 1991).[36] However, Sanity, Madness and the Family (Laing & Esterson 1964) is a powerful account

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[35] Although the ideas of labelling theory were taken up by feminist writers such as Chesler (1974), as discussed in the first section.

[36] It is certainly the case that Laing recirculates and reinforces the notion of the "schizophrenogenic mother" in his early work, even though he claims it is schizophrenogenic families, for example: "Peter's" mother is squarely blamed and described as self-obsessed; "Julie's" mother is "suffocating" (Laing 1960: 26 & 189). And in the 1964 work, for example, "Hazel's" mother is described as "grossly hysterical, giggly, dissociated, frigid" (Laing & Esterson 1964: 229). Later, at Kingsley Hall, and despite protestations of no authority figures, Mary Barnes' (1972) account suggests that ultimately the male therapists did retain authority over their (female) patients. However, in his later work Laing (1967: 93) did become critical of therapists' views of mothers "who are always the first to get the blame for everything".

of the constraints and differential treatment of daughters at that time. The gender issues laid out in this work are certainly not developed or fully acknowledged *as* gender issues, but Laing makes it clear that these girls were attempting to develop their autonomy, individuality and equal treatment within the family, raising potential relevancies for psychiatric understandings of the relationships between femininity, home and family, and autonomy.

In these critical accounts of schizophrenia, the same relation of powerful labelling psychiatrist/subjugated labelled patient is produced here as in the feminist literature. Moreover, anti-psychiatry and societal reaction theory have lost support in recent years; these explanations are often viewed as denying the reality or extent of people's suffering (Busfield 1989). This problem is directly related to the conceptualisation of language underpinning this body of work. Despite theoretical and political differences these writers all argue that schizophrenia is a social construction, but neither Szasz nor Laing pay much attention to the factors and processes underlying the regulation and control of those with disturbing or incomprehensible behaviour, and Scheff (1966) provides very few instances of residual rule-breaking (Busfield 1996). Thus ultimately these social constructionist accounts are not very illuminating. While psychiatry names and labels certain behaviours as schizophrenia, we have little idea of the ways in which this occurs or even whether psychiatrists do apply labels such as schizophrenia within clinical contexts in the way labelling theory and anti-psychiatry claim.

This is not to say that more informative accounts are not available. Goffman (1968) charts in detail the "moral career" of the mental patient from "offences against some arrangement for face-to-face living" (pg. 125) via various "career contingencies" (pg. 126) to the psychiatric ward where the patient is demoralised, discredited and controlled.[37] Furthermore, any actions and interactions of patients disapproved by psychiatric professionals, particularly disruptive or uncooperative behaviour, are likely to be viewed by psychiatrists as evidence of pathology. But neither schizophrenia nor gender are the focus of Goffman's account and his concentration on total institutions in general, and the psychiatric institution in particular, renders its relevance to psychiatric/patient relations in

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[37] Such "career contingencies" can take on gendered aspects, for example, a wife tolerates her psychotic husband until she finds another partner, a rebellious teenage girl becomes unmanageable when the prospect of an unsuitable affair arises (Goffman 1968: 126).

the era of community care uncertain; he specifically excludes those treated by psychiatry outside the asylum.

Therefore, anti-psychiatric and labelling explanations of schizophrenia have not been entirely gender-blind. But gender is either not thematic, or it is underdeveloped within these critical accounts of schizophrenia, even when it permeates the work, leaving the relevance of gender to psychiatric understandings of and responses to schizophrenia unclear. For example, the past and present behaviours and experiences of patients are said to be interpreted in terms of schizophrenia (Rosenhan 1973), but we have little idea how psychiatric understandings of femininity and masculinity might intersect with such interpretive work. And the writings of Szasz and Laing are indicative of relevancies in terms of issues around home, family, (in)dependence, employability and femininity but it is not apparent how these issues are oriented to by psychiatrists in interactive contexts with patients.

To summarise, mainstream psychiatry understands schizophrenia as a disturbance within the person chiefly caused by a genetic predisposition to the disorder in interaction with environmental stresses. In contrast, anti-psychiatric explanations present schizophrenia as unacceptable behaviour which breaks social rules, or as an understandable response to contradictory family interactions or a pathological society, with psychiatrists acting as agents of social control. However, understandings of power and gender, although very different in these polarised accounts, have circumscribed the kinds of explanations provided in similar ways to the literature on gender/women and schizophrenia. Power is either absented or conceived as a top-down hierarchical relation of powerful psychiatry/powerless patient. In the first case there is no acknowledgement that power is implicated in knowledge production, in the second case, once again, consideration of potentially more diverse and complex relations is precluded. In turn, gender is an assumed, but unexplicated, obvious difference, or it is undertheorised and underdeveloped. Both approaches suggest that gender is potentially salient to psychiatric understandings of schizophrenia, despite its distributional gloss of gender neutrality, but neither illuminates how understandings of femininity and masculinity may be made relevant to schizophrenia in clinical contexts.

I have argued that these problems are related to the conceptualisations of language underlying each approach: language is either a transparent medium for depicting gender differences in the category of schizophrenia, or it is a means for labelling disturbing persons and thus constructing schizophrenia. Further, the complex ways in which psychiatrists may understand and respond to patients' behaviours and experiences (past and present) in relation to schizophrenia, such as those related to home, family, (in)dependence and femininity, are not explored. Nor are the ways these understandings are played out in interactions between psychiatric professionals and patients. In this respect it is not clear whether psychiatric understandings of schizophrenia are related to notions of femininity such as dependence, home and (un)employability for all patients (as Szasz suggests) or whether psychiatrists draw on differential understandings of femininity and masculinity (as feminist writers suggest), or whether notions of dependence/independence take on subtly different meanings informed by professionals' understandings of femininity and masculinity. In addition, it is far from clear whether psychiatrists name and apply the label of schizophrenia as straightforwardly as this approach implies, nor how this occurs in clinical contexts. Therefore the psychiatric and sociological literatures on gender and schizophrenia suggest a reiteration of questions raised at the end of the last section, and some additional questions. How is schizophrenia articulated in clinical encounters? And how are the past and present behaviours and experiences of patients negotiated in relation to psychiatric understandings of gender and schizophrenia within interactions?

In this section, I have discussed gender's relevance to schizophrenia in psychiatric and sociological literatures. In the final section, I turn to discursive approaches to gender and madness, and schizophrenia. These approaches have different theoretical underpinnings and ask different kinds of questions to the previous work reviewed, which facilitate reconceptualisations of gender and language and raise further issues related to experience.

3. Discursive Approaches: Reconceptualising Language and Gender, and Revisiting Experience

In calling this third approach discursive, a caveat is necessary. Discourse analysis is a term used for a range of approaches including Foucauldian archaeology/genealogy (e.g.

Foucault 1971; 1972; 1973; 1990), the discourse analytic approach developed within the social study of science and social psychology (Gilbert & Mulkay 1980; 1984; Woolgar 1980; Potter & Wetherell 1987; Edwards & Potter 1992; Wetherell & Potter 1992) and conversation analysis (e.g. Sacks 1972; 1974; Atkinson & Heritage 1984; Schegloff 1987; 1997). I will be discussing some of the differences between these types of discourse analysis in the methodology chapter. However, for the purposes of discussing the literature here, there are some common assumptions about language, subjectivity, and knowledge shared by discursive approaches. In this section, I discuss feminist discursive approaches to gender and madness, discursive[38] analyses of schizophrenia and problems of experience. The primary focus throughout this section is on language.

3.1 Discursive Approaches to Gender and Madness

In the previous sections, I have discussed problems associated with conceiving language as a straightforward medium which describes, labels or reflects a real world. In feminist discursive analyses language becomes the medium through which different versions of social reality are created. As such language is constitutive of those social realities. When language is conceived in this way, discourse in the form of talk or texts, becomes the topic of analysis rather than being used as a pathway to the study of something else, such as stress, oppression or schizophrenia. Accordingly, this approach moves away from causal questions of "why" more women than men are mad or labelled as mad, to ask "what" knowledges, or discourses, of gender and madness are created in particular social and historical contexts. For example, feminist writers taking this approach have suggested that madness became feminised in the nineteenth century, symbolised by cultural representations of suicidal Ophelia, representing sexuality and emotionality, and sentimental Crazy Jane, representing feminine vulnerability and dependency (Showalter 1987). In twentieth century literature the schizophrenic woman becomes "the symbol of linguistic, religious, and sexual breakdown and rebellion" (Showalter 1987: 204). And in contemporary psychiatric understandings, pre-menstrual syndrome and post-natal depression are associated with discourses of women as biologically unstable, vulnerable and inferior (Ussher 1991).

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[38] One analysis included here is linguistic rather than strictly discursive.

When language is conceived as constitutive of social realities, then subjectivity, our sense of ourselves, becomes fragmentary, contradictory and changeable as persons are positioned within, produced and reproduced by different discourses and discursive practices. This "decentring the subject" challenges and transforms humanist conceptions of the person as having a stable, unified, coherent essence (Weedon 1997: 32). The question becomes "what" kinds of subjectivities are produced within discourses of gender and madness. For example, when the category of manic-depression was covertly gendered in terms of "wild women", dementia praecox in terms of "dour men", psychotic women were positioned as "out-of-control", psychotic men as stable (Lunbeck 1994: 144 & 149). And as the meaning of anorexia nervosa shifts according to the differing contexts of its production and reproduction, women are positioned as particular and contradictory kinds of subjects, for example, irrational, pathological, conflictual, romantic, self-controlled (Bordo 1990; 1993; Hepworth & Griffin 1990; 1995; Malson 1992; 1995; 1997; 1998). Discourses also accomplish social actions in the historical and social contexts in which they are formulated and deployed; they have practical social effects. For example, when women are construed in terms of their inner feelings and as compliant and harmless, and men are understood according to their external behaviours and actions, certain practical effects occur. As a result of these discourses, women are more likely to be sent into the psychiatric system, men into the penal system, even though they have committed the same kinds of offences (Allen 1987).

Therefore when language is reconceptualised, madness in general, and schizophrenia in particular no longer has a reality outside of language but rather what schizophrenia means is socially produced and reproduced within discourses which vary across time and place. Language is constitutive in a broader and more complex way than the social construction/labelling approaches reviewed earlier; the focus is on the *ways* that different understandings of madness and gender are constructed. And there is no "switch" between language as constructing and reflecting social realities. However, feminist discursive analyses of gender and madness have all focused on textual and interview material rather than interactive contexts between psychiatrists and patients.

This reconceptualisation of language suggests a very different concept of gender than in the women/gender and schizophrenia literature reviewed in section one. When language is conceived as constitutive, "women" and "gender" no longer have an essential nature or meaning. Rather, their meaning is (re)produced within discourses. However, in many cases, there is a continuing focus on women and/or categories where women predominate, although Allen (1987) and Lunbeck (1994) are notable exceptions. Thus some of the problems associated with focusing solely on women, discussed in the first section, re-emerge here. From a discursive perspective, it is no longer the case that "women" have an assumed essential, stable essence; the category of "women" can become "a site of permanent openness and resignifiability" (Butler 1992: 16). And the question becomes "how is 'woman' constructed as a category within different discourses?" (Mouffe 1992: 373). Moreover, some writers claim that there should be a continued concentration on women; women are positioned in different discourses which regulate them differently from men (Ussher 1991).

However, this can lead to three problems. Firstly, analysts may rely on an explicit or implicit comparison with, and assumed knowledge about men (e.g. Ussher 1991), as in the earlier literature on women and schizophrenia (Busfield 1996). Gender as relational is simultaneously assumed and unexplored. Secondly, it can result in a somewhat over-simplified and misleading picture (e.g. Showalter 1987). For example, when nineteenth century representations of men are considered, it is no longer clear that madness was the female malady Showalter (1987) claimed it to be (Busfield 1994). Thirdly, gender continues to mean women. When this is the case, feminist analysis "ironically privileges the man as unproblematic or exempted from determination by gender relations (Flax 1987: 629).

In contrast, a conception of language as constitutive facilitates a reconceptualisation of gender as a relational and contextual discursive production. Gender is conceived as a fluid category, its meaning created (and recreated) through social action and interaction in specific contexts. Such a conception assumes that there will be a relation, that gender is interrelated:

> ...gender relations are...constituted by and through interrelated parts. These parts are interdependent, that is, each part can have no meaning or existence without the others...Through gender relations two types of persons are created: man and woman. (Flax 1987: 628).

But what gender means will emerge in the specific social context in which it is formulated and deployed:

> As a practical social relation, gender can be understood only by close examination of the meanings of "male" and "female" and the consequences of being assigned to one or the other gender within concrete social practices. (Flax 1987: 630).

Further, this conception does not presuppose what that gender relation might be, or perhaps that there will be one relation. Gender relations have "no fixed essence" (Flax 1987: 624), but rather, vary across time and place according to the contexts of their production and reproduction (Flax 1987; Davies 1996). In this sense gender is better understood as a verb, a doing, rather than a noun, a being (West & Zimmerman 1987; Davies 1996). Moreover, the meanings of gender relations are formulated to accomplish particular social actions in specific contexts; they have practical social effects, as we saw in Allen's (1987) analysis of psychiatric and penal disposals. This conceptualisation of gender has certain theoretical affinities with (strands of) postmodernist/poststructuralist feminism (e.g. Scott 1986; Nicholson 1990; Butler 1990; 1994; Butler & Scott 1992; Hekman 1990; 1997; 1999; Weedon 1997). Reconceptualising gender as a relational and contextual discursive production focuses attention on the contexts in which psychiatry (re)produces meanings of femininity and masculinity in relation to schizophrenia. And a focus on interactive contexts enables consideration of the ways gender is made relevant as an accomplishment within interactions (Kitzinger 2000).

Gender conceived as relational, therefore, overcomes problems associated with concentrating solely on women and is consistent with a reconceptualisation of language as constitutive of social realities. If language creates social reality including our very sense of ourselves then knowledge and truth, including truths about gender, become problematised, destabilised and relativised, a prospect that is particularly appealing to some feminist researchers (Jacobus et al 1990). However, such a reconceptualisation of language leaves feminist analyses grounded in the "reality" of women's lives problematic, especially women's accounts, experiences and bodily states. Thus the problem of a conceptual separation between language and experience, which was discussed in the first section, re-emerges here unresolved in some of the discursive analyses.

A number of feminist discursive accounts draw on a variety of literary texts by women writers. It is suggested that women should be allowed to "speak for themselves" (Showalter 1987: 20; Ussher 1991). But the status of these accounts, vis a vis other texts that are analysed, is not made explicit. However, there appears to be an underlying, but unexplicated, assumption that women's accounts of their experiences of hysteria, schizophrenia, etc., have an intrinsic integrity and truth status which is presumed but not explained (e.g. Showalter 1987). A similar difficulty occurs in discussions of women's experiences of bodily states. For example, pre-menstrual tension and post-natal depression are discourses of women as biologically unstable, vulnerable and inferior and, *at the same time,* women's reproductive biology is real, and a pathway to madness (e.g. Ussher 1991). Once again, women's voices are assumed to have a real world validity that other discourses do not.

Therefore some analyses reproduce a separation between language and experience despite taking a discursive approach. There is a tension and contradiction between language and discursive practices on one hand, and the reality of women's lives and bodily experiences on the other, as writers move back and forth between discursively produced "truths" and a privileged truth.[39] Basing feminist research on women's experiences and perspectives is the central tenet of feminist standpoint theory (e.g. Harding 1986; 1991; 1997; Henwood & Pidgeon 1995; Smith 1997). Women's perspectives, grounded in their everyday lives, are said to have the potential to generate "less partial and perverse descriptions and explanations" (Harding 1991: 127). However, there are dangers in "romanticizing and/or appropriating the vision of the less powerful"; seeing "from below is neither easily learned nor unproblematic" (Haraway 1991: 191). And it is not entirely clear whether the experiences that particular women have, and express, can be generalised to notions of "women's experiences" as differences between women proliferate. Moreover, there is no necessarily straightforward correspondence between women's experiences and suppressed or subjugated knowledges. Women can, and often do draw on dominant (masculinist) discourses when speaking about their experiences (Kitzinger & Wilkinson 1997).

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[39] More recently a "material-discursive" approach has been posited to allow a synthesis of language and bodily experiences (Ussher 1997). But this appears to involve combining notions of physical bodies constructed within discourses *and* "real" material bodies and bodily experiences without any explanation of how the "real" and "experiences" can be understood, simultaneously, as constituted within language and outside of language.

Further, there may not be extra-discursive women's experiences waiting to be articulated, although some feminists do argue for the existence of unformulated and unspeakable experiences (e.g. Cain 1993). Concepts may provide new ways to feel rather than naming a feeling or experience already there (Hacking 1992). That is not to say that it is not possible to have extra-discursive feelings, such as pain, but as Coulter (1989) points out, it is through linguistic and intersubjective social processes that experiential life can be conceptualised and made intelligible to experiencers themselves as well as others. Thus the intrinsic integrity of women's experiences cannot be presumed in a feminist discursive analysis in the way some writers have done; there is no straightforward congruence between experience, subjugated/marginalised knowledges and "reality" or "truth". Moreover, it is not clear how experiences can be separated from language. If experiences are given meaning in language then they have "no inherent essential meaning" (Weedon 1997:33). Dissolving the separation between language and experience further rejects the "switch" between language as simultaneously constructing and reflecting the "real", and focuses attention on the way that "experience is a linguistic event" (Scott 1992: 34).

This suggests that experiences, including bodily experiences, should be understood as constituted and negotiated, interactively and inter-subjectively, within language. However, this does not mean that experience is "confined to a fixed order of meaning" (Scott 1992: 34). Experiences may not have singular meanings but rather they are likely to have a number of meanings or versions which may be contradictory and contested (Weedon 1997). For example, in Allen's (1987) analysis; the experiences of offenders are (re)formulated by psychiatric professionals to produce various gendered understandings of behaviour which support and/or justify disposal decisions. Offenders' experiences are not separate from the ways psychiatric professionals understand and respond to offenders' lives. However, in Allen's account, which focuses on court reports, we have a (temporarily) solidified version of offenders' experiences, rather than the negotiated interactive and possibly contested versions. A reconceptualisation of experience as constituted within language suggests that the experiences of patients will be formulated, negotiated and perhaps contested in relation to schizophrenia during psychiatric interactions with patients. And, given the research reviewed, they are also likely to be informed by understandings of femininity and masculinity. But reconceptualising language and experience in this way, does not have to mean that a person's distress is "not real", nor that people are passive victims. As Hacking (1995) demonstrates in his analysis of Multiple Personality Disorder, the distress of the person is real in the time and place in which it occurs. It is a culturally sanctioned way of showing and being distressed and an option for being and behaving.

However, the feminist discursive literature is overwhelmingly focused on textual materials and largely on categories in which women predominate. Therefore it is not clear how patients' experiences may be negotiated in relation to schizophrenia in interactive contexts. Very few analysts have taken a linguistic/discursive approach to the study of schizophrenia. However, two accounts suggest that schizophrenia is constituted within language and interactive contexts, and that the experiences of patients and carers/significant others are likely to be important resources in psychiatric decision-making.

The first account focuses on the linguistic interactive context of schizophrenia, although it is not a discursive analysis in the strict sense discussed. From this perspective, the "grammar" of schizophrenia can only be understood in the contexts of its application which is elaborated to mean the interactional domain where people are categorised (Coulter 1991: 161). Judgments, which in psychiatric diagnosis separate "delusions" from sub-cultural or aberrant (but harmless) beliefs, "hallucinations" from everyday fantasies and "thought disorder" from erratic or idiomatic conversation, are based on the exercise of common sense in the practical situation of enquiring into peoples' communicative behaviours. This exercise requires cultural competence. Thus analyses of texts (such as many of those reviewed in the previous section) are viewed as an "abstracted rendition" (pg. 170). It is in the context(s) of clinical practice that researchers will understand the "logic-in-use" (pg. 167) of the concept of schizophrenia. This argument, therefore, provides strong support for the importance of focusing on interactive clinical contexts for an understanding of the way schizophrenia is constituted interactively and inter-subjectively.

A more standard discursive approach has been taken to an analysis of a psychiatric admission interview between a psychiatrist and a patient, and the same psychiatrist and the patient's carer (Barrett 1988). The analysis documents the "performative and transformative power of writing" (pg. 292) and the way the biological and developmental history work-ups transform the identity of the patient to past, present and future schizophrenic. The analysis of the interaction between the psychiatrist and the carer (the patient's mother), demonstrates an important facet of psychiatric clinical work; patients are often surrounded by significant others who become involved with psychiatric professionals and have to be taken into account in psychiatric interactions and decision-making. "Mrs. James" portrayed herself as "caring in spite of the difficulties" (pg. 277) and this definition of her experience was accepted by the psychiatrist and emphasised in the case record. The mother's account of her experience was crucial in obtaining admission for her son. On the other hand, the patient's definition of his experience was transformed by the psychiatrist towards the psychiatric definition of schizophrenia (Barrett 1988), a process that has also been found to occur in case conference summaries (Soyland 1994)[40] and psychotherapists' written assessments (Ravotas & Berkenkotter 1998).

These two accounts establish the constituted and negotiated character of schizophrenia and its basis within language. They emphasise the importance of focusing on clinical contexts and interactions for an understanding of psychiatric discourses of schizophrenia. They also suggest that schizophrenia may not simply be a label directly and unproblematically applied to patients as anti-psychiatrists and some feminists suggest. Here it has a more mediated and uncertain quality; schizophrenia is an exercise in common sense, worked-up during the course of interactions and the writing of case records. Moreover, the meanings of patients' and significant others' experiences are not external to this process. However, gender is not thematic in Coulter's analysis, and is problematic in Barrett's.[41] Therefore these accounts cannot answer the question of what relevance gender has to schizophrenia in clinical interactions between psychiatric professionals and patients.

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[40] However these case conferences involved professionals only, not interactions between professionals and patients.

[41] Barrett (1988: 277) describes "Mrs. James" as "highly emotional" unreflexively drawing on and recirculating discourses of mothers as emotional within his own account without acknowledging or problematising what he is (re)producing.

In summary, discursive approaches, focusing on talk and texts, enable researchers to ask different kinds of questions centred on language, subjectivities and practical effects which are historically and socially located and variable. This conceptualisation of language provides a broader and more complex approach than earlier accounts of social construction. Language is reconceptualised as constitutive of social realities; what schizophrenia means is (re)produced within discourses that vary across time and place. More than this, it is constituted and negotiated within interactive contexts. This conception of language also facilitates a reconceptualisation of gender as a relational and contextual discursive production, turning attention towards contexts in which psychiatrists produce gendered understandings and thus the interrelations between femininity, masculinity and schizophrenia. Further, when language is conceived as constitutive the separation between language and experience is difficult to maintain conceptually. Rather, experiences are better understood as constituted within language; the "switch" between language as constitutive and reflective is dissolved. This does not have to mean that personal distress is disregarded or trivialised, nor that people are merely passive victims of psychiatric discourses. It does enable consideration of the way patients' experiences are formulated and negotiated in relation to schizophrenia during psychiatric interactions. But we have little idea how psychiatric understandings of femininities and masculinities are accomplished and made relevant to experiences in actual clinical interactions with patients. Nor how such gender understandings are related to schizophrenia.

Conclusion

Feminist research on women/gender and schizophrenia focuses on psychiatric labelling or stress and oppression in society. However schizophrenia is largely absent from the large body of feminist work on gender and madness, a problematic presence and a convenient absence. A conception of power in terms of roles and patriarchy produces a top-down hierarchical relation of male villains/female victims. Together with the focus on women, this literature does not explore the complexities of differential power relations or the interrelations between femininity, masculinity and schizophrenia. There is a "switching" between conceptions of language as simultaneously labelling and describing the world which underplays the potential diversity of psychiatric understandings of dependency, emotion, activity, parenthood and marriage. A separation between language and experience is maintained which precludes consideration of the ways experiences are constituted within language and power relations. This literature has not focused on interactive contexts and the extent to which psychiatric understandings of gender continue to be relevant in contemporary psychiatry and community care is not clear.

Turning to the psychiatric and sociological literatures, schizophrenia is conceived in polarised terms of either a real and essentially biological disorder within the person or as a social construction, a label applied to behaviour that breaks social rules as a means of social control. In these accounts power is either absented or it is conceived in a similar way to feminist explanations of powerful psychiatrist/powerless patient. And gender is either an obvious difference or it is underdeveloped, although both approaches suggest that gender is potentially relevant to psychiatric understandings of schizophrenia, despite its gloss of gender neutrality. Critical accounts of schizophrenia tend to treat language as a relatively straightforward means for labelling but it is not clear that psychiatry attaches the label of schizophrenia in the manner implied, nor how this occurs in clinical contexts. It is also not evident whether psychiatric understandings of schizophrenia are related to notions of femininity such as dependence, home and unemployability for all patients, or whether they are differentiated in terms of femininity and masculinity as the feminist literature suggests, but does not fully explore.

In contrast to the literatures above, discursive approaches offer a different focus centred on language, discursive practices, and subjectivities which are historically and socially located and variable. When language becomes constitutive of social realities, schizophrenia is understood as constituted and negotiated within discourses and the contexts of its production. In this conceptualisation there is no "switch" between language as constitutive and reflective, offering a broader and more complex approach than earlier forms of social construction. Gender is also reconceptualised as a discursive production; what gender means will be accomplished according to the contexts in which it is created and will have practical social effects. I have argued that gender should be understood as relational, made up of two interrelated parts which only have meaning in terms of each other, thus allowing a focus on the interrelations between femininity, masculinity and schizophrenia. Further, experiences are conceived as interactively and inter-subjectively constituted within language, dissolving the separation between language and experience.

However, feminist discursive analyses have largely focused on women and categories where women predominate, rather than gender relations, and they have all based their analyses on texts and interview materials rather than clinical encounters between psychiatrists and patients. In contrast, two linguistic/discursive analyses of schizophrenia suggest it has a negotiated indeterminate quality rather than simply being a label, emphasising the importance of focusing on clinical contexts. But these accounts do not focus on gender and it is therefore not apparent how discourses of femininity and masculinity interact with understandings of schizophrenia, nor how experiences are negotiated and gendered during interactions.

It is also not clear how contemporary psychiatric power operates within psychiatric/patient interactions since the move to community care. We do not know whether there continues to be a top-down hierarchical relation as Szasz (1976) claims, with professionals imposing their understandings on patients; whether professional/patient relations have become more complex with opportunities for patients to negotiate and contest psychiatric definitions; or whether contemporary psychiatric power should be better understood as "government in liberal society" (Miller 1986: 32). In the following chapter I take up the discussion of psychiatric power, considering how different understandings of power impact upon questions regarding articulations of gender and experience, and I delineate a discursive methodology for addressing these questions, with a particular emphasis on issues of power and gender.

The feminist literature on gender and madness, and the sociological literature on schizophrenia leave a number of questions unaddressed. How are gender understandings negotiated in relation to schizophrenia during contemporary psychiatric interactions with patients? What kind of power relations between professionals and patients are constituted in local encounters? How are the past and present experiences of patients and significant others negotiated in relation to psychiatric understandings of gender and schizophrenia? How is schizophrenia articulated in clinical encounters and made relevant to these activities?

Chapter Two

Researching Interactive Contexts: Contending with Power, Relevance and Situational Constraints

Introduction

In the last chapter I reviewed the feminist literature on women/gender and schizophrenia, and psychiatric and critical accounts of schizophrenia. I discussed and problematised the conceptions and assumptions about gender, power and language underlying these approaches. I went on to discuss discursive approaches to gender and madness, and schizophrenia, arguing that in these approaches language is conceived as constitutive of social reality; gender is reconceptualised as a relational and contextual discursive production, and experience is similarly reconstrued as interactively and inter-subjectively constituted within language. I concluded it is not apparent from the literature how discourses of femininity and masculinity interact with understandings of schizophrenia in clinical encounters, nor how experiences are negotiated and gendered during interactions. It is also not clear how contemporary psychiatric/patient relations unfold within clinical interactions.

This chapter is concerned with delineating a discursive methodology for addressing the research questions, with a particular emphasis on issues of power and gender, and the impact of researching an interactive psychiatric context on the research process. In the first part of the chapter I discuss how gender relations and experiences are implicated in power relations, exploring three differing approaches to understanding contemporary psychiatric power. I draw out what kind of understandings of power are produced when analysis is conducted at the macro level of broad discourses and the micro level of situated accomplishments. I argue that it is not evident that psychiatric/patient power relations at the local level will be determined by broader discourses, nor that they will be wholly situational accomplishments; the nature of contemporary psychiatric/patient relations cannot be presumed in advance. I go on to discuss participants' relevance, particularly in relation to analysing gender, and I argue for the utility of taking the conversation analytic (CA) criterion of relevance seriously in the analysis, that is, keeping it within the bounds of what is relevant to the participants. However, I also highlight some of the difficulties of analytically demonstrating background relevancies such as gender.

From these discussions I delineate a discourse analytic scheme that is based on a discourse analysis (DA) approach.[1] It focuses on a "naturally" occurring interactive psychiatric context and combines a Foucauldian understanding of power at the micro-level with attention to interactive context. This approach is feminist in its overall aims and attempts to keep the analysis within the meanings and orientations of participants.

The second part of the chapter considers the impact of researching an interactive psychiatric context on the research process. I discuss the ways that access and ethics are interwoven and continually present issues in a setting such as this and exert constraint on what constitutes the research context, who participates in the research and what data is collected. I suggest that the data should be understood as a product of the ethical programme embedded in the institution. I go on to discuss the way features of the research context, issues of power and relevance and taking a feminist perspective are addressed during the analytic process. And I delineate the decisions and strategies that formed the analytic process. I conclude that the methodological and analytic approach adopted allows me to address the research questions, considering how power relations are displayed in psychiatric/patient interactions, and the ways that gender relations and experiences are constituted, negotiated and contested in relation to schizophrenia during clinical encounters.

1. Discourse Analytic Methodologies: Questions of Power and Relevance

In this section, I discuss how articulations of femininity and masculinity, experiences and schizophrenia are implicated in power relations. I draw on arguments from the previous chapter regarding the power of psychiatry and compare with a Foucauldian understanding of power as "government in liberal society" (Miller 1986: 32), and a CA approach to power as a situational accomplishment. I raise questions about what kind of power relations pertain between psychiatric professionals and patients in the era of community

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[1] Throughout this chapter I refer to the style of discourse analysis developed in the social study of science and social psychology as discourse analysis (DA).

care, and the significance for analysing gender relations and experiences. I suggest that psychiatric power at the local level should be an analytic question and I delineate a discursive approach which combines a Foucauldian understanding of power at the micro-level with attention to how power and resistance are accomplished within psychiatric/patient interactions, and the way that broader discourses may be played out at the local level. I go on to discuss the CA criterion of participants' relevance and the implications for analysing psychiatric understandings of the relationship between gender and schizophrenia, arguing for the utility of taking participants' gender understandings seriously in the analysis.

1.1 Power Relations and Community Care

In the previous chapter I argued for a reconceptualisation of gender as a relational discursive production, articulated in specific contexts to accomplish particular social actions. However, gender cannot be understood without a consideration of power; gender relations are an effect of power (Davies 1996). There is general agreement amongst feminist researchers that gender relations in contemporary Western societies are power relations in which women are dominated and oppressed; femininity is constituted as devalued and as 'Other' with concomitant practical social effects (Flax 1987; Davies 1996). However, in some theoretical accounts there is a recognition that there are aspects of social life where women are less determined, and where some women may exercise power over other women[2] (Flax 1987). Further, in terms of mundane everyday interaction, women may be "active co-constructors of meaning" as power, oppression and resistance are accomplished (Kitzinger 2000: 167). This raises questions about what kinds of power relations are constituted (and perhaps resisted) in psychiatric interactions with patients and the significance of such power relations for articulations and contestations of gender understandings in relation to schizophrenia.

A similar question arises in connection with formulations and negotiations of the experiences of patients and significant others. A conception of experience as constituted within language and interaction suggests that experiences are unlikely to have singular meanings but rather will have contradictory and potentially contested meanings (Weedon 1997). On this understanding, experiences are not external to communicative work related

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[2] In particular in the intersections between race, class, sexuality, age and geographical location.

to schizophrenia (and gender). In other words, any exploration of the ways in which experiences are constituted should also attend to the power relations in which they are framed: what comes to count as a valid experience, who has the authority to decide and how might it be contested? In this respect "what counts as experience is neither self-evident nor straightforward; it is always contested, always therefore political" (Scott 1992: 37). Moreover, literature on psychiatric/patient interactions (Barrett 1988; Mehan 1990), psychiatric case conference discussions (Soyland 1994), and psychotherapists' written assessments (Ravotas & Berkenkotter 1998) suggests that professionals may have the authority to impose their definitions "thereby negating the others' experiences" (Mehan 1990: 173). However, it is not known whether the same professional/patient relations pertain in Britain in this era of community care, nor how gender understandings may inform definitions of experience.

When gender relations and experience are understood as thoroughly enmeshed in power relations, the question then becomes what sort of power relations are constituted between professionals and patients? And what are the implications for the constitution, negotiation, and potential contestation of gender relations and experiences? These questions impinge upon what has been called the community care debate: is community care an extension of social control, a progressive and humane social philosophy[3], economic expedience,[4] a recognition of patients' rights or an expansion of psychiatry and a form of governance? A full discussion of this debate is beyond the scope of this chapter. Instead I will focus upon three alternative conceptions of contemporary psychiatric power and their significance for exploring the ways that gender relations and experiences may be constituted in relation to schizophrenia during psychiatric interactions with patients.

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[3] The argument is that the move to community care is a humane progression related to developments in drug treatments (which obviated the need for long-term institutional care), and a growing understanding of the unsatisfactory conditions within institutions and the negative effects of institutionalisation (e.g. Murphy 1991; Pilling 1991; Jones 1993; Prior 1999; Zolese 2000), shown in studies of institutional life (e.g. Wing 1962; Goffman 1968). These changes in psychiatric outlook are said to have concurred with changing public attitudes to mental illness (Jones 1994). However, patients were being discharged from institutions before the introduction of new drugs. A range of factors (e.g. administrative changes, changing staff attitudes and rehabilitation policies) influenced the move towards decarceration, of which the new drug treatments were only one factor (Baruch & Treacher 1978).

[4] Scull (1984) suggests that similar arguments regarding treatments and asylum conditions occurred in the nineteenth century but did not lead to deinstitutionalisation. He develops an argument that links the deinstitutionalisation movement from the 1950s onwards with the rise of "welfare capitalism" (pg. 12). Thus the primary determinant, according to Scull, was economic; community care was less costly for government than institutionalisation in a time of fiscal crisis. There was a change from segregative methods of social control to neglect and repressive tolerance in "newly emerging 'deviant ghettoes'" (pg. 153).

The first conception is an extension of feminist explanations of schizophrenia in terms of sexist psychiatry, and anti-psychiatric accounts of labelling or societal reaction (e.g. Chesler 1974; Scheff 1966; Szasz 1976). In a top-down hierarchical theory of power, deinstitutionalistion or community care is simply a means for psychiatry to extend its social control out of the asylum and into the community. On this understanding, psychiatrists have substantial power and can use it to invoke dominant discourses of femininity and masculinity and enforce patients' conformity to them. In turn, psychiatric professionals will have the authority to impose their meanings of experiences on patients, or reformulate patients' experiences in terms of their understandings of schizophrenia and gender relations; attempts to resist or subvert psychiatric power are likely to be met with imputations of pathology. This account suggests a straightforward and unambiguous relation of powerful psychiatrists/subjugated patients.

In contrast, Foucault's understanding of power and governmentality suggests a very different understanding of power relations between contemporary psychiatry and patients. In Foucault's (1979; 1982; 1984; 1990) framework, power can be exercised by officials, such as psychiatrists, through institutional and other practices. However power understood as capillary, spreading through society from below, is exercised on us all, the dominated and the dominant. But power relations may produce concentrations of power or cleavages and hence domination (Dreyfus & Rabinow 1982). Whilst power may be repressive, such as in the prison or the asylum, it is also and mainly productive, "it induces pleasure, forms knowledge, produces discourses." (Foucault 1984: 61).

Moreover, Foucault (1990) makes it clear that power is relational so that resistance is present in every power relation:

> Where there is power there is resistance, and yet, or rather consequently,
> this resistance is never in a position of exteriority in relation to power...these
> points of resistance are present everywhere in the power network.
> (Foucault 1990: 95)

Resistance becomes a condition of power's operation. Power spreads "through the articulation of points of resistance" but it also through resistance that "power is disrupted"

(Dreyfus & Rabinow 1982: 147). However, power is not principally adversarial or confrontational, it is:

> a question of government...the way in which the conduct of individuals or of groups might be directed. (Foucault 1982: 221)

In this formulation, power is not exercised in a top-down manner; psychiatry becomes a "persuasive discipline" which attempts to engender self-regulation in patients (Lunbeck 1994: 153). Foucault therefore offers an alternative approach to understanding power; it is mainly productive rather than repressive, and dispersed rather than monolithic and hierarchical.[5]

Rose (1986a; 1986b; 1989; 1999) and Miller (1986) draw on Foucault's framework of power to develop an alternative conception of contemporary psychiatric/patient relations. Community care, promoted in the 1959 Mental Health Act (DHSS 1976) and extended in the 1983 Act, is related to the modernisation and expansion of psychiatry; deinstitutionalisation enabled psychiatry to form a "complex of powers over mental health" (Rose 1986a: 83). But rather than reducing psychiatric power and empowering patients, professional power has been rearranged leaving relations between professionals and patients largely unchanged (Rose 1986b). Nevertheless, contemporary psychiatry should not be understood in terms of social control but rather as "government in liberal society" (Miller 1986: 32); it seeks to "invest" rather than "suppress" subjectivity (pg. 29), encouraging us all to take responsibility for our mental health. The "psychological sciences", including psychiatry, are intimately involved in the management of the self in modern society (Rose 1989; 1999). Contemporary psychiatry does not aim to "destroy autonomy" but to "promote autonomy and encourage the acceptance of responsibility", restoring individuals back into purposeful, autonomous, choosing, responsible subjects (Rose 1986b: 202; 1989; 1999). In this relation, psychiatric power is exercised over patients but it is productive rather than repressive. This conceptualisation of contemporary

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[5] Foucault characterises his methodology in terms of "archaeology" (1971; 1972; 1973) and "genealogy" (1979; 1990). Archaeology is concerned with the structure of discourses, the relationships and regularities among discourses (or discursive formations) and the transformations and discontinuities of meaning that occur. Genealogy is characterised as a "history of interpretation" (Dreyfus & Rabinow 1982: 108) in which there are no underlying essences or laws, no continuous developments or progressions and no deep hidden meanings. Genealogy focuses on the relationship between power, knowledge and the body, analysing the historical and social processes whereby human beings are produced as objects and subjects.

psychiatric power suggests a relation of a persuasive governmental psychiatry/responsible, autonomous patient.

However, it is not clear how gender understandings might intersect with this concept of power relations, nor what kinds of gender relations are (re)produced within the psychiatric project of restoring lives. We do not know whether gender understandings have become less salient as psychiatry has extended out of the hospital into the community (Allen 1986) or whether the person being restored is "always a gendered subject" (Busfield 1996: 114). The literature on women/gender and schizophrenia would suggest that psychiatric notions of purpose and autonomy are likely to be shot through with gender differentiated understandings of what constitutes purposeful activity and expectations of autonomy; discourses of (in)dependence, activity, emotionality, home and employability could all have resonance here. Furthermore, while Foucault (1990) conceives resistance as present in every power relation, he gives few examples (Soper 1993; Still 1994), and Rose (1986a; 1986b; 1989) and Miller (1986) do not explore resistances to contemporary psychiatric power. And while power is said to work through individuals (Rose 1989), power relations are analysed at the level of legislative, administrative and professional discourses; there is no sense within Rose and Miller's work of how a rearranged professional power is managed, nor where points of resistance may occur in the promotion of patient responsibility and autonomy. In this respect, notions of resistance are rendered "opaque" (Kitzinger 2000: 175).

This is particularly important in terms of understanding the ways past and present experiences may be formulated and contested between psychiatrists and patients. It is not apparent how individuals' histories and current experiences may be shaped and played out in terms of understandings of gender and schizophrenia, nor how notions of "care" are understood.[6] With language reconceptualised as constitutive of experiences two issues arise here. Firstly, how discourses of care may be negotiated and gendered in clinical

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[6] Some of the literature on community care as a gender issue is suggestive here. For example, it has been claimed that women shoulder the burden of community care, tying them to a traditional caring role whilst reinscribing a romantic fantasy of "home" (Banton et al 1985; Showalter 1987; Ussher 1991; Gorman 1992). Related to this, male carers may receive a different and more positive response from professionals than female carers (Fisher 1997). However, the literature on gender and community care tends to marginalise the experiences of patients and male carers (Graham 1997; Fisher 1997) whilst relying upon the idea of experiences as unproblematically reflecting the real world, and external to negotiations with psychiatric professionals.

interactions. And, secondly, how experiences *between* patients and significant others are (re)formulated and contested within interactions. The interrelated nature of patients' lives in the era of community care, and the requirement for professionals to take carers and significant others into account in CPA meetings, suggests the potential for relational understandings. In this respect, a "personal trouble" can be reframed as a "relational one, and vice versa" (Emerson & Messinger 1977: 124) as problems become the object of professional scrutiny, evaluation and definition (Buttny 1996) and ascriptions of blame and change are accomplished (Buttny 1990). It has been suggested that a psychiatric diagnosis relieves those close to the patient of blame (Emerson & Messinger 1977; Warren 1987) but it is not clear how experiences between patients and significant others may be shaped within contemporary psychiatric interactions to define "troubles" and allocate blame, nor how understandings of gender and schizophrenia may be relevant to these activities.

Furthermore, an increasing concern for, and legislation towards, patients' rights may have constrained psychiatric power and empowered patients, at least to some extent. The mental health charity Mind instigated a campaign for mental health reform in the 1970s, attempting to constrain the powers of psychiatry through legal safeguards (Gostin 1975; 1983; Bingley 1983), and the 1983 Mental Health Act did include some significant changes. Contra Rose (1986b), Jones (1980; 1993) argues that the legislative framework of the 1983 Act may constrain psychiatric actions and interactions and has opened up the potential for antagonistic relations amongst professionals and between professionals and patients. On this basis contemporary relations between psychiatrists and patients may be more ambiguous and negotiated than labelling or Foucauldian accounts have conceived. The assumption appears to be that power relations at the local level will be determined by broader discourses and/or that the broad discourses which constitute relations will merely be reproduced locally. Similarly, experience is understood and analysed as structured at the same broad level of meaning (Miller & Rose 1994), with the same problems of opacity (Kitzinger 2000); there is little sense of the way different versions of experience may be locally negotiated and contested. Some analysts have attempted to link discourses produced in localised contexts with specific Foucauldian notions of power, resistance and governmentality; to "wed the micro-context of...talk to a more macro analysis" (Fox 1999: 90)[7]. But it is not entirely clear how locally produced meanings, situated accomplishments of power, resistance and gender can be mapped onto broader discursive formations, or indeed whether they should be.

The understandings of contemporary psychiatric/patient relations reviewed here are based on theoretical/textual analyses rather than clinical interactions. As Banton et al (1985: 191) point out "there is little analysis of the encounters of treatment, the power relations that are displayed". Therefore you cannot presume that contemporary psychiatric power works in a top-down fashion, as governmentality, or is constrained by wider discourses of patient rights in clinical contexts. We do not know how psychiatric/patient relations unfold within interactions themselves, nor how this affects negotiations of gender relations, experiences and schizophrenia.

As such a CA approach to discourse argues that participants "'do' power and powerlessness, oppression and resistance" within interactions (Kitzinger 2000: 174). Language becomes a social and practical tool which is organised to get things done.[8] Making sense of everyday social life is a continuous practice and accomplishment, contingent upon the context in which it is occurring, and talk is an important part of this sense-making activity.[9] Conversation analysts (Sacks 1972; 1974; Schegloff & Sacks 1974; Atkinson & Drew 1979; Atkinson & Heritage 1984; Schegloff 1987; 1997) study talk-in-interaction as instances of social action in people's ordinary everyday lives through which social order is produced and managed as an interactional and situational accomplishment.[10] A central component of conversation is the orderly way in which

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[7] For example, analyses of women in welfare rights groups and women designated as poor mothers by welfare professionals explicitly draw on Foucault's conception of resistance and reverse discourses (Kingfisher 1996; Croghan & Miell 1998) and Fox (1999) employs the notions of resistance and governmentality in her analysis of a cognitive social control programme for violent offenders.

[8] An early and influential work in the philosophy of language, by Austin (1962), suggests that language does not "mean" in a stabilised way. When people speak they are not just describing or stating something they are also doing things with words. Austin (1962) identifies three dimensions of the "use of language" as "locutionary acts", "illocutionary acts" and "perlocutionary acts" (pg. 109). Put very simply, "locutionary acts" refer to the sense or meaning of an utterance, "illocutionary acts" to the force (e.g. ordering, requesting), and "perlocutionary acts" to what the utterance achieves, such as persuading or justifying.

[9] Ethnomethodology (Garfinkel 1967; Turner 1974) focuses on the practical sense-making activities of people in their everyday lives. This activity is viewed as inseparable from the management and organisation of mundane activities; as people go about their daily lives they are constantly seeking to understand what is going on. Ethnomethodology focuses not only on language use but also on a whole range of practical activities for organising and understanding social life, for example Garfinkel's (1967) study of ""Good" Organisational reasons for "Bad" Clinic Records".

[10] Analysts focus on the structure and sequential position of utterances within a segment of conversation and the way social actions, such as greetings, or getting a phone conversation underway, are accomplished.

speakers organise and manage turn-taking in an interaction by the use of "adjacency pairs"[11] and other sequential orderings. An important part of the analyst's task is to demonstrate that "what was going on" is oriented to by the participants in the interaction rather than created by the analyst (Atkinson & Drew 1979: 32; Schegloff 1987: 112; 1997: 184). This approach emphasises the multifaceted, contingent and situated nature of discourse where the meaning of talk can change from turn to turn and moment to moment, and certainly from situation to situation.

CA, therefore, focuses on the analysis of discourse at the micro-level of situated interaction. This approach to language could explore how schizophrenia is articulated in clinical encounters and how the experiences of patients and significant others are made relevant and shaped within interactions. The extent to which CA is a useful approach for analysing and understanding power, however, especially unequal power relations, is a contentious issue. It has been claimed that CA is not concerned with, or is not theoretically and analytically equipped to deal with, the conflicts and tensions in social life (e.g. Wetherell & Potter 1992; Gill 1996; Billig 1999). As such CA "conveys an essentially non-critical view of the world" (Billig 1999: 552) suggesting that it is antithetical to political critique in general and feminist analysis in particular.[12] Or, alternatively, that analysts need to extend outside the limits of CA to a broader level of "intelligibility" (Wetherell 1998: 403) in order to understand how power works and thus provide political critique.

However, it is not the case that CA cannot attend to power but rather that it does not necessarily do so and when it does power and resistance are viewed as "micropolitical achievements...produced in and through actual turns of talk" (Mellinger 1995).[13] From this perspective psychiatric power is accomplished through a range of interactional moves

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[11] In adjacency pairs, the first part of an utterance produced by one speaker sets up the range of relevant and expected responses by a second speaker, for example, questions - answers, requests - acceptances/rejections, accusation - denial/justification/counter-complaint/apology (Atkinson & Drew 1979: 49-50). Further, the second part of an adjacency pair may be a preferred response (one of the expected options) or a dispreferred response (an unexpected option or no answer at all) (Schegloff 1987).

[12] This is captured in Speer's (1999: 471) notion of feminism and conversation analysis as an "oxymoron", although Speer herself does not subscribe to this view.

[13] Bogen & Lynch (1989) provide a good example of resistance as a situational accomplishment in their analysis of Oliver North's testimony before the Congressional committee investigating the Iran-Contra affair. Through a number of interactional and discursive moves, including reiterating rather than elaborating documentary materials, North inverted the relation between interrogator and suspect and resisted the committee's attempts to assimilate his testimony into the historical account.

which control access to and the distribution of talk (Scheff 1968; West 1984; Burman 1995; Mellinger 1995). In turn, patients can resist, for example by reconfirming and defending claims that have been challenged, setting their own agenda or initiating their own interpretations (Mellinger 1995; Burman 1995). Therefore, CA can provide a basis for analysing power, and thus be a form of political critique; in this respect it is not necessarily antithetical to feminism (Kitzinger 2000).

On this basis, power and asymmetries in power relations are not structured or determined by broad discourses external to local interactions, exerting constraint on individuals at the local level, but rather are constituted and made relevant within interactions. When social structure is conceived as constituted within local interactions, then it is suggested that the distinction between macro and micro levels of context "dissolves" (Speer 1999: 473; Hutchby & Wooffitt 1998). Or to put it another way, context external to a particular interaction is analysed as "a topic and a resource" within the interaction (Lynch & Bogen 1996: 259). A CA understanding of power as a situational accomplishment and an analytic focus on the fine details of talk, therefore, provides an analytic means for exploring the way that power unfolds within psychiatric/patient interactions: how power is produced and resisted through talk:

> ...it is precisely in the mundane contexts of interaction that institutional power is exercised, social inequalities are experienced, and resistance accomplished (Widdicombe 1995: 111)[14]

However, while analysis can certainly focus on power as a situational accomplishment, and on external factors as resources within interactions, simply displacing "structure" onto "resource" does not resolve the problem. Nor is it entirely apparent whether such an approach will provide a good understanding of the way power works in psychiatric/patient interactions and the implications for structuring experiences and negotiating gender relations. For example, if professionals or patients include a legal consideration such as a reference to patients' rights in an interaction, is this simply a resource deployed as a means for getting something done, or a constraint determined by broader "rights" discourses? And how are we to understand and analyse institutional practices such as interactions

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[14] Widdicombe (1995) puts this approach into practice in her analysis of youth subcultures and identities, and Burman (1995) analyses the interaction and power relationship between therapist and client in two feminist psychotherapy sessions, although Burman is not a conversation analyst.

amongst professionals talking about a patient before and after interactions with the patient, and from which s/he is excluded? Are these interactional moves for accomplishing and resisting power or are wider referents at play? Therefore, it is not evident that psychiatric/patient relations should be analysed wholly as a situational accomplishment.

DA attempts to draw on insights from both Foucauldian and CA approaches.[15] Potter & Wetherell (1987; 1992) have been major proponents in the development of this branch of discourse analysis. They acknowledge the influences of both structuralism (de Saussure 1983) and ethnomethodology/conversation analysis, as well as Austin's (1962) philosophy of language, in their 1987 book which lays out their basic approach. Foucault (1980b) and Billig (et al 1988; 1991) are added as later influences. From these influences they delineate an approach that aims to combine a sensitivity to power relations with a focus on the interactive context of language-in-use. They analyse how discourse is constructed, the functions it performs and its consequences/effects.[16] Talk is examined for systematic patterns and themes which Potter and Wetherell call "interpretative repertoires", the "broadly discernible clusters or terms, descriptions and figures of speech" which create "versions of actions, self and social structures" (Wetherell & Potter 1992: 90).

Following CA, the interactive context of language-in-use is one of the main pillars of Potter and Wetherell's approach. They suggest that the best kind of material for analysis is "everyday, unsolicited talk" (1992: 98), although in practice they make widespread use of interview material pointing out the "technical and practical difficulties" (1992: 99) of obtaining mundane everyday talk on many of the topics and issues that interest researchers.[17] The second pillar of Potter and Wetherell's approach comes from their theorisation of power and ideological practices, drawing on the work of Foucault (1980b), Hall (1988; 1992), and Billig (et al 1988; 1991). From Foucault, they argue that discourse

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[15] This approach has been developed within the social study of science (Gilbert & Mulkay 1980; 1984; Woolgar 1980) and social psychology (Potter & Wetherell 1987; Billig et al 1988; Billig 1991; Edwards & Potter 1992; Wetherell & Potter 1992).

[16] Discourse can be constructed using various linguistic devices which make it rhetorically persuasive and effective, often giving accounts the appearance of disinterest or external constraints thus protecting them from the charge that they are false, partial or in the actor's/speaker's interests.

[17] However, interviews are said to be conducted in a conversational manner with the interviewer providing comments and responses that are more typical of everyday talk than in more formal interview and research settings.

analysts should explore the discursive processes through which statements/knowledges become framed as true or false. They combine these ideas with recent Marxian reformulations of ideology (Hall 1988; 1992) to advocate an approach that reconceptualises ideology as ideological practices and effects. In this reformulation, not all discourses are ideological nor are ideological discourses distinguishable from "truth".

In this way, Wetherell & Potter attempt to combine "genealogical and ideological modes of analysis" (1992: 86). They also draw on Billig's (et al 1988; 1991) work on rhetoric and ideology,[18] suggesting that Billig's formulation allows more prominence for conflicts and tensions than is possible within conversation analysis. These ideas are put to work in their study of Maori-Pakeha relations in New Zealand where racist discourse is said to have:

> the effect of categorizing, allocating and discriminating between certain groups and, in the context of New Zealand, it is discourse which justifies, sustains and legitimates those practices which maintain the power and dominance of Pakeha New Zealanders. (Wetherell & Potter 1992: 70).[19]

Therefore, DA offers an approach which has the potential to combine important aspects of Foucauldian theorising in terms of power with a CA stress on the interactive context of language-in-use. It appears to be able to locate broader categories and discourses such as gender and professional ideologies in local interactions, thus connecting up the micro with the macro. As such it suggests an alternative for conceiving and analysing the way power works, how experiences are constituted and gender relations (re)produced within psychiatric/patient interactions. From this perspective, attending to broad themes (interpretative repertoires) *and* the details of talk would enable analytic consideration of the ways alternative versions of patients' experiences are constructed in relation to schizophrenia, and the (potential) versions they are designed to counter, including the absence of particular versions or accounts (Billig 1991; Gill 1996). Professional talk can be analysed to identify repertoires of professional practices and gender which function to

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[18] Billig (et al 1988; 1991) suggests that common sense has a history and is a form of ideology in that it reinforces current arrangements of power and domination through repeating taken-for-granted assumptions. In this formulation ideology is not false ideas but operates through discourse.

[19] Wetherell & Potter (1992) identify various interpretative repertoires in Pakeha discourse such as (Maori) culture as heritage and as therapy, and community as nation, which are said to justify and maintain the status quo, that is the unequal relations between Maori and Pakeha.

justify and maintain unequal relations between professionals and patients, women and men with schizophrenia.

However, it is questionable that this formulation of DA remains sufficiently within the spirit of either a Foucauldian conception of power or a CA focus on interactive context. Firstly, the general reliance on interview material raises the question of whether analysts take sufficient account of the interactive context.[20] It is also debatable whether the interview can be construed as an ordinary, everyday situation; interviews are "particular types of social encounters" (Ribbens 1989: 579). Whilst interviewees are likely to draw on a variety of discourses, the discourses they use and what they use them *for* will be oriented to the task at hand, that is the interviewer's questions and the interview situation,[21] posing difficulties in "extrapolating from interview talk to activities in other settings" (Potter 1997: 150). Given these problems, and the advantages of studying naturally occurring talk demonstrated by conversation analysts, Potter and Mulkay's (1985) dictum that "naturally occurring data must provide the initial touchstone" (pg. 269) should perhaps be taken more seriously. This means focusing on a context in which psychiatric/patient interactions are oriented to the business of everyday life which would occur whether a researcher was present or not.[22]

Moving on to the issue of power, it is not clear that the gains outweigh the "tensions" when ideology and genealogy are blended together (Wetherell & Potter 1992: 59).[23] It is also debatable whether the notion of ideology is necessary. Foucault's (1980b; 1982)

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[20] For example, of the interview extracts in Discourse and Social Psychology (Potter & Wetherell 1987) and Mapping the Language of Racism (Wetherell & Potter 1992), monological extracts far outweigh those that include the speech of the interviewer. Thus the role of the analyst/interviewer in the production of the discourse is largely absent (Bowers 1988). This is not to say that it is not possible to take the interaction between interviewer and interviewee(s) into account, as Widdicombe (1995) demonstrates in her study of youth subcultures and identities, but that discourse analysts using interview materials do not always do so, making their emphasis on interactive context problematic.

[21] It seems highly likely that a white, middle-class researcher holding a tape-recorder and asking questions such as, "was there a time when you wore conventional clothing (.) or high street fashions?" (Widdicombe 1993: 98), will be understood as anything other than an interview situation.

[22] However, in prioritising naturally occurring talk I am not implying that it is "untouched by human hand" (Silverman 1987: 8).

[23] Wetherell and Potter appear to manage this tension only by incorporating those aspects of Foucault's power/knowledge formulation which will fit their approach and disregarding the remainder. In this respect their conceptualisation is much closer to a Marxist view of ideology. When Wetherell and Potter (1992: 139) argue that Pakeha discourses such as "community as nation" are ideological justification for exploitative social relations with the Maori, this sounds very like the classical Marxist notion of ideology (i.e. ideas promulgated by the ruling class to sustain their position).

conception of power suggests the possibility of a more differentiated analysis; if power relations are not "traced down to their actual material functioning" then the "illusion" that power only works in a top-down fashion is perpetuated (Dreyfus & Rabinow 1982: 186). There is a sense of this "illusion" in Wetherell and Potter's analysis of Maori-Pakeha relations.[24] We can say that power relations are likely to be displayed in the context of psychiatric/patient interactions, and I have posed questions about what kinds of relations are constituted and how power works in relation to gender, schizophrenia and experience. But if power is an analytic question, rather than "already known" (Gill 1996: 148), how should it be analysed in psychiatric/patient interactions?

If it is not clear that power at the local level is either determined by broader discourses or wholly a situational accomplishment, then this suggests that in order to understand the way that power works in psychiatric/patient interactions an analytic approach is required which allows for the twin possibilities that power is accomplished and resisted within psychiatric/patient interactions, *and* that broader discourses may come into play at the local level. As such, power becomes a more fundamentally analytic question; professional/patient relations are not analysed as "generated ex nihilo" but neither are they conceived as wholly determined by "pre-existing factors" (Hutchby 1997: 175-6; Emerson 1981).[25] This has a number of implications for research and analytic practice in terms of what sort of materials form the basis for analysis and the analytic strategies employed. Firstly, the site for research should be a context where I have access to 'naturally' occurring encounters between psychiatric professionals and patients, rather than interview material.[26] I have drawn on audiotaped (and some notated) talk between psychiatric

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[24] Despite the differences between discourse analytic approaches discussed here, they are less discrete camps than some of their proponents claim, and Potter (1997; Speer & Potter 2000) has modified his approach in recent years. Within DA, analysts take various orientations ranging from Foucauldian style analyses (e.g. Parker 1992) through to analyses inspired by, and close to, CA (e.g. Widdicombe 1993; 1995). As such, recent debates between CA and DA should not be "framed as a false dichotomy" (van Dijk 1999: 459; Silverman 1998).

[25] Hutchby (1997) draws this conclusion from a CA study of a British television debate show. He traces the way relations between the political/professional participants and the studio audience are locally managed, building structures of alignment. But he also identifies how participants orient to broader and more overarching political affiliations.

[26] Relatively little research has been undertaken on psychiatric/patient interactions particularly in Britain and since the 1983 Mental Health Act in comparison with large bodies of CA/DA work on medical encounters (e.g. Cicourel 1987; Silverman 1987; West 1990; Fisher 1991; ten Have 1991; Coupland et al 1994; Gill & Maynard 1995) and (psycho)therapeutic interactions (e.g. Labov & Fanshel 1977; Davis 1986; Buttny 1990; 1996; Burman 1995; Edwards 1998). Research on psychiatric/patient interactions has analysed in-take interviews (Scheff 1968; Barrett 1988; Bergmann 1992; Hak 1992; Hak & de Boer 1995; Mellinger 1995), an unsuccessful gatekeeping/exit encounter (Mehan 1990), interviews with patients shortly after admission

professionals, patients and significant others in a type of case conference called 'The Care Programme Approach' (CPA). Interactions from CPA meetings for people with a diagnosis of schizophrenia enable me to consider what kind of power relations are constituted, attending to how locally produced meanings and social order are accomplished and the way broader discourses and practices come into play in localised contexts.

However, a caveat regarding notions of 'context' and 'natural' settings is necessary here. In general terms "context...is not a self-evident, easy-to-define, and agreed-on thing" (Tracy 1998); for example, for conversation analysts such as Schegloff (1997) context is invoked and accomplished by speakers themselves whereas for other researchers context may include the social features of participants (e.g. gender, age), the setting and non-verbal actions (Tracy 1998). These distinctions become particularly acute and complex in an institutional setting such as a psychiatric unit. What constitutes 'naturally' occurring talk and a 'natural' setting for the researcher is less straightforward in a psychiatric setting where issues of access and ethics circumscribe the context and thus the boundaries of the setting and the talk. In turn, this impinges on notions of what counts as extrinsic and intrinsic context and distinctions between micro and macro approaches to power.

My methodological approach, therefore, is situated within DA but it is oriented to the micro-politics of power exercised (and resisted) in the everyday context of social interaction. Furthermore, the material for analysis is based on talk in the psychiatric clinic, rather than interviews. This is proposed as an analytic scheme for combining a Foucauldian understanding of power at the micro-political level with attention to the interactive context of language-in-use. In this way I attempt to gain an understanding of how power works in the context of psychiatric/patient interactions, and the way that experiences and gender relations are negotiated and contested in relation to schizophrenia within interactions. Underlying this approach are distinctly feminist aims. In broad terms, feminist analysis is based on a concern for women's lives, a desire to elucidate the conditions of women's lives and a commitment to social change (Wilkinson 1988; Gill

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and before leaving (Wootton 1977) and case conferences (Soyland 1994). However, with the exception of Wootton (1977), all of the cited research was conducted in America, The Netherlands, Australia or Germany. Where relevant, some of this work has been discussed in this and the previous chapter.

1995; Busfield 1996). But this does not mean that research has to focus solely on women (Busfield 1996). Feminist reflexivity explicitly acknowledges these political values and commitments and their influence on the research whilst also taking responsibility for the (political) consequences of their work (Wilkinson 1988; Gill 1995; Henwood & Pidgeon 1995).

In summary, power relations will determine the understandings of gender and the meanings of individuals' histories and experiences that are formulated in relation to schizophrenia and the extent to which such formulations are imposed, encouraged, negotiated or contested. It is not clear whether psychiatric understandings of gender and experience will be imposed on patients, or whether gender understandings will inform the psychiatric project of restoring lives to autonomy and purpose, or whether patients and significant others will contest and reformulate psychiatric discourses. It is also not evident that power relations at the local level of psychiatric/patient interactions are fully determined by broader discourses, nor that power is wholly a situational accomplishment. I have argued that in order to analyse how power works in local psychiatric/patient encounters, and thus how gender and experiences are constituted in relation to schizophrenia, power should be a fundamentally analytic question.

I have outlined an analytic approach which combines a Foucauldian understanding of power at the micro-level with attention to the interactive context of language-in-use. I draw my data from the interactive context of CPA meetings and attend to the ways broader discourses and institutional practices come into play at the local level, and how locally produced social order and meanings are accomplished and resisted. This approach will enable analytic consideration of the complexities of differential power relations between psychiatric professionals and patients and the implications for structuring gender relations and experiences in relation to schizophrenia during psychiatric/patient interactions. However, taking up the discursive approach outlined above raises further questions about how gender should be analysed. In the following section I focus on whether the analysis can and should remain within the bounds of what is relevant to interactional participants.

1.2 The Problem of Participants' Relevance

An important difference between discursive approaches is the extent to which they are concerned with the meanings and sense-making activities of speakers themselves. As we have seen, a key part of CA is that analysis should stay within the bounds of participants' orientations and relevance (Schegloff 1992; 1997; 1998). Participants' relevance, or its lack, has implications not only for how gender (and power) is analysed, but also for how it is understood to operate in a psychiatric context. In this section I discuss the issue of participants' relevance, focusing mainly on issues related to the analysis of gender, drawing out why this issue is significant for researching the relationship between gender and schizophrenia in a psychiatric context.

A major tenet of CA is that analysts can and should remain within the boundaries of the meanings produced by participants; analysis should be thoroughly grounded in the understandings of the participants (Atkinson & Drew 1979; Schegloff 1987; 1992; 1997; 1998). Following on from this, it is suggested that analysts (and readers) do not need to know the (gender) identities of participants in order to make sense of the interaction; what is of interest is the relevance of categories for the participants themselves, and the use to which they are put within the interaction (Edwards 1998). If analysis is not grounded in participants' understandings, then it is argued that it is in danger of becoming disconnected from the context of its production producing the potential for "academic and theoretical imperialism" (Schegloff 1997: 165). This is not to say that power and gender cannot be analysed with a CA approach, but that they need to be *"shown"* (Schegloff 1997: 180, italics in original) to be relevant to participants.[27] Moreover, Sacks' (1972; 1974) work on membership categories and standardized relational pairs may be particularly useful for an analysis of gender relations.[28]

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[27] As Schegloff (1997) demonstrates in his short extract "Chicken Dinner 1", categories such as gender can be oriented to by participants and thus be relevant to an analysis even when they do not appear to be overtly connected to the activity at hand. Analysis can, therefore, elaborate "those forms of conduct by which persons 'do' gender" (Schegloff 1997: 182).

[28] Membership categories are common sense equivalent kinds, for example mother, husband. Membership categorization devices (MCDs) are collections of categories that go together, for example the MCD "family" includes mother, father, child etc.. If one category from an MCD is used then another category from that MCD may also be relevant, what Sacks (1972: 219) calls the "relevance rule", e.g. mother is relevant given the use of child and vice versa. Categories within a collection may also be paired relationally in "standardized ways", e.g. mother-father, husband-wife (Sacks 1972: 37). People not only draw on common sense knowledge about activities associated with members of particular categories, e.g. babies cry, but also a whole range of characteristics and features that might be expected of particular category members and relational pairs. Moreover, a paired relational category "constitutes a locus for a set of rights and obligations concerning the activity of giving help" (Sacks 1972: 37). Many membership categories and relational pairs

In terms of researching discourses of gender and schizophrenia in a psychiatric context, this analytic approach has theoretical and political advantages. I have argued that both gender and schizophrenia should be conceptualised as categories whose meanings are socially produced within discourses in specific contexts, rather than having essential meanings. Moreover, the aim of the research is to explore and elucidate professionals' understandings of the relationship between the two. Staying within the bounds of participants' understandings, therefore, is consonant with this conceptualisation and aim. Such an approach has certain advantages for a feminist analysis; it can demonstrate the ways masculinities and femininities, women and men are produced within talk rather than existing outside of language, and it can ground analysis in women's (and men's) own understandings, a primary goal of feminist analysis (Kitzinger 2000). As such, this kind of analysis may provide a more, rather than less, effective political critique than one which "elevates the researcher's politics and uses this to guide interpretation" (Widdicombe 1995: 111), providing strong grounds for taking participants' relevance seriously in this analysis.

However, it may be the case that "not all gendering activity gets indexed explicitly in talk" (Hopper & LeBaron 1998: 61; Ochs 1992) and there may be few words that do explicitly index gender (Stokoe & Smithson: in press). This presents a problem: if I go beyond the understandings of participants, I may be imposing my own meanings and concerns. But if I do not, how am I to analyse instances when participants do not *explicitly* orient to gender or schizophrenia but these understandings may be relevant in non-obvious ways (Frith 1998; Kitzinger 2000), a circumstance that is likely to occur within psychiatric/patient interactions, at least for some of the time? In this respect participants' knowledge of and dealings with the social world rely on "ideal types" or typifications, such as woman, unemployed person, postal worker, etc., which they draw on in "face-to-face dealings with people" (Schutz 1972: 185 & 197). As such, gender is an omnirelevant category "embedded in a background of relevances that are simply 'there' and taken for granted" (Garfinkel 1967: 118), or what Zimmerman (1998: 90) has more recently called a "transportable identity".

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are also gender identities suggesting that characteristics, features and obligations associated with them may also take on gendered meanings, thus providing a useful basis for a gender analysis grounded in participants' understandings.

One way to attempt to solve this problem is to stretch and re-work the meaning of relevance to a broader context than that proposed by CA; if analysts understand discourse as "the unceasing human activity of making meaning" within a wider "argumentative social fabric", then "a more productive sense of...relevance is possible" (Wetherell 1998: 403). In effect, the analyst becomes a member (of the context/culture in a wider sense of the word) and uses her member's knowledge to elucidate participants' understandings. For example, I could assume that "everyone knows this is a woman or a man", evidenced by participants' use of gendered first names and pronouns, and analyse the interaction and discourses accordingly. However, while gender may be an omnirelevance, this is not sufficient to claim that the specific activity at hand is associated with professionals' gender understandings.[29] And while gendered pronouns can show relevance through their "noticing" by participants (Hopper & LeBaron 1998), their mundane use does not necessarily do so. As such, Wetherell's (1998) proposal only side-steps the problem. If the analysis is no longer bound by the participants' relevancies, *whose* relevance other than the analyst's is it?[30] In bringing in my own cultural knowledge I would be potentially privileging and imposing my own understandings and relevance over those of the participants, thus overriding the primary aim of the research.

It has been suggested that it is possible to conduct effective gender analyses without the need to go beyond participants' explicit orientations (Speer & Potter 2000; Speer 2001).[31] However, relying solely on explicit orientations runs the risk of losing potentially important background understandings of psychiatric professionals, with implications for the analytic findings.[32] Furthermore, a proposal for a two-step analysis which starts with participants' orientations but goes on to include analysts' cultural knowledge (Stokoe &

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[29] As Schegloff (1997: 165) points out, a woman can also be "a Californian, Jewish, a mediator, a former weaver, my wife, and many other" category terms.

[30] This becomes even more problematic with DA's continuing reliance on interview and focus group material, where exchanges are "researcher-prompted" (Schegloff 1998: 415). Now it is not just the case that the interaction between interviewer and participant is not fully taken into account, but that the topic is "relevant to the...talk as a matter of recipient design" (Schegloff 1998: 415). That is, it is the researcher's context and relevance, not the participants'. Moreover, the recent use of focus groups and seminar discussions in DA does not get around this problem.

[31] However, analysts have generally drawn their materials from interviews, focus groups and student seminar discussions where gender topics can be introduced by the researcher, or conversations and media sources have been pre-selected for gender relevance, rather than the sort of data and context I am researching.

[32] For example, if professionals' explicitly orient to femininity in relation to a particular activity but their background understandings of masculinity are also operating, I could conclude that contemporary psychiatry is only concerned with femininity in this context.

Smithson, in press) does not overcome the problem of elucidating *participants'* background understandings.

However relevancies, including gender, can be "manifested without being explicitly named or mentioned" (Schegloff 1997: 182; West & Zimmerman 1987; Ochs 1992). It is not necessarily the case that participants must *overtly and explicitly* orient to the category of gender in order to demonstrate its relevance (Schegloff 1997: 182, Kitzinger 2000) but it is not entirely clear what counts as an orientation, what the status of background knowledge is within CA (Stokoe & Smithson, in press) and thus whether and how background relevances can be elucidated and demonstrated. Nevertheless this does not mean that the criterion of participants' relevance should be abandoned (Kitzinger 2000).[33] But it does have implications for analytic practice and the strategies employed. Taking relevance seriously, but recognising that gender and schizophrenia may be operating as background relevances for some of the time, suggests that a number of analytic approaches are required. I attend to instances where gender and schizophrenia are explicitly oriented to by psychiatric professionals, patients and significant others, and I look for instances where they are relevant in non-obvious ways. That is, I analyse the interactions for professionals' background operative conceptions of gender and attempt to show that what is occurring is associated with gender (and/or schizophrenia) and not something else.[34]

Therefore I aim to keep the analysis within the bounds of what is relevant to the interactional participants whilst also elucidating how background relevances, such as gender and schizophrenia, may be operating. In this way I aim to gain a fuller understanding of how discourses of femininity and masculinity interact with understandings of schizophrenia, how experiences are negotiated and gendered during

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[33] Kitzinger (2000) suggests that background relevances can be shown to be relevant to interactive participants without an explicit naming of the category, as demonstrated in Sacks' (1984: 423) discussion of Ellen's "sense of innocence". She suggests that Sacks analyses Ellen's story "as an instance of mundane ordinary everyday racism-in-action" (pg. 172). While this may not strictly be the case, Sacks certainly does explore background relevances to Ellen's "sense of innocence" in terms of her taken-for-granted whiteness or ordinariness.

[34] For example, I attend to the way patients' biographies and experiences are made relevant and shaped within interactions, and I consider gender understandings as one of a range of potential background relevancies for what is occurring. I also draw on Zimmerman's (1998: 90) notion of gender as a "transportable identity" to consider whether the gender identities of patients, once invoked and made relevant, may continue to have an unrestated background relevance across a stretch of interaction.

psychiatric/patient interactions and what sort of power relations are constituted between professionals and patients.

In summary, I have discussed differing analytic orientations to power and participants' relevance, issues which are particularly important for an analysis focused upon questions of power, gender and experience. From this discussion I have delineated a discourse analytic approach which is feminist in its aims and which will enable me to explore the questions about psychiatric power, gender, and experience that I have raised. I have adopted an analytic approach situated broadly within DA, but with certain modifications to the emphases and concerns of some DA work. Firstly, I focus on the interactive context of CPA meetings for patients with a diagnosis of schizophrenia. Secondly, power is approached as a fundamentally analytic question: I have argued that a Foucauldian understanding of power at the micro-level combined with attention to the interactive context will allow me to consider the way negotiations, resistances and contestations are played out at the local level whilst also allowing for the possibility that broader discourses may come into play. Finally, I take relevance seriously, keeping the analysis within the boundaries of participants' understandings and concerns. But I also attempt to contend with the likelihood that gender, and possibly schizophrenia, will have a background relevance which nevertheless needs to be shown to be relevant to participants. This methodological approach will enable me to consider how power relations are displayed in psychiatric/patient encounters, and the ways that gender understandings and the experiences of patients and significant others are produced, negotiated and potentially contested in relation to schizophrenia during psychiatric/patient encounters.

In this section I have delineated a discourse analytic approach which will enable me to address the research question of how gender understandings are negotiated in relation to schizophrenia during contemporary psychiatric interactions with patients, and related questions about power and experience. In the next section, I turn to the research process and discuss the issues that arise when research is conducted in the interactive context of a psychiatric unit and the implications for data collection and analysis, and understandings of intrinsic and extrinsic context.

2. The Psychiatric Unit as Interactive Context: Doing Access, Ethics and Analysis

Research based on interview material gives analysts considerable control over the research context and process in terms of locating the participants they want to research, collecting the data they are interested in via some sort of interview schedule and analysing the (relatively) orderly data which results. In contrast, researching an interactive context, particularly an institution such as a psychiatric unit, raises issues throughout the research process: from how you find a suitable setting, and where and how you get access to interactions within that setting, to what counts as data and how you analyse it when you return from the setting. These dilemmas are similar to those encountered by ethnographers:

> ...access is not just a matter of walking through the door. It is an ever-present, ongoing concern, which includes inventing yourself as an ethnographer and deciding what counts as data...It is not just a matter of 'being there' and snapping it up, writing it down or photocopying it. You still have to work out how to 'be' and where 'there' is...(Rachel 1996: 124).

In this section, I consider the situational constraints that arise when researching interactions in a psychiatric context. In particular, I discuss the "ever-present" issue of access and the way it is interwoven with ethics in this kind of setting. These situational constraints have implications for: who participates in the research; what kinds of interactive data are collected; and how that data is analysed. And they raise broader issues of what counts as context and talk, macro and micro.

2.1 Access and Ethics as Continuous and Interwoven Constraints

As Silverman (1987) points out, chance factors play an important role in getting research started in a medical setting. This was the case for me.[35] I first contacted Dr. North, consultant psychiatrist at Treetops psychiatric unit, in November 1996 to discuss the project. Treetops is attached to a general hospital in the Home Counties of South East England and Dr. North is responsible, along with one other consultant psychiatrist, for the mental health care of the population of the borough of Worthington, which composes half

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[35] After sending out a number of exploratory letters to psychiatric institutions, without success, a colleague at Brunel University met a consultant psychiatrist (Dr. North, a pseudonym) at a party, mentioned my research, and the consultant expressed an interest.

an NHS Trust area. Dr. North's responsibilities cover in-patients on the ward, out-patients visiting the psychiatric unit, day patients at the Day Unit, community patients at the community mental health centre and residential patients at a hostel. In this section, I trace the way that situational constraints of access and ethics are interwoven in this sort of setting exerting constraint throughout the research process, and I discuss the implications for what kind of context is researched, the sort of data obtained, and who participates in the research.

The first issue to arise, once Dr. North had agreed, in principle, to taking part in the research, was what sort of context(s) within the psychiatric unit would provide me with interactive data and how I would gain access to that context. The key criteria for the research context, dictated by the research questions and analytic approach, were access to professional talk about patients with a diagnosis of schizophrenia, and the potential to audiotape that talk. However, researchers do not have a free hand in a psychiatric setting, and potential contexts were discussed at length with the consultant. The context of CPA meetings was agreed for a number of reasons. Firstly, psychotherapy was not routinely offered to people with a diagnosis of schizophrenia at Treetops. Secondly, case conferences such as CPA meetings are discrete "convenient" events where the researcher can assume a less problematic role than, for example, wandering around the wards (Silverman 1987: 8-9). Thirdly, virtually all patients with a diagnosis of schizophrenia are placed on a full CPA at Treetops. As CPAs are scheduled for patients every three to six months, a year in the psychiatric unit would, theoretically, give me the opportunity to approach all the people with a diagnosis of schizophrenia in this particular catchment area. Fourthly, CPAs are organised well in advance providing time to contact staff and patients to obtain their consent. They also provided a clear and discrete focus for ethical approval from the medical ethics committee. Finally, after discussing possible contexts such as group sessions, diagnostic interviews and ward rounds, CPAs were the *only* context I was offered and which met the main criteria.

Therefore, obtaining access, even in principle, to an interactive setting within the psychiatric institution was dependent upon a combination of what the consultant deemed to be a suitable context, what was available given the key criteria of the research and ethical considerations regarding obtaining patient and staff consent and ethical approval for the project. As such, access and ethics were major defining factors for what constituted a suitable interactive context. This meant that a whole range of other kinds of interactions within the institution were placed beyond the bounds of the research, limiting the context. As such, practical and ethical considerations constrained what I could do from the outset, and if I wanted interactional psychiatric talk I had to work within those constraints. Thus the "natural" setting and "naturally occurring talk was defined and circumscribed institutionally; the extent of context for research was constructed through what I could obtain access to. In turn, what is relevant to participants, and what counts as intrinsic or extrinsic (micro or macro) is defined by the degree of access and made visible to me accordingly.

Ethical considerations obviously loom large for a research project in an institution such as a psychiatric unit where professionals are bound by their own ethical rules of patient confidentiality and informed consent. Moreover, patient groups and mental health charities such as Mind have campaigned for greater awareness and watchfulness in these areas, which has influenced psychiatric units and the professionals working in them. I was therefore entering a setting where an ethical programme was already embedded in the institution. Moreover, ethical considerations are heightened in a project focused on people with a diagnosis of schizophrenia who may be vulnerable (Mind 1993; 1994). Patients' rights to informed consent and confidentiality were therefore paramount, but the medical ethics committee were also concerned that the same rights be extended to professionals taking part in the research. I prepared one information leaflet and consent form to be given to patients and another for staff (copies of the information leaflets and consent forms for patients and staff are in Appendix 1). I based my ethical practice on <u>Mind's Policy</u> (1993) and <u>Principles of Confidentiality</u> (Mind 1994) and the British Sociological Association's <u>Statement of Ethical Practice</u> (1991). Detailed information on the ethical guidelines and practice are in Appendix II.

When I first approached Dr. North, she made it clear that ethical considerations and approval were required for access. It was her suggestion that I speak to Mind, the implication being that if they approved the ethical aspects of the research then it would probably be acceptable to the managers, staff and ethics committee, which largely proved correct. Mind (1993; 1994) have stringent ethical guidelines for practice (rather than research specifically) and strongly advocate informed consent for all patients except in exceptional circumstances. From the outset this meant that I had to obtain (properly) informed consent from every patient.[36] This imperative set constraints by circumscribing what and who I could research; patients had to be contacted, have the research explained to them verbally and in writing and sign the consent forms before the research took place. In practice, this meant that I audiotaped suitable meetings, because interactional events had to be scheduled well in advance. And I had a limited view of the psychiatric setting because I could only audiotape suitable meetings. Furthermore, I researched meetings with suitable patients because they had to be well enough to understand the research and give properly informed consent. Thus, the kind of interactive context researched, the sort of data obtained, and the participants who took part were all determined largely by the situational constraints of access and ethics. And in each case the extent and scope of the research was limited as the range of different contexts and interactions within the institution, and certain patients (particularly those who were unwell and likely to be troublesome to professionals) were placed out of bounds.

However, having walked "through the door" (Rachel 1996: 124), the issues of access and ethics were not "solved", but continued to exert constraints throughout the research process. I attempted to approach every patient with a diagnosis of schizophrenia who was scheduled for a CPA and whose name I was given.[37] A few potential patients were lost because their CPAs were organised at short notice. I had to strike a balance between phoning sufficiently often to keep abreast of upcoming CPAs but not so often that I became a nuisance. It had been agreed in consultation with staff that I would approach patients via their keyworker or named nurse who would contact the patient, explain the research verbally to them, and give them an information leaflet.[38] On the day of the scheduled CPA I would arrive early so that I could answer any questions the patient might

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[36] This was not an easy prospect given that people with a diagnosis of schizophrenia are a "particular group thought inherently incapable of giving *genuine* informed consent" (Rogers et al 1993: 7, italics in original).

[37] I obtained information about suitable potential patients principally from the two consultants, and sometimes from the day unit manager and ward staff. I phoned the consultants at regular intervals and they gave me names and dates, from their diaries, of forthcoming CPAs for patients diagnosed with schizophrenia.

[38] As the terms suggest, one professional is appointed as the primary contact for each patient. Keyworkers were either community psychiatric nurses or approved social workers for community patients, and psychiatric nurses for day unit patients. Named nurses were appointed for ward patients. The keyworker/named nurse has regular contact with the patient and knows her/him well, providing in principal a good channel between me and the patient.

have about the research and get the consent form signed. In practice it did not work so smoothly. Staff were very busy and often did not have the time (or inclination) to go through this process. The result was that patients often (but not always) arrived for the CPA knowing little about the research and not having seen the information leaflet.[39] In this respect I often travelled to all of the sites without knowing whether the research would actually proceed (and sometimes it did not).

However, keyworkers and named nurses, by acting as mediators between me and the patient, also became sub-gatekeepers. Although all the professionals had given blanket consent to the research at the outset, they could facilitate, block or ignore the research in practice and thus control access to every patient. Professionals had varied responses to the project; some were very positive about the research and went to some lengths to obtain patients' consent, some said they wanted to help but in practice never did, and some were dismissive. It is difficult to ascertain how helpful/unhelpful professionals were being because they were always dealing with a patient who could be "too unwell", "too paranoid", "not want a stranger there" and so on, so that I could not know whether it was the patient or the professional who was actually saying no. Over my time in the setting and from conversations with various professionals, I built up an impression of who was supportive of the research and who was not and tentative reasons for this. It appeared to be the case that professionals' responses to the research and therefore their sub-gatekeeping activities depended on the site, who they saw me as and the extent of Dr. North's authority.

Professionals at the community centre are furthest removed from the hospital and the consultants and had the most varied responses.[40] As I moved closer to the hospital things became easier. On the ward I was introduced by Dr. North as the "research psychologist" and ward staff seemed quite happy to approach every patient. I was several different people, then, depending on the site and the individual professional; I could be a PhD

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[39] On many occasions I sat in reception, or a spare room, or even the meeting itself, going through the information leaflet and presenting the consent form for signature.

[40] As the manager explained to me, the community mental health team is "more flat in terms of authority" and community staff are "more resourceful and autonomous whereas on the ward they are part of a team and not able to make decisions". In this respect, whilst the consultants have ultimate responsibility they are not closely involved with the day-to-day workings of the community team and only visit the centre for CPAs and weekly team meetings.

researcher/student, a research psychologist, or Dr. North's "spy" and this seemed to have a strong effect on professionals' responses to the research and thus their willingness to approach and obtain access to patients. In turn this was coupled with professionals' attitudes to Dr. North and the level of her influence at particular sites.[41] Professionals largely invoked ethical reasons for not approaching a patient or for a patient's refusal along the lines that my presence would be detrimental to the patient's well-being or on-going care. Dr. North's response was that staff were being "over-protective" or, at other times, that staff were "paranoid" and felt "threatened". This neatly captures the dilemma: on one hand they were acting as ethical guardians and protectors of their patients, on the other hand they were invoking ethical discourses to justify their actions. Either way, issues of access and ethics intertwined constantly in my dealings with professionals and impacted considerably on who participated in the research, adding further constraints and limitations.

However a caveat to what I have said above is necessary. A major problem with a great deal of social science research, particularly in a busy medical setting, is why anyone should agree to have "an outsider nosing around" (Silverman 1987: 1). All the professionals at the psychiatric unit and associated sites were extremely busy, under pressure and often had heavy case loads. Whilst I have suggested above that some professionals were unhelpful or dismissive, the question is, why should any of them have bothered to help at all? As my sponsor, Dr. North had a stake in the research.[42] For the other professionals I was mainly a highly peripheral and occasional blip on their screens. This is reflected in the sheer number of mundane chasing phone calls I had to make in order to track them down if I needed them to contact a patient. If I left messages, they rarely phoned me back. And why should they? Apart from the few professionals who talked of supporting research and education, what most of the professionals probably wanted from me was to go away and let them get on with their work. When it comes to

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[41] However, whilst some of the community professionals covertly did not seem to want to be involved in the research, most of them did eventually participate. This was due to the fact that day unit and ward patients were often "revolving door" cases, or were assigned community professionals whilst still on the ward/day unit and so community professionals attended day unit and ward CPAs. In these cases the professional on the ward/day unit had secured access to the patient for me and community workers were somewhat presented with a *fait accompli*.

[42] My presence may not have been as "intellectually stimulating" as Dr. North had originally envisaged, but she did seem to enjoy discussing the progress of my research in front of the other professionals, and having pledged her support at the outset she seemed determined to see it through.

why the patients would want me in the meetings, there are likely to be a whole variety of reasons. Two patients said that they believed their gender did affect how they were treated and wanted to take part for that reason. Two patients were 'sold' the research as 'giving something back' and seemed to go along with this. Sometimes it became clear from the analysis of the transcript that patients had a particular agenda and perhaps thought that my presence could help their case.[43] However it was not always evident why they had agreed. Overall, I was asking a lot of these busy professionals and vulnerable patients and offering very little, if anything, in return.[44]

During the fifteen months I spent in the setting, forty-nine names of potential patients were passed to me and sixteen participated; a success rate of approximately one in every three potential names. Of those potential participants who did not take part in the research, fourteen refused and six patients were not approached. Eight potential participants were lost because I was unable to contact the keyworker to make the arrangements or on one occasion the keyworker was unable to contact the patient.[45] Five CPAs were cancelled and to my knowledge were not rescheduled while I was there. More detailed information on data sources, participants and background to the psychiatric unit and CPAs are in Appendix III.

Ethical issues continued to constrain my research and access to patients and data in other ways. As the British Sociological Association's (1991) ethical guidelines highlight, such guidelines do not provide a finite set of principles; dilemmas and choices will arise during research. My actions also rested on personal values and responsibility. In the course of the research, situations arose where I had to make immediate ethical decisions. This usually occurred when my own interests in completing the research conflicted with the situation at hand. I was tempted to make small transgressions to secure a particular patient, particularly when the research was going very slowly. In the end I did not succumb to temptation, feeling a personal responsibility to the patients concerned but I was also fully aware that a transgression of the agreed ethical procedures could jeopardise the whole project. In this way, ethical considerations were intertwined with access to patients

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[43] For example, one patient wanted to request psychotherapy and a ward patient wanted home leave.

[44] I did suggest on the information leaflets that I hoped the research would increase awareness and understanding of professional responses to gender and mental distress, in the long term. But I suspect this had little influence on professionals' and patients' more personal and situated responses to the research.

[45] All the contact problems occurred at the community centre.

throughout the research but my personal ethical responsibilities were underwritten by the ethical requirements of the institution.

In addition, using an audiotape recorder in the meetings added further complications. It highlighted the problem of when a meeting begins and ends, for the obvious reason that the tape recorder had to be switched on at some point and switched off at another point. Although meetings appeared to be discrete events, in practice several meetings were often run in sequence; even when there was only one meeting, beginnings and endings were far from clear, certainly for the purposes of research. This problem operated at two levels. At a mundane level I was a novice in the setting and it took some time to learn the way meetings worked.[46] But at another level it was an ethical issue. I had been given access to audiotape meetings but no one had specified what that meant in practice. Meetings could have three parts; there was a period of time in which the patient was present, but some meetings also included a pre-meeting (when professionals discussed the case before the patient arrived) and/or a post-meeting (when professionals discussed the case after the patient had left). I quickly realised that the pre- and post-meetings were rich sources of talk amongst professionals where the patient and her/his problems could be formulated in different ways in the patient's absence than in their presence. I was invited to the pre-meetings and so I asked if I could turn on the tape recorder. Similarly, I remained in the room after the patient had departed and left the tape running.

However, at the third meeting I attended in the community centre, there was no pre-meeting; the patient arrived without any preamble and the main meeting began. When the main meeting was over and the patient had left, Dr. North immediately asked me to turn off the recorder saying "the meeting's over now". But the professionals continued to discuss the patient. After the other professionals had left Dr. North said that the pre-meetings would have to stop because there had been complaints from the patients' organisation. She then said that she did not understand why I wanted to "tape so much" when they take so long to transcribe and then, that she was very aware of the tape recorder and did not want to say anything "stupid". She added that she can feel quite tense during the main meeting because "everything has to be managed properly and the patient handled

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[46] As Atkinson and Drew (1979) show in a formal court setting, and Schegloff and Sacks (1974) demonstrate in ordinary conversations, openings and closings are situated linguistic accomplishments.

correctly" so after the patient leaves it is a "winding down process" when she can relax and be "more informal".

This was the moment, then, when the beginnings and endings of meetings for research purposes had to be agreed upon and I was anxious not to lose the intra-professional meetings. I argued that all the different parts of the meeting formed a whole event and I needed to capture the whole, and I tried to reassure her about the analysis. She agreed that I could tape all parts of the meeting but I left it under her control, saying that if she wanted the tape turned off on any particular occasion she should say so and I would immediately comply. She never asked me to turn off the tape again. The pre-meetings ceased at the community centre but continued at the day unit and on the ward. Officially the problem was solved but it continued to reappear with other professionals from time to time.[47] Dr. North raised ethical reasons for circumscribing the scale of the audiotape recording, on the patients and her own behalf.[48] These ethical issues were directly related to how *much* access I could have and continued at an informal level throughout the research. Such issues further constrained what interactional data I collected; when a professional asked for the tape recorder to be turned off, interactions were lost. But more than this, ethical considerations or justifications became an intrinsic part of what the interactive context *meant* for the purposes of research. Dr. North's request to turn off the tape recorder provides a concrete instance of how the boundaries of this setting and the talk were defined and circumscribed by the participants, framing what relevancies are available to the researcher and what is to count as intrinsic/extrinsic, micro/macro. As such, it is not just that participants defined the context and what was relevant *within* the talk, they also defined the context and relevance *for* the talk.

In summary, conducting research in an interactive psychiatric context is by no means a straightforward process; "doing" access and ethics in a psychiatric setting has methodological implications. In short, the ethical programme embedded in the institution constrained what I could do, and if I wanted interactive psychiatric talk I had to work

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[47] For example, a community psychiatric nurse asked for the recorder to be turned off during a post-meeting, invoking confidentiality. On another occasion the pre-meeting had begun and I had turned on the recorder but a social worker started talking about another patient, realised the tape recorder was running, and expressed concern. I left it running but assured her that the conversation would be wiped.

[48] It is one possible effect of my presence there that the issue of pre-meetings was raised and they were discontinued at the community centre, but I have no way of knowing.

within these constraints. In practice, this meant I audiotaped suitable meetings, because interactional events had to be scheduled well in advance. I had a limited view of the psychiatric setting, because I could only audiotape suitable meetings. I researched meetings with suitable patients, because they had to be well enough to understand the research and give properly informed consent. I collected what data I could, because access was not only influenced by who I was perceived to "be", but also intertwined with ethics to govern how I could attend meetings, and which patients I could research. These situational constraints impacted upon what constituted the research context, who became participants and who did not, and what interactive data was collected and what was not. Nevertheless the constraints discussed here should not be regarded merely as evidence of the difficulties of obtaining interactive data in contexts such as psychiatric institutions, nor as undermining in some way the interactive data which forms the basis of my research. Rather, that entering an institutional context and collecting "naturally" occurring interactive talk, raises issues and dilemmas that have to be resolved and cannot help but impact upon the process and the kind of data collected. Thus the interactional data is very much part and product of the institutional setting from which it has been taken.

In this section, I have discussed the situational constraints of access and ethics which are interwoven in a psychiatric context, and the implications for the research process and the interactive data collected. In the next section, I outline how the data was analysed after it was brought back from the research setting.

2.2 Analysis

In this section, I outline the decisions I made and strategies I employed to analyse the data, and I consider the ways in which issues outlined in previous sections in terms of power and relevance, features of the interactive context and taking a feminist approach, are dealt with during the analytic process.

The first question, when commencing analysis, is a feature of the context I was researching: what counts as data? As part of the ethics of the institution, patients had been given the option of audiotaping or note-taking. I had eleven audiotaped meetings and five in note form. In addition I had conducted semi-structured interviews with five professionals at various sites and collected secondary materials such as patient information leaflets and internal documentation. And I had kept a fieldwork diary throughout the research process. I decided that the audiotaped material must form the primary source of data for analysis but the notes from meetings, which I had taken in verbatim form as far as practicable (rather than writing for gist), could also form part of the material for analysis. The interviews, secondary sources, and diary were used for background information. The audiotapes were transcribed in their entirety using transcription conventions based on those commonly used by discourse analysts (e.g. Edwards & Potter 1992; Wetherell & Potter 1992; Potter 1996b; Edwards 1997; Wetherell 1998; Speer 2001), which in turn are a cut down version of the conventions developed by Jefferson (1985).[49] I tried to achieve a balance between notating the main features of talk, readability and the amount of time I had available for transcription (transcription conventions are in Appendix IV).

Transcription is also the point at which the names and identifiers of all the participants have to be changed. This raises the issue of naming practices and brought into the analysis a whole range of dilemmas about ethics, gender, relevance and power. The ethical constraints of the research context required that such changes be made, but (re)naming participants is also not a neutral activity and brings gender and power issues to the fore. Should I neutralise the power and gender connotations of naming, for example using "A", "B" etc., so that speakers become "interchangeable", use first names giving an air of "informality" which may be at variance with the setting, identify the speakers by their positions within the institution, such as "doctor", "patient", etc., (Billig 1999: 553), or aim to represent the naming conventions within the psychiatric setting? All of these practices have their advantages and disadvantages but I decided to reflect the naming practices within the research context. While this produces a "mixed, or unbalanced, code" (Billig 1999: 553), this imbalance is an intrinsic feature of the setting and conveys the relationships which are part of that setting.[50] Thus I use the terms doctor and patient,[51]

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[49] However, no set of conventions can provide a neutral or accurate transcription, and the conventions chosen depend on the aims and level of the analysis (Edwards & Potter 1992; Potter 1996a), as well as practical considerations. In deciding on which conventions to use, I took into account that my focus was on interactive talk and participants' orientations and meanings but not on the very fine detail of conversation analysis.

[50] Nevertheless, and as I have argued in the first section, such pre-allocated roles and gender names do not in and of themselves preclude more differentiated power and gender relations.

[51] Professionals working in the community and at the residential hostel tended to use the term "clients" instead of "patients", but the consultants used "patients" regardless of where the meeting was conducted. On balance and overall, "patient" was the term most often used by the professionals.

patients are given first names, as are the other professionals with the addition of identifying roles (e.g. social worker, community psychiatric nurse etc.). Significant others are named according to how they are addressed within the meeting which seemed to vary according to age and how long the professionals had known them. I only contravened this naming scheme for professionals and patients with non-English names.[52] I decided to give all participants English pseudonyms in order to meet my ethical obligations and ensure anonymity.

Moving on to the analysis itself, DA descriptions of analytic practice often suggest that a preliminary stage of analysis involves coding the data.[53] However, it is not clear how "unwieldy" (Potter & Wetherell 1987: 167) the discourse has to be before such coding becomes too difficult and, possibly, counterproductive. The decision of whether to code, or not, may be related to the nature of the research context and the kind of data being analysed. CPA meetings could have as many as ten participants[54] interrupting each other with introductions, changes, and reintroductions of topics and agendas. It was not apparent, then, that coding would be helpful or even possible and I decided that it was not practicable or productive for analysing the sort of interactive data I had collected. Instead I began analysing the data with intensive reading and re-reading of the transcripts to familiarise myself as far as possible with the material. At this stage I also noted passages that appeared interesting, given the research questions. From this, I began a detailed analysis of all the talk using a number of strategies to aid the analytic process. I looked for different kinds of interactional resources and rhetorical devices being deployed within the talk, such as three-part lists (Jefferson 1990),[55] disclaimers (Hewitt & Stokes 1975),[56] and

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[52] Nineteen out of thirty-seven professionals, and only three out of sixteen patients were of African/African-Caribbean, Asian, or Irish ethnicity.

[53] This is described as an "inclusive" process which squeezes "an unwieldy body of discourse into manageable chunks" (Potter & Wetherell 1987: 167). It may involve an iterative process of some analysis before the coding is done, but the aim is to search for categories informed by the research questions to create (overlapping) bodies of "instances" (pg. 167).

[54] Or as few as three participants in a meeting.

[55] Three-part lists serve as a resource for interactants. They can be used for a variety of interactional work including signalling completion of a turn of talk, "topic-shifting" and "offense avoidance" (Jefferson 1990: 79)- note how this in itself is a three-part list! List items and their position within the list, particularly the third item, can be manipulated to accomplish actions such as "damning with faint praise", "'discovery' of inadequacy", or provide a sense of impartiality on the speaker's part (pg. 78).

[56] Disclaimers are an "interactional tactic" which are deployed in advance by speakers to preserve situational definitions or identities which are likely to be disrupted or discredited (Hewitt & Stokes 1975: 1). For example, "credentialing", one of several types of disclaimers, is employed when a speaker is attempting to avoid an undesired typification which they know will result, such as "I'm not prejudiced but..." (pg. 4).

extreme case formulations (Pomerantz 1986).[57] These features of talk have been identified and developed largely by conversation analysts and provide useful analytic levers for understanding how the talk is organised and what it is designed to do. In addition, and given the research context and the sort of business at hand, I looked for problematisations: who or what was formulated as a problem and what were the proposed solutions (Widdicombe 1993).

At the same time I began to focus in on my research questions. Firstly, I examined the talk for the kinds of power relations constituted and displayed between professionals, patients and significant others. I considered how power was being accomplished, managed and resisted within the talk, looking at who and what was framed as believable and not believable (Zimmerman 1974), how participants resisted and how the interaction was controlled (Scheff 1968; West 1984; Burman 1995; Mellinger 1995). I examined where points of resistance to and subversion of professional power occurred and points of reassertion. I took into account what kinds of power relations were constituted, what they were designed to accomplish within the meetings in terms of decision-making about patients' futures and their practical effects. I also looked for instances where broader discourses were oriented to by participants and brought into play, such as rights discourses and legal considerations, institutional practices, and noticeable breaks in subject matter that were difficult to fully account for within the interactions themselves.

I went on to consider the way that gender was made relevant to the interactions and activities at hand. I began by looking for instances of specific orienting to gender by participants, what kinds of gender understandings and relations were produced, what they were designed to do and their practical effects. I went on to examine how gender, as a background understanding, was relevant in non-obvious ways. I drew on Sacks (1972; 1974) notion of membership categories and standardized relational pairs and the associated characteristics and features, rights and obligations expected of paired relational categories, and on Zimmerman's (1998) notion of gender as a "transportable identity". I conducted this analysis both at the level of explicit categories and more covert category

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[57] Extreme case formulations, such as "everyone", "everything", "nothing", "perfect" are employed to legitimise a claim when speakers are "accusing, justifying, and defending" (Pomerantz 1986: 219). They can be used to defend challenges to a person's legitimacy, give a sense of objectivity or suggest that a phenomenon or behaviour is general and widespread and thus not requiring explanation or accounting for. For example, what "everyone" does is not idiosyncratic or due to the speaker's personality.

understandings to explore how gender was relationally produced within interactions. I looked at what kinds of past and present experiences and behaviours of patients and significant others were made relevant and shaped within the talk and whether and how they became gendered and to what effects. And I considered the extent to which versions of experiences were negotiated and contested. Finally, I explored the relationships between psychiatric practices, gender understandings, experiences and schizophrenia. I looked for instances where schizophrenia was articulated within interactions but, as expected, these were relatively rare. This also led me to consider the ways that professionals' understanding of schizophrenia could be operating as a background relevance. For this task, I considered talk about themes such as medication, relationships and employment which I had identified during the analysis.

During the course of the analysis, I kept an on-going file of promising themes. From this I developed a number of potential recurring themes and I formulated conjectures about what the main discursive themes were within the talk, and their effects. I then went through all the transcripts again looking for confirmations and disconfirmations, or deviant cases. When I found instances that did not fit my analytic proposals, I examined them again in detail to decide whether they were exceptional in some way, and thus exceptions which did not undermine my analytic scheme, or not (Potter & Wetherell 1987). If they were not, then that part of my analysis had to be reconsidered, rearranged or discarded. I often took these 'exceptions' to a discourse group I attended regularly. Looking for disconfirmations was particularly important for deciding upon background relevancies. In some cases, they could not be satisfactorily confirmed or disconfirmed and had to remain at the level of conjecture. While some of these conjectures are included in the analytic chapters that follow, they are always marked off as such. Overall the analysis was a highly iterative process that continued into the writing-up stage.

The final issue for analysis is how a feminist approach impacts upon the analytic process. The overall aim of the research is to examine psychiatric professionals' gender understandings in relation to schizophrenia and, from this, to explicate the conditions of the lives of women positioned as women and schizophrenic. This is no less the case for focusing on men as well as women. However, contradictory concerns in terms of trust and responsibility came to the fore during the research and analytic process. Psychiatry has a highly politicised history and the relative paucity of outsider research in contemporary psychiatric institutions, and the responses of some of the professionals in my research, suggest that professionals are wary of researchers and the degree to which they may be critical of their practices.

Dr. North opened up the possibility of doing my research at Treetops and supported me throughout the research process. On several occasions she made it clear that this involved 'trust' on her part, setting up the expectation that I would be 'responsible' with the data. But, responsible to whom: Dr. North, all the professionals involved, the patients, or the women patients in particular? The answer is all of them, but this produces a number of potentially competing responsibilities. In practice I found that my sense of responsibility fluctuated according to what was happening during the research and the stage of analysis. For example, when the research was going too slowly and Dr. North made a special effort to get more participants,[58] or one of the professionals took the time and trouble to explain the background workings of the institution to me, I felt a strong sense of my responsibilities towards Dr. North and the other professionals. On other occasions, when patients' versions were undermined during meetings, and when the themes became clearer in the analysis, my sense of responsibility shifted towards the patients, particularly the women. Therefore, while a feminist approach should include taking responsibility for the consequences of the work, it is not always a straightforward matter. This is particularly so in the context researched here, where professionals may be made open to damaging criticism and all the patients are vulnerable. I have attempted to achieve a balance between all these responsibilities while not avoiding a critical approach to analysis and keeping in mind that my overall aim is a feminist one.

Conclusion

I have argued that gender relations and experiences are thoroughly enmeshed in power relations but we do not know whether psychiatric understandings will be imposed on patients (and significant others) in clinical encounters, nor whether gender relations will intersect with the encouragement of purpose and autonomy, nor is it clear the extent to

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[58] On one occasion there was a CPA scheduled at the residential hostel but Dr. North was away and had arranged for another psychiatrist, who was not involved in the research, to attend the meeting. The consultant went to some trouble to contact the manager of the hostel and arrange for me to include this CPA in the research.

which patients will contest psychiatric definitions of gender and experiences. As such, Foucauldian analyses have tended to elucidate broad legislative and professional discourses. In contrast, a CA approach focuses on the sense-making activities of people as situational accomplishments; people 'do' power and gender within interactions. DA attempts to combine attention to broader discourses and notions of power with analysis of language-in-use, although some variants of this approach appear to presume the direction of power in advance and pay insufficient attention to the interactive context. I have argued that it is not evident that power relations at the local level of psychiatric/patient interactions will either be determined by broader discourses, or that they will be wholly situational accomplishments.

Grounding analysis in the meanings and concerns of participants of interaction rather than those of the analyst is a key tenet of CA and, I have argued, is a pertinent issue when analysing gender, power and schizophrenia at the local level of psychiatric/patent interactions. Keeping within the bounds of what is relevant to participants has advantages for an analysis with feminist aims, and is consonant with the conceptions of gender and schizophrenia underpinning the research. I have discussed potential problems of demonstrating participants' relevance when gender and schizophrenia may be operating as background understandings and I have outlined some analytic strategies for attempting to contend with these problems.

From these issues and concerns I have delineated a discourse analytic scheme which is feminist in its overall aims and is based on a DA approach. I focus on a 'naturally' occurring interactive context: Care Programme Approach meetings for patients with a diagnosis of schizophrenia. Power becomes a more fundamentally analytic question: I combine a Foucauldian understanding of power at the micro-level with attention to the interactive context. This will enable me to take account of negotiations, contestations and the accomplishment of power within interactions, and the ways broader discourses come into play at the local level. I take participants' relevance seriously: I aim to keep the analysis within the bounds of participants' meanings while also contending with background relevancies of gender and schizophrenia.

However, focusing on a 'naturally' occurring interactive psychiatric context carries its own demands and limitations, with implications for the research process. Issues of access and ethics are 'ever-present' and interwoven in this kind of setting, exerting constraints on what constitutes the research context, who participates in the research, and what sort of interactive data is collected. As such, the data collected is a product of the institutional setting and the ethical programme embedded in it. Features of this interactive context re-emerge to influence the analytic process, along with issues of power and relevance. I have discussed analytic decisions such as what counts as data, what (re)naming practices should be employed and whether to code the data. And I have detailed the analytic strategies and processes of analysis. I have also raised the problem of how to balance competing responsibilities which ensue when researching a psychiatric context from a feminist perspective.

In this chapter, I have discussed a discursive approach which enables me to address the research questions raised at the end of the previous chapter. This methodological and analytic approach allows me to consider how power relations unfold in psychiatric/patient interactions and the ways that gender relations and experiences are produced, negotiated and resisted in relation to schizophrenia during clinical encounters. In the following chapters, I turn to the main findings of the research. I begin with a focus on how psychiatric practices are constituted and managed in psychiatric case conferences. I discuss broader legislative and 'rights' discourses that come into play during interactions and illustrate some of the typical features of CPA meetings. And I draw out what kinds of professional/patient relations are constituted within interactions.

Chapter Three

Constituting Psychiatric Practices and Professional/Patient Relations: Discourses of Benevolence and Responsibility, Supervision and Restricted Participation

Introduction

The previous chapter delineated a discursive methodology, based on a modified DA approach, which combines a focus on the 'naturally' occurring interactive context of Care Programme Approach meetings with a Foucauldian understanding of power at the micro-level. I argued for a scheme in which power is conceived as a fundamentally analytic question; power is analysed as an interactional accomplishment but I also suggested that the analysis should take account of points at which broader legislative and rights discourses may be oriented to and played out at the local level. I argued for the importance of keeping the analysis within the bounds of what is relevant to participants, particularly in relation to understandings of gender, and the need to take account of the ways that understandings of gender and schizophrenia may operate as background relevances within interactions. I went on to discuss the demands of researching an interactive psychiatric context and the implications for the research and analytic process.

This chapter initiates the substantive findings of the research. It is concerned with how power relations unfold in local encounters between psychiatric professionals and patients, with a particular focus on the discursive constitution of psychiatric practices and professional/patient relations.[1] In the first part of this chapter I present a background discussion of the 1970s 'rights' campaign for mental health reform and the 1983 Mental Health Act. I draw on debates surrounding the impact of this campaign and the 1983 Act on professional power and relations between professionals and patients (Jones 1980; 1993; Rose 1986a; 1986b). Beginning with a discussion of the wider legislative framework enables me to raise questions regarding psychiatric practices and professional/patient relations and, at the same time, provides an understanding of broader

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[1] Professionals also attend to and accomplish intra-professional relations within meetings, but this is less directly related to the research questions. Nevertheless relations between professionals are an important part of the overall workings of CPA meetings and therefore I provide a background analysis of intra-professional relations in Appendix V.

contemporary discourses that participants may orient to within interactions. In the main body of the chapter I use extracts from Care Programme Approach (CPA) meetings to provide an initial understanding of the power relations displayed in local clinical encounters. This is intended to provide a framework for the chapters that follow in terms of the implications for structuring understandings of gender, schizophrenia and experience, and the extent to which such understandings may be imposed, negotiated or contested.

I argue that discourses of psychiatric benevolence and persuasion, and of patient responsibility and co-participation constitute a relation of benevolent psychiatry/responsible patient; a relation that is reinforced by professional framing of compulsion as a last resort and one that is consonant with governmentality rather than social control. Nevertheless this is an asymmetrical relation in which professionals accomplish superior knowledgeability and final responsibility. I suggest that whilst practices and relations are situational accomplishments, professionals also incorporate broader legislative concerns into their interactions with patients which are played out in terms of formulations of compulsion, voluntarism, "forgetting" and solicitations of patients' agreements to these framings.

The final part of the chapter discusses an alternative relation of supervisory psychiatry/untrustworthy patient which is more asymmetrical and, again, points to wider concerns related to the mandate of community care. In turn, consumer discourses severely restrict patient participation at the same time as they found it. I argue that supervisory and consumer discourses indicate the limits of governmental psychiatry for this set of patients. The simultaneous encouragement and limitation of self-regulation for patients suggests that professionals' background understandings of schizophrenia are informing practices, even though it is not articulated as a category. I conclude by drawing out the implications of contemporary psychiatric/patient relations for negotiating, contesting or imposing gender understandings and the meanings of patients' experiences in local encounters.

It is generally considered that the 1959 Mental Health Act marked a significant change in mental health legislation, repealing all previous legislation (Rose 1986a; Jones 1994). It established community care as preferable to hospitalisation and informal admission as preferable to compulsion. While doctors were assigned appreciable powers, particularly in terms of treatment without consent, Rose (1986a) argues that this was not a case of increasing psychiatric social control given the emphasis on reducing hospitalisation and increasing links with other professionals. The Act was viewed as "having been enlightened and forward-looking" (DHSS 1976: 1). However, in 1975 the Labour government decided to review the 1959 Act because of changes in treatments, services and general attitudes to mental illness (Jones 1994). In the same year the mental health charity Mind instigated a campaign for mental health reform to constrain the powers of psychiatry through legal safeguards.

Gostin (1975), the legal director of Mind, produced a critique of the 1959 Act together with a series of recommendations for changes to the law which would protect the human rights of patients. The main planks of Gostin's (1975) critique concerned the imprecise criteria for compulsory admissions, limited access to and powers of the Mental Health Review Tribunals (MHRTs), intrusive and/or irreversible treatment without informed consent and the curtailment of basic rights (such as court access, voting, and sending and receiving mail). In short, he argued that the coercive power of psychiatry denied patients their most fundamental rights. Gostin (1975) proposed changing the criteria for compulsory admissions,[2] increasing the powers of the Mental Health Review Tribunals (MHRTs)[3] and establishing a further independent body (Committee on the Rights and Responsibilities of Staff and Residents of Psychiatric Hospitals, CORR) together with an advocacy system.[4] Finally, he argued that the powers of social workers should be increased to enable independent assessment before admission, based on the criterion of the least "restrictive setting" for the patient (pg. 37). In effect, MIND and Gostin were instigating a "project for a massive displacement of psychiatrists from their clinical authority" (Rose 1986b: 188).

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[2] Criteria should be changed from "in the interests of his own health and safety or for the protection of others" (DHSS 1976: 4) to those of "dangerousness" or "grave disablement" with a caveat regarding "treatability" (Gostin 1975: 33-35).

[3] Powers of MHRTs should be increased to encompass verification of all admissions and automatic reviews.

[4] CORR would review treatments and safeguard the rights of patients. In particular, it should review what Gostin (1975) termed "suspect" treatments (pg. 116), such as surgery, electroconvulsive therapy, hormonal treatments and any treatment to which the patient has not given informed and voluntary consent. The advocacy system would place an advocate in every hospital. Furthermore, the basic rights of in-patients (such as "free expression and association", pg. 111) would also be safeguarded by advocates and CORR.

Despite a change of government and some amendments, the Mental Health Amendment Bill was passed in 1982 and consolidated into the 1959 Act to create the Mental Health Act 1983. In many respects the 1983 Act was a "compromise package" (Jones 1993: 205), reflected in Mind's comment that many of their "basic principles have been adopted" but "there is still much with which Mind must remain dissatisfied" (Bingley 1983). Nevertheless there were some important changes. The powers of MHRTs were increased; the time span before patients could apply for review was reduced, automatic reviews for formal patients were introduced, and MHRT powers to discharge were increased. An independent body, the Mental Health Act Commission, was established to visit and interview formal patients and protect their rights.[5] The powers of social workers were also increased, in line with Mind's recommendations, along with the notion of "least restrictive setting", placing a duty on social workers to provide an assessment of the patient prior to compulsory admission and an independent judgment regarding whether it is "appropriate to make an application" (Jones 1994: 52). The 1983 Act also clarified the issue of consent to treatment introducing a three-tier system,[6] however, the right of informal patients to refuse treatment remained a common law right (Gostin 1983).

Section 117 of the 1983 Act also places a duty on District Health Authorities in conjunction with social services to provide after-care for patients who have been compulsorily detained under section 3, but not for all patients, a matter that Gostin (1983) raises as a cause for continuing concern. Under this section patients leaving hospital are subject to the Care Programme Approach (CPA) which was introduced in 1991 (Jones 1994). The <u>Mental Health Act 1983 Code of Practice</u> (DoH&WO 1993) provides guidelines for implementing CPAs which place responsibility on the responsible medical officer to ensure that a care plan for the patient is established, prior to discharge, in a multi-professional discussion which considers and organises "the patient's continuing health and social care needs" (DoH&WO 1993: 106).

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[5] While this body was proposed by the Royal College of Psychiatrists, and has few powers, Mind claims that it "differs remarkably little" from the CORR proposal (Bingley 1983).

[6] Under the new system certain treatments (psychosurgery and hormone implants) require informed patient consent *and* a second opinion (section 57), while other treatments (electroconvulsive therapy and certain medications) require patient consent *or* a second opinion (section 58). While the former requirement covers both formal and informal patients, the latter only applies to formal patients, and medication can be administered to formal patients for three months without their consent. However, all other treatments can be given to formal patients without their consent and sections 57 and 58 can be overridden "if treatment is required urgently" (Jones 1994).

Feminist writers such as Chesler (1974), anti-psychiatrists and societal reaction theorists have viewed psychiatry as acting as an agent of social control (Scheff 1966; Rosenhan 1973; Szasz 1973; 1974; 1976; 1997). And, in his chronicle of the "moral career" of the mental patient, Goffman (1968) depicts patients as demoralised, discredited and controlled within the asylum. While patients can make "secondary adjustments" by "working the system" (pp. 186-9), any past or present behaviour can justify a prescribed treatment, and disapproved actions and interactions may be assigned a psychiatric label. What these approaches have in common is an understanding of psychiatric power as hierarchical, with psychiatric professionals wielding considerable power over their patients.

However the recent concern for patients' rights and current mental health legislation raise doubts about whether contemporary psychiatric power should continue to be understood as a form of social control. Rose (1986b) suggests that there were some significant changes in the 1983 Mental Health Act but rather than reducing psychiatric power and empowering patients, professional power was rearranged leaving relations between professionals and patients largely unchanged:

> ...the consequences of rights strategies do not amount to a simple reduction of such power, but rather to its reframing and reorganization...Rights-based strategies do not transform the relations of dominance between professionals and those subject to them, but redistribute status, competence and resources amongst the professionals of unhappiness. (Rose 1986b: 204 & 209).

But contemporary psychiatry is said to be a form of "government in liberal society" which endeavours to "invest" subjectivity rather than "suppress" it (Miller 1986: 29 & 32). In this respect, psychiatry aims to "encourage the acceptance of responsibility", restoring individuals to choosing responsible subjects (Rose 1986b: 202; 1989). And, where this is not possible, to provide the minimum of support to enable patients to function in the community (Miller 1986).

But Jones (1980; 1993) takes a different stance on what she calls "the new legalism" (1993: 197) arguing that civil rights provisions incorporated into the 1983 Mental Health Act have only established "rights against" certain abuses for compulsorily detained patients rather than "rights to" professional services for the vast majority of psychiatric patients (1993: 213). In this respect, and as detailed above, the new provisions are almost entirely applicable to compulsorily detained patients even though the vast majority of in-patients are informal.[7] As such, the legal approach to mental health is said to have hindered access to treatment for many chronic patients and increased the potential for conflict rather than co-operation between psychiatric professionals and patients (Jones 1993).

Rose's analysis suggests that rights campaigns and the ensuing legislation established a distribution of professional power but did not transform relations between professionals and patients, although in Rose and Miller's formulations psychiatric power is productive rather than repressive. However Jones' argument indicates that the current legislative framework may constrain psychiatric actions and interactions and open up potential for antagonistic relations between professionals and patients at a localised level. Moreover, the Mental Health Act 1983 Code of Practice suggests that patients should be included as co-participants in negotiations and decision-making regarding their future.

The conceptions of psychiatric power, professional/patient relations and patient participation discussed above present a very different view of psychiatric power to that of traditional notions of social control. This debate, therefore, raises questions about professional power, practices and patient participation in localised psychiatric settings. How is professional power managed interactively in local encounters between professionals and patients? What kinds of professional/patient relations are constituted? And how might schizophrenia be relevant to the power relations displayed? Within CPA meetings, psychiatric professionals and patients not only "do things with words" (Austin 1962) in the sense of blaming, justifying, excusing, etc., participants also "do" psychiatry; that is they frame what psychiatric practice *is*. And in so doing, participants also constitute professional/patient relations. I use a range of extracts from CPA meetings to explore the ways in which psychiatric practices are framed, looking at issues of persuasion, responsibility, supervision and choice (Miller 1986; Rose 1986a; 1986b; 1989), and the

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[7] For example, in 1989/90 only six and a half percent (17,000) of admissions to hospitals in England were compulsory (Jones 1994). However, I was told by the manager that 30% of in-patients at Treetops were compulsory admissions (see Appendix III) perhaps reflecting the increasingly "acute" status of in-patients since 1989/90.

points at which broader "rights" discourses (Jones 1993) come into play within local interactions. And I draw out what kinds of professional/patient relations are constituted within interactions.

1 Psychiatric Practice as Benevolence: "help"

"Help" is employed mundanely in meetings to characterise what psychiatric professionals do. In each of the three short extracts below, the doctors frame psychiatry in terms of "help" (extract 1, lines 5 & 7, extract 2, line 629, extract 3, line 81). In the first extract, Dr. South is opening the main meeting for Natalie, the patient, who has just been transferred from another area. This is the first care plan meeting Natalie has had in Worthington NHS Trust and with this psychiatric team, and Dr. South is laying out what the meeting is for, "this meeting is to bring everyone involved together to discuss how we can help you best" (lines 4-5).

Meeting 10 (main meeting) : Natalie (notes only)

3 Dr. S.: and Erica you're the keyworker now ((to Natalie)) we met in the
4 clinic you've been under Crowlake health care and this meeting is to
5 bring everyone involved together to discuss how we can help you best
6 ((Natalie hands Dr. South a yellow sheet of paper)) you've brought the
7 sheet of paper filled in to say what you need help with [.] ((looks at
8 what is written on the paper)) so how are you how are things going

In using "help" in this way, the consultant is framing the meeting, and all the professionals in it ("everyone" and "we", line 5) as friendly, help*ful*, and wishing to do good, the "best" they "can" for Natalie. The yellow piece of paper that Natalie hands to the doctor is an official sheet which is given to patients and on which they are encouraged to write down anything they want to talk about in the meeting, although many patients do not seem to use it. Dr. South also presents what Natalie has written on the paper in terms of "help", ("to say what you need help with", line 7) which extends friendliness and inclusiveness ("involved", line 5) to Natalie; she has a "say" and her "need" will be taken into account. In extract two, Dr. North is closing the main meeting and has signalled in the preceding segment that they are finished, "alright well thats good OK", and Diane's husband has thanked the doctor for her "help" (text not included here), although this is by no means the first time "help" has been deployed in this meeting. The doctor uses it as a final opportunity to reinforce a previous discussion regarding the chain of mediation from Diane via Sarah to herself.

Meeting 2 (main meeting) : Diane
627 Dr. N.: so please with regards y'know to encourage Diane to discuss things if
628 there is a problem make sure that (.) Sarah knows about it because
629 y'know if we don't know what the problems are we can't help you

In two rhetoric of argument constructions she formulates what she and Sarah do as "help", which is emphasised. So "if there is a problem" then "make sure that (.) Sarah knows", followed by "if we don't know what the problems are" then "we can't help you". These syllogistic arguments suggest that Sarah's knowing about a problem will enable both Sarah and Dr. North ("we") to make it better. In this extract helping is made contingent upon knowledge. Finally in the third extract, the consultant is using "help" to signal that the meeting for Douglas, the patient, is drawing towards a close.

Meeting 8 (main meeting) : Douglas (notes only)
81 Dr. S.: anything else you feel you need help with [.]
82 Douglas: money ((everyone laughs)) no I think I'm alright

The extreme formulation, "anything else" implies both that the professionals have already given Douglas "help", and perhaps that they can "help" with (almost) anything. Here the extent of psychiatric benevolence is given a wide sphere. Douglas' response is interesting in that after a noticeable pause he calls her bluff. It is presented as a joke, and everyone laughs, but his reply, "money" is telling. It is surely the "anything" that most people short of money would truly like help with and it makes fun of Dr. South's previously implied claim.

The ubiquity of framing psychiatric practice as "help" has a low level but nevertheless powerful effect which is three-fold. Firstly, it presents psychiatry as a benevolent practice which is very far from anti-psychiatric notions of social control and enforced treatment (e.g. Laing 1967; Szasz 1973; 1974; 1976; 1997). Secondly, it implies that patients are co-participants to some degree in their treatment and care; they tell the professionals what their problems and needs are and the professionals "help" to solve those problems and do their best to meet those needs. Thirdly, it also contains the covert implication that patients should take some responsibility for their mental health; they should know what their problems and needs are and be responsible for bringing them to the attention of the professionals, as in the exhortation that Diane should "discuss things" (extract 2, line 628). The discourse of "help" therefore suggests an initial relation of benevolent psychiatry/co-participating, responsible patient. In addition to the low-level discourse of "help", practices are framed in terms of what psychiatry does and does not do; psychiatric practice involves advice and persuasion, not force.

2. Advice and Persuasion: "thats my advice...I'm not forcing you" and "in the end they did persuade her"

The benevolence of psychiatric practice is extended and strengthened through discourses of "advice" and "persuade", and claims that psychiatry does not "force" patients to do things they do not want to do, a framing which patients are entreated to agree with. The first extract below is part of a much longer discussion regarding why Diane did/does not take her medication. The consultant uses the claim of Diane's husband, George, at line 451 as an opportunity to pursue the matter further. Diane's attempt to provide a reasonable explanation, "I thought I was better" (line 455), enables the doctor to launch into a formulation of the proper relationship between professionals and patient.

Meeting 2 (main meeting) : Diane

451 George: she stopped taking the medication doctor=
452 Diane: =I stopped taking my [med]ication
453 Dr. N.: [yes] yes °ye::s I kno::w° (1.0) mm why did you
454 do that though
455 Diane: I thought I was better
456 Dr. N.: °ya:::° but you should take advice you see Diane you >you know< you
457 must you must take other peoples ad[vice]
458 Diane: [yes]
459 Dr. N.: er the fact that you're better (.) um (.) doesn't mean that that you you're
460 you're going to be better without some tablets

Psychiatric professionals are framed as "people" (line 457) who give "advice" (twice, lines 456 & 457) and patients like Diane "should" and "must" take that "advice". The use of "people" deprofessionalises the "advice" but it is nevertheless clear to whom the doctor is referring. As such the deprofessionalisation downplays the power relation between professionals and patients and presents psychiatry and psychiatric practices as benevolent - it is just people giving advice. It also presents Diane as a consumer of services, someone who asks for and takes "advice". However, notions of advice and consumerism are interspersed with a large number of command words and "you"s which combine forceful exhortation with the suggestion that it is Diane's responsibility to seek and obtain that advice, "you should", "you you know", "you must", "you must" (lines 456-457). And the closing salvo regarding being "better without some tablets" suggests that Diane is rather foolish and does not have the knowledge or understanding to make decisions about her treatment; she does not understand that it is the tablets that make her better. It provides further justification for the necessity of Diane seeking and taking (expert) advice.

In the second extract the professionals are discussing Diane in the intra-professional pre-meeting. Diane has recently been discharged from hospital and the usual course is for patients to attend the day hospital as a step on the way to full community status. However, Diane has refused to go to the day hospital. Sarah, the CPN, presents the problem in quite forceful terms which suggest that professionals do not "push" a patient to do something she "rea:::lly doesn't will not" do.

Meeting 2 (pre-meeting) : Diane
59 Sarah (CPN): she shes adamant that she rea:::lly doesn't will not go to the day unit so
60 I didn't push it=
61 Dr. N.: =oh no it's alri::ght if she doesn't want to go:: she doesn't have to go::
62 thats OK:: um

In presenting Diane as "adamant" Sarah suggests that pushing Diane to the day unit would be forcing her to do something against her will and Dr. North concurs, reframing in terms of consumer choice. Diane has a choice and psychiatric professionals do not force patients to do things. These two extracts therefore suggest that psychiatric professionals give "advice", which patients are responsible for seeking and taking, and they do not force. In the following extract these two themes are explicitly juxtaposed as the doctor attempts to elicit the patient's agreement that she is not being forced to take her medication. Earlier in the meeting Dawn, the patient, has challenged the doctor over what the medication does and how long she will be on it and the doctor has said "the next couple of years" (text not included here). Now towards the end of the meeting Dawn raises the issue again, reframing Dr. North's vague formulation "couple" to the more concrete "TWO years".

Meeting 7 (main meeting) : Dawn
360 Dawn: its TWO years I'm on that drug
361 Dr. N.: well I've I've said a couple of years yeah but I don't mean (0.6) literally
362 two years but y'know we're gonna keep on reviewing it every time you
363 come to the outpatients thats why you've got the appointments so that
364 you can say what you think about it
365 Dawn: oh=
366 Dr. N.: =but I mean its not that you're forced to have it its y'know (0.8)
367 Dawn: yeah=
368 Dr. N.: =but I think it my advice to you would be to have it for a couple of
369 years=
370 Dawn: =a couple of years until it settles down I see=
371 Dr. N.: =°absolutely thats right° thats my advi::ce but I mean I hope I'm not
372 forcing you to have it cos I don't mean that
373 Dawn: no OK (2.2)

In effect, Dawn is reorienting to and challenging the doctor's earlier assessment about her medication. In a complex response, Dr. North confirms her previous assessment but proceeds to downplay her (re)statement with a series of mitigations, "but I don't mean (0.6) literally two years", "but...we're gonna keep on reviewing it", "you can say what you think about it", and "but...its not that you're forced to have it" (lines 361-4 & 366). These mitigations suggest that the doctor has read Dawn's question not as a request for confirmation but as a challenge. The mitigations soften the original assertion and work to suggest that the medication will be constantly under review, she will have a say, and she is not forced to have the medication. As such, Dawn's medication becomes a more inclusive and consultative endeavour. Moreover, the final mitigation at line 366 in terms of compulsion is contrasted with an alternative definition of psychiatric practice as benevolence; taking medication is a matter of "advice" (line 368), not "force" (lines 366). Dawn's response at line 370 is less challenging but somewhat noncommittal; in reiterating and adding to the doctor's framing she suggests that she understands what the doctor is saying but does not explicitly give her agreement. It appears that the doctor reads it this way as she goes on to reiterate the contrast between "force" and "advice", this time framed in such a way as to solicit Dawn's agreement that she is not being forced to take the medication (lines 371-2).

The theme of "thats my advice...I'm not forcing you" is not only an explicit formulation of psychiatric practice as benevolent counsel that eschews compulsion, but is also deployed to solicit the patient's agreement to this understanding. In this and the previous extract professionals appear to be incorporating a legal consideration into the interactions; patients are not forced to do something against their will, and they are not forced to take medication. However, in framing compulsion in this way and soliciting patients' agreement that they are not compelled, the question arises as to whether this should be understood as an interactional resource, or whether broader legislative and 'rights' discourses are being brought into play in these local interactions. In this respect, and as discussed in the introduction, while informal and community patients have the common law right to refuse treatment, psychiatry does have some recourse to legal force in terms of compulsory admission to hospital under sections 2 and 3 of the 1983 Mental Health Act. In the next extract, I turn to how professionals present the use of legal force.

In the following two extracts, professionals are discussing Diane's recent hospitalisation. I have chosen these two extracts because the first involves a discussion between the consultant and Diane herself, the second between the consultant and another professional in the intra-professional post-meeting. In both extracts, "sectioning", the colloquial term for compulsory admission,[8] is framed as something professionals "have" to do, "we used to have to get you on a section" (extract one, lines 434-5), and "she came into hospital without having to be sectioned" (extract two, lines 655-6).

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[8] 'Sectioning' refers to a section of mental health legislation which specifies the criteria for compulsory admission.

Meeting 2 (main meeting) : Diane

432 Dr. N.: so I think we have just gotta get it ri:::ght we've got to get the
433 medication right and hopefully now Diane you you will come forward
434 for treatment because I mean in the the (.) before we used to have to
435 get you on a section but this time you didn't come in on a section did
436 you? in the end [you came in yourse::lf]
437 Diane: [no I came in voluntary] yes=
438 Dr. N.: =ye::s and thats much better really if you can (.) if you can work with
439 us instead of us trying to chase you y'know? h h h h

In presenting compulsory admission in terms of "have to", the doctor is framing compulsion, the use of legal force, as a last resort; it is a "necessity", the "only available course of action" (Emerson 1981: 4-5). This is made clearer by the contrast between "have to get you on a section" and "come forward for treatment" (lines 433-5) and between "work with us" and "trying to chase you". These contrasts formulate psychiatric practice in terms of voluntarism and consensual teamwork, the "first-resort remedies" of preferred psychiatric practices, what "*should* or *ought* to be done" (Emerson 1981: 3. emphasis in original). Making a joke about compulsion at line 439, depicting it in terms of "chasing", again underplays the power relation between professional and patient; "chase" sounds benign and slightly comic conveying the idea of professionals running around trying to catch patients. While the above extract contrasts compulsion with a psychiatric/patient relationship in which the patient volunteers ("come forward") and co-participates ("work with us"), in the next extract it is contrasted with professional persuasion.

Meeting 2 (post-meeting) : Diane

652 Dr. N.: I think Emma White (.) worked with her quite closely didn't she:: I
653 think she got to trust Emma
654 Sarah (CPN): yes
655 Dr. N.: and because of that she came into hospital without having to
656 [be sectioned]
657 Sarah (CPN): [thats right yeah]
658 Dr. N.: even though I came there and I thought I was sectioning her because
659 she >kept on saying no-no-no-no I'm not going into hospital< no no

660 no::: nothing wrong with me I'm fine its just things going o::n um but
661 in the end they did persuade her to go in so I think thats really quite a
662 good step

In this extract the last resort of formal admission (lines 655-6) and the preferred practice of persuasion (line 661) are sandwiched either side of an extreme depiction of Diane. In a three-part list of "she >kept saying no-no-no-no I'm not going into hospital<", "no no no::: nothing wrong with me", and "I'm fine its just things going o::n" (lines 659-60), Diane is positioned as extremely uncooperative to the point of downright refusal, as denying that there is anything wrong with her, and as attributing any blame for what is happening elsewhere. This depiction of uncooperation, denial and possibly lack of insight on Diane's part not only adds weight and force to the achievement of professional persuasion, but also suggests that, had "sectioning" been the outcome, it would have been necessary and justifiable (Emerson 1981).

The themes of "advice", and "persuade" work to strengthen the framing of psychiatric practices as benevolence. Moreover, discourses of "force" and "having to section" suggest that compulsion is abstained from whenever possible and only reluctantly employed as the last resort. Benevolent and persuasive psychiatry also requires a certain kind of patient who takes responsibility for seeking and taking advice, and who volunteers for and co-participates in their treatment and care. Discourses of help, advice, and persuasion present psychiatric practice as benevolence and constitute a relation of benevolent, persuasive psychiatry/responsible, voluntary, co-participatory patient at this localised level. This relation suggests that psychiatric practices are more concerned with governmentality in local encounters, encouraging patient responsibility (Miller 1986; Rose 1986b; 1989), than social control per se (Chesler 1974; Scheff 1966; Szasz 1976).

Therefore relations of benevolent psychiatry/responsible patient are accomplished within interactions; they are not just determined by "pre-existing factors" (Hutchby 1997: 175). However, professionals do orient to and incorporate broader legislative concerns into their interactions in terms of "force" and "sectioning" and it seems improbable that these considerations are simply interactional resources, "somehow generated ex nihilo" (Hutchby 1997: 176). For example, the doctor's claims that she is not forcing Dawn to take her medication, and her solicitation of Dawn's agreement, suggest that legislative and 'rights' discourses are coming into play. While the limits of compulsion (last resort) and rights (voluntarism) are invoked and framed interactionally within meetings they suggest certain ambiguities regarding the extent of psychiatric power. It is not entirely clear to what extent professionals can enforce patient compliance with, for example, medication. Compulsory medication for certain community patients has been mooted, but it has not been implemented (Jones 1993) and the criteria for admission under sections 2 and 3 of the 1983 Mental Health Act mean that "services can take no action until there is demonstrable evidence that they are 'sectionable'" (Jones 1993: 239). Moreover, "anticipated relapse...is not sufficient" and "detention in hospital should not be used to attempt to coerce the patient to accept treatment" (Jones 1994: 21 & 25). Equally, while community patients (like informal in-patients) have the common law right to refuse treatment (Gostin 1983), it is also not clear the extent to which they can exercise this right, in the face of professional pressure.

Thus, when the doctor claims that she is not forcing Dawn to take the medication and solicits Dawn's agreement to this understanding, the uncertain extent and limits of professional power and patient rights are played out at this local level. Similarly, the framing of compulsion as a last resort, and voluntarism and participation as preferred practice, is a practical accomplishment within the interaction. But it is difficult to account for these formulations without reference to a wider framework which specifies the "least restrictive setting" for patients, and patient involvement in their treatment and care.[9] In this sense, then, the current legislative framework could be said to constrain both professionals and patients at the local level (Jones 1993).

But relations constituted between professionals and patients also contain a number of asymmetries. While professionals downplay the power relation, for example they are just "people" giving advice, it is the professionals who are framed as having the knowledge to give that advice, and patients who do not have sufficient knowledge to make decisions about their treatment. It is also the professionals who invoke and frame the meaning and

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[9] Emerson (1981) makes a similar point in his discussion of last resorts. He suggests that last resorts are practical accomplishments providing a "justificatory decision logic" (pg. 19) but he also refers to broader "prevailing law and policy recommendation" since deinstitutionalisation whereby compulsory admission has come to be seen as "at best a limited, partial response" which should be made "reluctantly and only in extreme instances" (pg. 2).

limits of compulsion and rights and seek patients' agreement to this framing, not the patients. And it is the professionals who invoke and assign the range of responsibilities for patients. As such, while professionals do attempt to engender responsibility in patients within interactions (Miller 1986; Rose 1986b; 1989; Lunbeck 1994), limits are also placed on the extent of self-regulation. Responsibility is framed in terms of what patients should bring to and take from the professionals. This somewhat circumscribed notion of self-regulation operating under the auspices of professional regulation suggests that professionals are retaining ultimate responsibility whilst simultaneously building responsibility into the professional/patient relation.[10]

However, the uncertain extent of professional power and patients' rights, played out interactionally in local encounters, has the potential for creating local difficulties for professionals. Or, to put it another way, if patients are not forced to take their medication how do professionals manage the problem of persuading and encouraging them to do so? The next section looks at the ways professionals invoke and assign patient responsibility in the areas of taking medication and attending appointments, areas that are potentially contentious and uncertain, through the discourse of forgetting.

3 Responsibility: "forget"

The previous sections have detailed a number of ways that professionals invoke and assign patient responsibility; through discourses of "help" and "advice" responsibility is framed in terms of patients knowing what their problems and needs are and being responsible for bringing them to the attention of the professionals, and being responsible for seeking and taking advice. However, "forget"ing is a further important means through which professionals attempt to assign patient responsibility, particularly in the areas of taking medication and attending appointments. A number of writers have explored expressions of remembering and forgetting as discursive productions, deployed in specific contexts to accomplish social actions such as justification, claiming credibility and attributing responsibility (Edwards & Potter 1992). In particular, forgetting can involve situated moral claims; members of particular categories are not allowed to forget certain matters and hence forgetting can implicate issues of responsibility (Coulter 1985; Lynch

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[10] The argument that patients should be responsible for seeking and accepting treatment while "absolute responsibility falls...on...the doctors" has been made by a number of writers (Scott 1973: 47; Parsons 1952; Baruch & Treacher 1978).

& Bogen 1996). In turn, avowals of forgetting can be used as an evasion strategy, for example to obstruct lines of questioning during an interrogation, but "it cannot be assumed that all failures to recall are feigned" making such avowals particularly effective (Lynch & Bogen 1996: 183 & 199).

In this section I trace the way that professionals invoke "forget" to assign responsibility to patients for taking medication and keeping appointments, and how patients deploy avowals of forgetting in talk about the same topics. In the first extract the doctor is discussing with Diane, the patient, the possibility of taking oral medication rather than her present injection of medication. This is part of a longer discussion regarding the side effects that Diane is experiencing, and why she did not take her oral medication in the past. The extract begins with the doctor raising the possibility of Diane taking "a tablet" which is framed as a matter of necessity rather than choice "you would have to ta::ke it"

Meeting 2 (main meeting) : Diane

171 Dr. N.: you could take a tablet that might do you (0.7) just as much good as
172 well=
173 Diane: =yes=
174 Dr. N.: =but you would have to ta::ke it
175 Diane yes
176 Dr. N.: not just (0.4) forget to take it
177 Diane: no I wouldn't forget to take it doctor

The necessity for taking the medication is then contrasted with an alternative of not taking the medication which is framed in terms of forgetting, "not just (0.4) forget to take it" (line 176). The deployment of "forget" here could be a literal reference to the difficulty of remembering to take tablets everyday and/or positioning Diane as someone with a poor memory who is prone to forgetting to take her medication. However, framing the taking of medication in terms of necessity and the alternative as "forget"ting suggests that this activity is something Diane, as a patient (with a diagnosis of schizophrenia), is not allowed to forget. As such, the doctor is attempting to assign responsibility for tablet taking to Diane; it is an activity that Diane cannot "just (0.4) forget". The employment of "forget", then, enables the doctor to impress upon Diane that she *must* take the tablet, it is her responsibility.

In the above extract, the doctor is attempting to invoke and assign responsibility for taking medication prospectively ("would", line 174), however in the following extract it is assigned retrospectively. In the second extract "forget" is invoked in relation to a missed outpatient appointment. Matthew, the patient, and the doctor have been discussing the numerous activities that Matthew is involved in and the doctor has expressed some surprise at how much he does. The extract begins with the doctor framing Matthew's other activities in terms of "planning" and not "forget"ting, "you must be quite good at planning things" and "you don't forget to go" (lines 375 & 378). This framing suggests that Matthew is well-organised and responsible, and his agreement to this characterisation is easily solicited. But the doctor uses this framing, and Matthew's agreement, as an opportunity to reintroduce the problem of Matthew not coming to his last out-patient appointment with her.

Meeting 3 (main meeting) : Matthew

375 Dr. N.:	you must be you must be quite good at planning things if you've been
376	getting to all these places?
377 Matthew:	mm
378 Dr. N.:	you don't you don't forget to go::
379 Matthew:	no
380 Dr. N.:	well why did you forget to come to see ME:::? then ((said in bantering
381	tone of voice))
382 Matthew:	I don't know [I just]
383 Dr. N.:	[h h h] you'd better write it down have you got a diary or a
384	calendar or something have you?
385 Matthew:	I had it pinned up on my wall
386 Dr. N.:	and you still forgot
387 Matthew:	I thought it was after this meeting you see

While having so much to do could be a mitigating excuse for a missed appointment, the doctor has already established, and elicited Matthew's agreement to, the notion that he is organised and responsible in other areas of his life. Thus, the missed appointment becomes problematised and reprehensible. The bantering tone and laughter (lines 380 & 383) suggest that she is put out about the missed appointment but is attempting to press Matthew on the issue while keeping it on a light note. Matthew begins what appears to be a non-committal response at line 382 but he is interrupted by the doctor. She provides a three-part list of *aides-memoire,* "a diary or a calendar or something" (lines 383-4) which connects up memory, organisation and responsibility and which also now becomes prospective, "you'd better write it down" (line383). The generalised list completer ("or something") implies that there may be many more relevant aids (Jefferson 1990), placing the activity of attending appointments in the realm of something that is easily organised and therefore one that patients should not forget. Responsibility for keeping appointments is thus placed on Matthew.

However, Matthew makes use of the generalised list completer, "something", to provide an alternative *aide-memoire* ("pinned up on my wall"), thus denying his inability to organise and the inference of irresponsibility. But the consultant continues to press him forcing Matthew to invoke an alternative explanation in terms of a misunderstanding, "I thought it was after this meeting" (line 387). In this way, keeping appointments is assigned retrospectively and prospectively by the doctor as Matthew's responsibility; it is his responsibility that he missed his previous appointment and that he keeps future appointments. Matthew's alternative formulation of a misunderstanding does not undermine the assignment of responsibility but merely provides mitigation for the missed appointment on this particular occasion, thus affirming that he is responsible for keeping appointments.

Therefore, professionals use the discourse of "forget" to invoke and assign patient responsibility for taking medication and keeping appointments. In turn, patients also make claims about forgetting in relation to the same activities. In the next extract Nicola, the patient, has not attended her last out-patient appointment with the doctor and the doctor is remonstrating with her. Dr. North begins with the suggestion that the appointment may not have been "right" and that Nicola "ignored" it (line 9) which suggests lack of volition and thus irresponsibility on Nicola's part, she should have changed it. But Nicola immediately claims a failure of memory, "I didn't remember" (line 11), interrupting the doctor to do so.

Meeting 5 (main meeting) : Nicola

9 Dr. N.: if you have an appointment and its not right don't just igno::re it but
10 ring up and [change it]
11 Nicola: [I did]n't remember it honestly um
12 Dr. N.: you didn't remembe::r don't you write it down in your calendar then?
13 Nicola: sometimes
14 Dr. N.: yeah OK because you you >really do need< to to do that because
15 otherwise (.) you you don't keep the appointment °you forget° (1.3)
16 alri:::ght um (1.1) OK::

The use of "honestly" following Nicola's avowal of forgetting appears to acknowledge that such an avowal *could* be read as evasive whilst founding this particular claim as a genuine instance of failure to recall the appointment. As such it is particularly difficult for the doctor to tell whether it is being used evasively and enables Nicola to make an effective claim of "no definite responsibility" (Lynch & Bogen 1996: 199) for the missed appointment. However, as Lynch & Bogen (1996) point out, responsibility can still be assigned for "recalling what "anybody" (in a relevant category) *should* recall under the circumstances" (pg. 200, emphasis in original). And, as we have already seen, patients should recall their appointments. The doctor's repeat of Nicola's claim at line 12 followed by the invocation of an aide-memoire, framed as a question, suggests that the doctor is challenging the believability of the claim (Mellinger 1995).[11] In a similar fashion to the previous extract, the doctor assigns responsibility via the aide-memoire and solicits Nicola's agreement.

However Nicola avoids a straightforward agreement or disagreement with her response, "sometimes" (line 13), and thus manages the difficulty, occasioned by the doctor, of neither admitting irresponsibility nor undermining her previous avowal of forgetting. The doctor does not pursue this equivocal response but instead founds the necessity of keeping appointments as Nicola's responsibility, "you >really do need< to do that because otherwise...°you forget°" (lines 14-15). The two pauses suggest that the doctor is waiting for some form of agreement from Nicola but when they are not forthcoming she moves

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[11] Mellinger (1995) suggests that psychiatrists use partial repeats to challenge the "unbelievable" responses of patients.

on. Avowals of forgetting by patients, and the (re)assignment of responsibility by professionals works in a similar way for talk about medication.[12]

Therefore, professionals use the discourse of "forget" to invoke and assign patient responsibility in the particular areas of taking medication and keeping appointments, and patients also deploy "forget" in terms of avowals of non-recall in the same contexts. However, while such avowals by patients are ambiguous and temporarily ward off "definite responsibility", professionals use patients' avowals of forgetting to re-establish responsibility. The theme of "forget"ting was only mobilised by professionals in relation to these two topics suggesting that these are the particular activities that patients are not allowed to forget. The contexts in which "forget" is deployed suggest connections both to professionals' background understandings of schizophrenia and the broader mandate of community care. Assigning patient responsibility in these particular areas is especially salient for patients with a diagnosis of schizophrenia, given media and public concerns regarding 'dangerous' schizophrenic patients in the community, suggesting that professionals' background understandings of schizophrenia are operating here.

The theme of "forget" is consonant with the aim of engendering responsibility for mental health initiated in the 1959 Mental Health Act and the move to community care (Rose 1986b). As such, the mandate of community care, and the associated uncertainty of the limits of compulsion and rights are played out in terms of responsibility in local interactions. Professionals' attempts to build responsibility into their relation with patients, therefore, are the localised outcome of wider legislative discourses; professionals do not compel patients to take their medication and attend appointments, it is a question of understanding their responsibilities. And patients do not refuse treatment, it is a question of lapses of memory. In this way, the deployment of "forget" circumvents compulsion and rights and reframes them in terms of responsibility. It is in the potentially difficult contexts of medication and appointments, where self-regulation meets the exigencies of broader discourses of psychiatry's own responsibilities, that instilling a "desire for self-control, a desire to discipline themselves" (Lunbeck 1994: 181) is particularly important.

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[12] For example, when Matthew makes a negative claim about his medication, "the times when I forget to take my medication it doesn't make any difference", the doctor replies, "if you didn't remember to to take it (.) for a long time then it probably would make a difference".

The themes of "help", "advice", "persuade", and "forget" suggest that psychiatric practices at the level of local encounters involve going through the patient and attempting to secure patients' agreement, compliance and self-regulation through discourses of benevolence, persuasion and responsibility. Equally, in many instances, as we have seen in the extracts above, patients go along with and/or utilise these discourses themselves. However psychiatric practice is also framed in terms of another discourse which is somewhat contradictory to the practices discussed so far. Themes of professional supervision of patients are regularly deployed in meetings constituting a different kind of professional/patient relation and suggesting that engendering self-responsibility is an imperfect and limited endeavour.

4. Supervision: "see" and "monitor"

The previous sections have discussed a number of ways in which professional/patient relations are constituted interactionally in terms of benevolent, persuasive psychiatry/ participatory, responsible patient. A key feature of patients' responsibility for their mental health concerns medication and appointments, although asymmetries in professional/patient relations imply that patient responsibility remains under the auspices of professional regulation. However, professionals regularly employ supervisory discourses in meetings which indicate that this is an important aspect of psychiatric practice. Supervisory discourses both constitute an alternative coexistent psychiatric/patient relation and suggest that professionals may, in turn, be attending to the possibilities of their own surveillance. In this section, I explore the way professionals deploy the themes of "see" and "monitor" in their discussions with patients and other professionals. Seeing is not simply a matter of cognitive perception. As Coulter & Parsons (1990) have demonstrated, seeing is embedded in practical action, its meaning varying according to the context of its use, and does not necessarily connote perceptual activities per se.

In the first extract Sarah, the CPN, is going over what will be written in Matthew's new care plan. Discussion preceding this extract has concerned Matthew, the patient, claiming that his medication "doesn't make any difference" and the doctor stating "we should continue with the care plan", implying that the medication will not be changed. The doctor has then requested that Sarah "go through the care plan" (text not included here). The extract begins with Sarah presenting her account as a summary of what they have agreed in the meeting, implying a consensus which belies the disagreement over medication between the doctor and Matthew, "what we've got so far" (line 284). However, she then amends this to a personal framing suggesting, perhaps, some uncertainty, "how I see the care plan" (lines 284-5).

Meeting 3 (main meeting) : Matthew
284 Sarah (CPN): if I could just go through what we've got so far from the meeting >how
285 I see the care plan would be< is that um just to monitor your mental
286 state overall you'll still have to see me every two weeks for the depo
287 so the depo will be the same (.) is that right to continue with that?

The care plan is framed in terms of what the professionals will do, "monitor", and what Matthew has to do, "see me" (lines 285 & 286). "Monitor" carries the notion of supervision, suggesting regular surveillance of Matthew's "mental state", although the force of this surveillance discourse is downplayed by the preceding qualifier, "just", which suggests it is really only a minor matter.[13] In contrast, Matthew "see"ing Sarah seems to indicate regular contact with the CPN for the purposes of administering his injection (depo is the term used for an injection of medication). The imperative "have to" before "see me" conveys the sense that seeing the CPN for his injection is a matter of necessity rather than choice, mirroring discourses in Diane's meeting regarding "have to take" the tablet (section 3). The use of "still" (line 286) reiterates the doctor's implication that the medication will not be changed, an understanding that Sarah checks with the doctor.

The themes of "monitor" and "see" in this extract, then, appear to have little to do with, and run somewhat counter to, notions of patient responsibility. Together with other instances of professional talk such as "checking out" a patient's ability to mother, and "keep an eye on" a patient's side-effects (see Appendix V), these themes indicate that a major part of psychiatric practice is the supervision of patients. Supervisory discourses imply that while patients should be responsible for their mental health, they are not very

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[13] A similar diminishing of the force of surveillance discourse occurs in Diane's meeting, where "monitor your mental state" is amended to "make sure you're alright" (see first extract, Appendix V).

responsible or entirely trustworthy. They constitute a different kind of professional/patient relation of supervisory psychiatry/untrustworthy patient which coexists with benevolent, persuasive psychiatry/responsible patient. In turn this indicates that the project of engendering self-responsibility and self-regulation (Rose 1986b; Lunbeck 1994) is a troublesome endeavour that requires professional supervision at the local level.

Moreover, while Rose (1986a) suggests that community psychiatry has extended medical scrutiny "beyond the hospital and into the home" (pg. 75), supervision is formulated in regular but partial terms (administering medication, checking mental state), or particular terms (mothering a new baby, side effects of medication), rather than panoptic surveillance. In addition, professionals' supervisory practices may also be attending to the possibility of their own supervision: patients should be "seen" to have been "seen". In the second extract, Robin, the patient, is in the process of being transferred to another Health Authority and much of the discussion in his CPA concerns arrangements for his transfer. In the sequence before the extract begins, the doctor has been indicating that she will be responsible for referring Robin to the consultant at the new hospital but "they'll take time before they see you" (text not included here). The time delay between referral and being "seen" sets up a problem of supervision and professional responsibility for that supervision in the "meantime" (lines 358 & 370).

Meeting 14 (main meeting) : Robin
358 Dr. G.: meantime til they (0.9) completely ta take care of of you in future (.)
359 we will not I will not discharge you from Treetops hospital um I I will
360 see you in the outpatient
361 Robin: yes=
362 Dr. G.: =in six weeks time from now
363 Robin: yes thank you doctor North=
364 Dr. G.: =OK
365 Robin: yes thank you
366 Sam (ASW): every six weeks
367 Dr. G.: er I'll see him six weeks er from now on I'll make an appointment and
368 give °it to you OK°?=
369 Robin: =yes=

370 Dr. G.: =°after the meeting° (.) meantime um if a CPN could see you once a
371 month (1.2) and er once a month er Sam you're going to see him

The doctor begins by establishing where professional responsibilities lie; Robin is their responsibility, he will not be "discharged", until the new health authority "completely ta take care of of you" (lines 358-9). She goes on to list a number of different professionals who will be "see"ing Robin, "I will see you in the outpatient" (lines 359-60), "I'll see him six weeks from now" (line 367), "if a CPN could see you once a month" (lines 370-1), and "once a month Sam you're going to see him" (line 371). The sheer number of "see"ings in this extract suggest some anxiety on the doctor's part that in the process of transfer no one will be "see"ing Robin and he will be left unsupervised - despite the fact that he is now living in a staffed Mind hostel. In this way a series of regular professional contacts with Robin is established for the interval before the new health authority take over "complete" responsibility. As such, it would seem that it is not just a question of Robin's supervision but also of professional responsibility for that supervision. Further, given that these detailed professional responsibilities will be written up in the care plan document, it appears that the doctor is also attending to the possibility of her own surveillance and protecting herself and the other professionals against a future charge that Robin was left unsupervised. In this way, professional supervisory responsibilities are documented in the care plan record and Robin is "seen" to have been regularly "seen".[14]

Therefore, themes of "see" and "monitor" constitute an alternative, more asymmetric, relation of supervisory psychiatry/untrustworthy patient which coexists with benevolent psychiatry/responsible patient and suggests that patients are not sufficiently responsible for their mental health and require professional supervision. In addition to establishing supervisory practices, professionals also seem to be attending to the possibility of future supervision of their own work and responsibilities. This alternative relation of supervisory psychiatry/untrustworthy patient and professional concerns to establish and document their supervisory practices is accomplished in local interactions. But documentary records have a life beyond particular interactions (Garfinkel 1967). Thus supervisory discourses

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[14] Garfinkel (1967: 186-207) makes a similar point in his analysis of "Good organizational reasons for 'bad' clinic records". He suggests that clinical records are designed to protect staff from contingent readings, including "occasions under which the record may be used as part of the ongoing system of supervision and review" (pg. 194).

could also be regarded as the localised outcome of broader media and government concerns regarding 'dangerous' (to others or themselves) community patients, such as the Zito case, and Ben Silcock who famously climbed into the lion's enclosure at Regent Park Zoo, and was killed. Such examples of community patients who "fell through the net" (Jones 1993: 245) were cited by the CMHT manager as the impetus behind the introduction of CPAs. In this sense then, CPA meetings in general, and supervision discourses within meetings in particular, could be said to be means for 'stitching the net'. And documenting such practices are the means to be "seen" to be doing so.

The relation of supervisory psychiatry/untrustworthy patient indicates the discursive limits of patient responsibility and thus the limits of governmental psychiatry. However, governmental psychiatry also incorporates the notion of a co-participatory patient who volunteers for and participates in her/his treatment and care. In the final section, I explore the extent and limits of patient participation. If supervisory discourses frame the limits of patient responsibility, paradoxically, discourses of choice and consumerism point to the limits of patient participation.

5. Restricting Patient Participation: "choice" and "give it a try"

In the previous section, I have discussed the ways that participants, particularly professionals, frame psychiatric practices within interactions to constitute professional/patient relations along two dimensions. On the one hand, benevolent psychiatry requires a responsible, voluntary, participatory patient, and on the other, supervisory psychiatry suggests that patients are not sufficiently responsible, indicating the limits of patient responsibility. I have already detailed the ways benevolent psychiatry incorporates the notion of a co-participatory patient and I have suggested that professional formulations of voluntarism and participation as preferred psychiatric practice may be related to the wider legislative framework. In this respect, the Mental Health Act 1983 Code of Practice (DoH&WO 1993: 2 & 107) makes specific reference to the requirement for professionals to "involve" patients in their treatment and care, and "consider" their "wishes and needs". Consumerism and choice are key means through which patients may participate and be involved in their care, consonant with a governmental psychiatry which is said to seek to restore patients to "the status of a choosing individual" (Rose 1989:

228). However, patient consumerism and choice may not be in the interests of a powerful psychiatric profession (Thomas 1997). In this section I explore the way that discourses of choice and consumerism are deployed within local interactions and their practical effects in terms of limiting, rather than encouraging, patient participation.

The discourse of "choice" is frequently employed by professionals within CPA meetings and can be associated with a range of topics from arrangements for future meetings to medication and activities. The extracts below concern three different areas of patient "choice": the position for having an injection of medication, which medication, and which activity at which community centre. But in each case patient "choice" is formulated in terms of fixed choices. In the first extract, professionals are discussing Diane, the patient's, previous CPN as part of a longer discussion between the three professionals regarding why Sarah the CPN will be "good for" Diane (text not included here). In this extract, "choice" is presented in terms of how Diane has her injection.

Meeting 2 (post-meeting) : Diane
833 Dr. N.: well I I ye:::s well actually I I don't think her last CPN was really quite
834 (1.1) compatible personality wise=
835 Betty (CSW): =no [I don't think he was]
836 Dr. N.: [I think he was prob]ably rather (0.6) domineering [so] obviously
837 that doesn't
838 Betty (CSW): [yes]
839 Sarah (CPN): so that made it worse for her y'see I give patients the choice how they
840 want their injections standing up laying down I mean thats their home
841 and thats their choice if they're relaxed its easier for me

This "choice" (twice, lines 839 & 841) is not just Diane's but formulated in general terms of "patients" (line 839) suggesting that it is given to all (this CPN's) patients. The choice of "standing up laying down" (line 840), is associated with "home" (line 840) conveying the notion that people should make their own choices in their own homes, and is framed as good professional practice that benefits the patient and the professional, "if they're relaxed its easier for me" (line 841). The second extract concerns Tony, another patient, choosing between two different types of medication, "either I take **** or **** I couldn't take both / ya but you chose ****" (lines 431-3).

Meeting 6 (main meeting) : Tony (**** denotes name of medication)

429 Dr. N.: and at one time you were taking the **** but that °didn't suit or
430 something°?
431 Tony: I got a message from you that um either I take **** or **** I couldn't
432 take both
433 Dr. N.: ya but you chose ****
434 Tony: yes I did=
435 Dr. N.: =so presumably **** didn't do much for you or you would've chosen it
436 wouldn't you?

The formulation of choice between types of medication is used to support the doctor's claim that the dispreferred medication "didn't suit", "didn't do much for you" (lines 429 & 435), the implication being that the preferred choice of medication does suit/did do something for him. And in this extract, the doctor solicits Tony's agreement that he made a choice. Finally, the extract below is from Michelle's meeting and is related to professionally organised activities at two different community centres.

Meeting 11 (main meeting) : Michelle

150 Michelle: (   ) their their their meeting clashed with with the um (.) Castle
151 °on Tuesday° and another thing its like that meeting on Wednesday I
152 went to that meeting its full of elderly ladies but I thought that I'd
153 rather be like (.) y'know like cookery at the Castle because of the
154 elderly ladies
155 Dr. N.: well you've got a choice=
156 Michelle: =yeah=
157 Dr. N.: =you can go to one or the other
158 Michelle: yeah exactly I'd rather be at the Castle

Unfortunately the tape was inaudible prior to this sequence but Michelle's response is framed in a way which suggests that she is promoting one venue and rejecting another ("their meeting clashed...on °Tuesday°, lines 150-1), and one activity over another in a contrast between "meeting...full of elderly ladies" and "cookery at the Castle" (lines 152 & 153). The doctor sums this up as "choice...one or the other" (lines 155 & 157). Once again the doctor solicits Michelle's agreement that it is a matter of her choice (line 155).

These three extracts, then, present professional discourses of three different areas of patient "choice". However, in each case it is formulated in terms of fixed choices. Not only is "choice" fixed, it is also extremely limited so that psychiatric discourse of patient "choice" enables professionals to found the notion that patients have choices while at the same time limiting the extent of choice. In this way, the discourse of "choice" covers over the limitations of patient participation; Diane can choose the position in which she has her injection, but not whether she has it; similarly, Tony can choose which type of medication but not whether he has medication; and Michelle can choose which organised activity she attends at which community centre, but not whether she attends activities at all.

Therefore the discourse of "choice" simultaneously founds and limits patient participation. In deploying "choice" in this way, professionals maintain the semblance of a participatory, choosing patient while controlling the extent of choice/partcipation. Patients are not only given "choice" but are also encouraged to be informed consumers. The discourse of "give it a try" suggests that patients are consumers of psychiatric services and can pick and choose, try things out, and most importantly, not do things if they have tried and do not like the activity, medication, or whatever. In the following two extracts, professionals are framing a course of action for the patients in terms of trying an activity or medication. In the first extract, Betty, the CSW, is attempting to persuade Diane to attend the women's group at the community centre, something that Diane has been reluctant to do.

Meeting 2 (main meeting) : Diane
303 Betty (CSW): its finished at twe:::lve really (.) I mean it it y'know if you came for
304 just one or two sessions and see how you feel and if you really feel its
305 not for you well then fine but you've never really given anything a try:::

Betty formulates her persuasion in terms of informed consumer choice, "if you really feel its not for you well then fine" (lines 304-5), combined with two extreme formulations which suggest that Diane is not making an informed choice, how can she know if she has not tried it, "you've never really given anything a try::: " (line 305). Moreover, if Diane has "never" tried "anything" this suggests a person with a closed mind and a closed existence. This formulation carries a number of implications; that Diane has a choice, choices should be informed, and if Diane does not like women's group she can choose not to go. The second extract concerns medication; the doctor frames an additional or alternative medication as a matter of trying, "you're giving it another TRY:::" and "if you want to give it a try" (lines 398 & 401).

Meeting 6 (main meeting) : Tony (**** denotes name of medication)
396 Dr. N.: and um what about the medicatio:::n are we happy with tha::t?
397 Tony: the ****
398 Dr. N.: but you're giving it another TRY::: if if you felt like it but I think you
399 need to think about it
400 Tony: yes theres no hurry is there=
401 Dr. N.: =no hurry no so you >if you if you< want to give it a try again you let
402 me know

Formulating "try"ing the medication in terms of "if you felt like it"/"if you want to" conveys the notion that it is Tony's choice. The theme of "try" suggests, as in Diane's extract, that if Tony does not like the medication he can choose not to take it. The theme of "give it a try", therefore, founds the notion that patients are consumers of psychiatric services. In the above extracts it seems to be deployed as a means of persuading patients to do something they are reluctant to do and to solicit their agreement that they have a choice. However, consumerism, like choice itself, is somewhat limited. The following extract is an example of what happens when a patient attempts to be a consumer. As in Diane's extract above, the professionals have been trying to persuade Christine, the patient, to attend professionally organised activities at the community centre. They have been suggesting to Christine a number of activities that she could attend and are attempting to co-ordinate these activities with days when Christine's son is at the childminder. At this point Christine asks for a "programme" in order to "do something that fits" (lines 479-80).

Meeting 1 (main meeting) : Christine

479 Christine: do you have a programme of what goes on? then I can (.) do something
480 that fits
481 Claire (CPN): well what we have to do Christine is yes I can give you a programme
482 but (.) I have to (0.5) sort of discuss it with whoever is running it in
483 terms of y'know actually what the numbers are etc etc

Christine's request positions her as a consumer of services, much like one might ask for a programme of events from a leisure centre. However, Claire, the CPN, immediately makes it clear that Christine is not a straightforward consumer. In a disclaimer that suggests that Christine can, of course, have a programme ("yes I can give you a programme but...", lines 481-2), the CPN then undermines the usefulness of such a thing by invoking organisational constraints in terms of others who are not present, but have to be consulted by the professional ("I have to...discuss it with whoever is running it"), and a three-part list of "numbers", "etc", "etc" (lines 482-3). The paucity of the three-part list leaves the nature of what has to be discussed somewhat vague but is sufficient to found the inference that Christine cannot simply pick and choose between activities. Organisational constraints are thus invoked to undermine consumerism and place control back in psychiatric hands.

The above extract is suggestive of the limits of "give it a try" consumerism. It would seem that patients can "try" activities and medication from a (very) limited subset of options suggested and controlled by the professionals. Moreover, the extent to which patients can decline things they have "tried" is not entirely clear. The CSW claims that Diane can reject the women's group ("if you really feel its not for you well then fine", lines 304-5), and Tony "try"ing an alternative form of medication suggests an option to decline one of the alternatives. However, this might be less than straightforward if the patients decline the course of medication or activity preferred or desired by the professionals.

Consumerism is not only deployed as a means of persuasion, it can also be used to cover over the limits of choice and defer patient disagreement. In the final extract, the professionals have been discussing how Robin, who is being transferred to another health authority, will get his injection of medication ("depo") in the intervening period, given that he no longer lives in the Worthington NHS Trust area. In this extract Robin is offered a similar kind of fixed "choice" as in the earlier extracts; this time it is *which day* he has his injection of medication. Robin raises an objection framed in terms of combining travelling and the injection:

Meeting 14 (main meeting) : Robin

844 Robin: its a bit much isn't it on the medication it remains to be seen (.) when I
845 travel
846 Sam (ASW): : you won't have the medication til you're going home=
847 Robin: =yeah (1.0) yeah
848 Sam (ASW): what do you think
849 Robin: I haven't got much say in it really
850 Sam (ASW): >no no< you have a choice (.) do you want to have the injection the
851 same day as the sports?
852 Robin: well thats what they're saying innit I have to
853 Sam (ASW): do you want to <u>try</u> it and if its not suitable we could change it back to
854 the Monday or another day=
855 Robin: =yeah yeah try it and see see what happens
856 Sam (ASW): see what happens tomorrow

Robin is invited to say what he thinks (line 848), and responds by undermining the notion that he has a say ("I haven't got much say in it really" line 849). The social worker immediately asserts that he does have a choice between having the injection on the same day as sport, or, unsaid but implied, not. But Robin builds on his "not much say" argument, countering "choice" with the notion of compulsion, "thats what they're saying innit I have to" (line 852). The claim of "not much say" and "I have to" explicitly challenges, and threatens to expose, the limitations of "choice". The social worker's response however puts the genie back in the bottle; he invokes consumerism, "<u>try</u> it" (line 853) together with an explicit suggestion that if Robin "tries" and does not like it ("if its not suitable"), then he can decline to have his injection on a Friday and choose from a further subset of options, "change it...to the Monday or another day" (lines 853-4), and Robin goes along with this idea of consumerism. Notice that in dealing with the "problem" in terms of combining injection and sports, the professional is able to ignore that of injection and travel. In this way, then, Robin's challenge to the professional discourse of "choice" is countered by that of consumerism, "try", which covers over the limitations of choice and works to close down, or at least defer, any further disagreement.

Therefore the themes of "choice" and "give it a try" severely restrict the extent of choice and consumerism at the same time as they found it. As such, professional talk about patient choice and consumerism does not 'mean' the exercise of either and suggests the limits of governmental psychiatry in much the same way that supervisory discourses point to the limits of patient responsibility. Contra Rose (1989: 228) it does not seem to be a case of restoring these particular patients to "choosing individuals"; talk of choice obviates meaningful choice.

Conclusion

Psychiatric practices are accomplished within local CPA interactions and constitute two professional/patient relations. Themes of "help", "advice", and "persuade" constitute a relation of benevolent, persuasive psychiatry/responsible, voluntary, co-participatory patient. In this framing patients should know what their needs are and bring them to the attention of professionals, be responsible for seeking and taking advice, and volunteer for and co-participate in their treatment. Professionals do their best to meet patients' needs, dispense advice, work with patients, and generally encourage patient responsibility and participation. This formulation is reinforced by themes of "I'm not forcing you" and "having to section" which frame compulsion as a last resort. The discourse of "forget" is a particularly important means by which professionals assign patient responsibility in the areas of medication and keeping appointments, activities that patients are not allowed to forget. In turn, patients' avowals of forgetting are sufficiently ambiguous to ward off "definite responsibility" (Lynch & Bogen 1996: 199) in the same contexts, but are used by professionals to re-establish responsibility.

This professional/patient relation suggests that contemporary psychiatric practices are more concerned with governmentality, engendering self-responsibility and self-regulation (Miller 1986; Rose 1986b; 1989; Lunbeck 1994) than social control (Laing 1967; Szasz 1973; 1974; 1976; Chesler 1974), although it is an asymmetrical relation in which the professionals accomplish knowledgeability and ultimate responsibility.

While benevolent psychiatry/responsible patient relations are accomplished interactionally within meetings, I have also suggested points at which broader legislative concerns are incorporated into interactions. The uncertain limits of professional compulsion and patients' rights (Gostin 1983; Mental Health Act 1983; Jones 1993) are played out in local interactions in terms of formulations of compulsion (last resort), patient rights (voluntarism and participation as preferred practice) and soliciting patients' agreements that they are not compelled to take their medication. Similarly, professionals' assignments of patient responsibility and patients' avowals of forgetting in the particular contexts of medication and keeping appointments, circumvent the indeterminacy of compulsion and rights and appear to be related to the broader mandate of community care.

However, discourses of supervision and restricted choice constitute an alternative, more controlling, relation of supervisory psychiatry/untrustworthy patient. Themes of "see" and "monitor" suggest that while patients should take some responsibility for their mental health they are not very responsible and/or trustworthy, requiring professional supervision. Supervisory discourses both establish the need for regular contact with patients and a documentary record that professionals are meeting their own responsibilities, once again pointing to wider concerns regarding 'stitching the net' (Jones 1993). Similarly, patient participation is circumscribed through themes of "choice" and "give it a try" consumerism. Consumer discourses found the notion of patient choice, and are deployed as a means of persuasion for reluctant patients or to defer patient disagreement, while simultaneously closing down meaningful choice. Supervisory and restricted consumer discourses, therefore, indicate the limits of patient responsibility and participation and thus of governmental psychiatry for these particular patients. They suggest that psychiatric power incorporates elements of control alongside governmentality.

Schizophrenia as a category is not articulated explicitly in the accomplishment of professional/patient relations but this should not be taken to mean that it is irrelevant. Rather, the limits of governmental psychiatry for this group of patients suggests that background understandings of schizophrenia are operating here: when professionals make efforts to assign patient responsibility in the specific contexts of medication and appointments; when they establish that patients must be "seen"; and when patient choice is kept under strict professional control. In other words, when the encouragement of self-regulation is framed as so necessary but so limited. A number of background understandings appear to be underpinning this framing: notions that if schizophrenic patients do not take their medication they will become 'psychotic'; that if they do not attend appointments and are not supervised they could become dangerous or vulnerable; that if they are allowed more choice they will choose to abandon treatment with the same results; that these particular patients are not likely to be fully restored to responsible, choosing individuals. Thus the limits of governmental psychiatry, accomplished within local encounters, suggest that professionals' background understandings of schizophrenia are being played out here in terms of schizophrenia as a delusional disorder where complete recovery is "probably not common" (American Psychiatric Association 1994: 282).

This chapter has established an initial understanding of how contemporary psychiatric power relations unfold within clinical interactions, providing a framework for the chapters that follow. The analysis suggests that co-existing relations of benevolent psychiatry/responsible patient and supervisory psychiatry/untrustworthy patient are accomplished within local encounters, but broader discourses are also played out within interactions. Contemporary psychiatry at the local level is more concerned with governmentality than social control, yet patient responsibility and participation is limited, and supervision is imposed. I have argued that background understandings and assumptions about schizophrenia underpin and intersect with professional discourses of responsibility, supervision and choice. But gender understandings do not appear to do so: notions of patient responsibility and choice are not differentiated by gender.

Contemporary psychiatry at the local level involves professionals working with patients to secure their agreement and compliance, which involves considerable professional persuasion and negotiation and suggests that opportunities are likely to open up for negotiating and contesting the meanings of gender understandings and experiences. However, the limitations of responsibility and participation, encapsulated in supervisory discourses and restricted consumerism, imply that professionals may be less benevolent when faced with versions that run counter to their own understandings and preferences. In the next chapter I explore contemporary professional/patient relations further through an examination of where points of resistance occur in the promotion of patient responsibility and participation, and points of reassertion of psychiatric authority at this local level. And I consider the way that understandings of gender and schizophrenia may be invoked as a means of reasserting professional authority.

Chapter Four

Localised Resistance to and Reassertions of Psychiatric Power

Introduction

In the previous chapter, I discussed two co-existing professional/patient relations accomplished within local clinical encounters. Discourses of psychiatric benevolence and persuasion, and patient responsibility and participation constitute psychiatric practices in terms of encouraging self-regulation in patients. However, discourses of professional supervision and patient consumerism indicate the limits of responsibility and participation suggesting a more controlling, supervisory psychiatry. I suggested that professionals incorporate broader legislative concerns into interactions which are played out in terms of framings of compulsion as a last resort, patient voluntarism as preferred practice and assigning patient responsibility for taking medication. I argued that the simultaneous encouragement and limitation of patient responsibility and participation was indicative that professionals' background understandings of schizophrenia were operating, even though schizophrenia was not articulated as a category. I concluded that understandings and assumptions about schizophrenia, but not gender, intersect with professional discourses of responsibility, supervision and choice. I suggested that as professionals attempt to gain patients' agreement and compliance, opportunities are likely to arise for negotiation and contestation, but it is not clear how professionals might respond to patients' interpretations and preferences that do not accord with their own.

This chapter continues the focus on power and is concerned with patient resistance and professional reassertions of power in localised interactions. I begin with a short discussion of three different frameworks for understanding psychiatric power: in terms of social and gender control (Scheff 1966; Goffman 1968; Rosenhan 1973; Chesler 1974; Szasz 1976); a Foucauldian understanding of power and resistance at the micro-level (Foucault 1984; 1990; Widdicombe 1995; Kingfisher 1996); and a CA approach that views power and resistance as a situational accomplishment produced through turns of talk (Mellinger 1995). I draw on these frameworks to raise questions about contemporary psychiatric power and patient resistance in local encounters.

The main part of the chapter uses extracts from CPA meetings to explore accomplishments of power and resistance. I argue that patients draw on the framework of benevolent psychiatry/responsible patient to resist psychiatric control of patient participation and responsibility. Patient appropriations and reformulations of professional discourses of choice, and responsibility temporarily disrupt psychiatric control of decision-making and assessment but ultimately reaffirm these dominant discourses. While these small-scale disruptions are not likely to affect broader power relations they are significant in terms of securing professionally dispreferred practical outcomes for patients. I trace how power and resistance are accomplished turn-by-turn within interactions as professionals attempt to control access to and the distribution of talk, use partial repeats to challenge the unbelievable claims of patients and position themselves as more knowledgeable. And patients accomplish resistance through interrupting professionals, defending claims that have been challenged and initiating their own interpretations. However I suggest that wider legislative and rights discourses are played out within interactions in terms of professional concessions to dispreferred decisions and reluctance to engage with topics that undermine the benefits of medication.

In the second part of the chapter I discuss professional reassertions of power in response to patient resistance. I argue that the intra-professional post-meeting is a powerful institutional practice, determined by broader discourses, which affords professionals an "off-stage" context (Scott 1990: 14) in which to reassert power through (re)ascriptions of pathology; ascriptions which foreground and draw upon understandings of schizophrenia. However, while such reassertions of power suggest that patient disruptions are only temporary, they do not impact upon professionally dispreferred decisions secured by patients. Finally, I suggest that understandings of femininity (but not masculinity) are an occasional, rather than consistent, resource in professionals' responses to patient resistance. However, contra feminist accounts such as Chesler (1974), I argue that motherhood is framed as a burden, patients are pathologised without recourse to gendering and professionals override gender understandings if useful for the activity at hand. I conclude that localised professional/patient interactions involve disruptions and reassertions of professional power in which professionals draw on understandings of schizophrenia and occasional feminine genderings but they also concede to dispreferred decisions in the face of patient resistance.

From a feminist perspective writers have drawn on labelling theory to argue that the (usually male) therapist has substantial power over the passive and pathologised (female) patient, and uses it to enforce gender-role conformity (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992). However, this understanding of psychiatric power as hierarchical and repressive was not borne out in my analysis of contemporary psychiatric/patient relations in the previous chapter. But it is not clear from this initial analysis whether and how patients may resist psychiatric power, nor how professionals might respond to such resistance. Goffman's (1968) account of the asylum is suggestive of the likely professional response to patients who are disruptive and uncooperative:

> ...higher management may construe this alienative expression as just the sort of symptomology the institution was established to deal with and as the best kind of evidence that the patient properly belongs where he now finds himself. (Goffman 1968: 268).

Attempts by patients to resist psychiatric power may be met with imputations of pathology, but it is not evident whether gender understandings may be a resource in professionals' responses to patient resistance.

Foucault (1979; 1984; 1990) provides a different understanding of power and resistance. In his conceptualisation power is relational so that resistance is present in every power relation and a condition of its operation: it is "through the articulation of points of resistance" that power spreads but it is also through resistance that "power is disrupted" (Dreyfus & Rabinow 1982: 147). However, notions of resistance can be "opaque" in Foucauldian accounts (Kitzinger 2000: 175); for example, in Rose (1986b; 1989) and Miller's (1986) analyses of contemporary psychiatric power it is not clear where points of resistance may occur in the promotion of patient responsibility. Nevertheless Foucault's conception is theoretically productive for understanding the local capillaries of power even though he does not provide a methodology for analysing localised negotiations of power and resistance:

> ...it is precisely in the mundane contexts of interaction that institutional power is exercised, social inequalities are experienced, and resistance is accomplished. (Widdicombe 1995: 111).

In such 'everyday forms of resistance' (Scott 1985; 1990), accommodation and resistance may be better understood as a continuum rather than a dichotomy; resistance often involves the appropriation and ultimate reproduction of dominant discourses whereas seeming accommodation may be a form of resistance (Kingfisher 1996). These kinds of everyday resistances do not necessarily impact upon broader power relations but "this does not mean... that they are insignificant" (Moore 1988: 182).

An attention to the micro-politics of power and resistance has also been taken by a CA approach which views power as a situational accomplishment; that is, power and control are viewed as "micropolitical achievements...produced in and through actual turns of talk" (Mellinger 1995: 394). In this framework psychiatric power is accomplished through a range of interactional moves which control access to and the distribution of talk, for example: asking direct questions, evaluating patients' answers and propounding alternative explanations (Scheff 1968; Mehan 1990); selectively reinforcing or ignoring patients' responses (Scheff 1968); interruptions (West 1984); using partial repeats to challenge the 'unbelievable' responses of patients (Mellinger 1995); and positioning self as more knowledgeable (Burman 1995). Whilst psychiatrists and therapists have the discursive and interactional advantage, as it were, patients and clients may resist by reconfirming a prior claim that has been challenged and defending that claim (Mellinger 1995), or by setting their own agenda, commenting on the therapist's explanation, or initiating their own interpretation (Burman 1995).

Contemporary psychiatry attempts to obtain patients' agreement and compliance in decision-making regarding their future treatment and care within local interactions, suggesting that opportunities are likely to open up for patients (and significant others) to resist and disrupt professional power. The frameworks outlined above raise questions about psychiatric power and patient resistance in local encounters. In what ways do patients resist psychiatric power and how do professionals respond? Are gender understandings a resource in the reassertion of professional authority? And how are understandings of schizophrenia relevant to these activities? I use a range of extracts from CPA meetings to explore these issues looking at where points of resistance occur in the professional promotion and limitation of patient responsibility and choice, and where points of reassertion of professional authority occur. And I explore how gender understandings are invoked and deployed as an occasional, rather than consistent, resource for re-establishing professional authority.

1. Resisting Psychiatric Power : Patient Appropriations and Reformulations of Discourses of Choice and Responsibility

In the previous chapter I discussed the way that relations of benevolent, persuasive psychiatry/responsible, participatory patient are constituted within interactions through themes of "help", "advice" and "forget" which frame professionals as people who dispense expert help and advice and encourage patient responsibility and participation. In turn patients are assigned responsibility for seeking and taking professional advice, taking medication and keeping appointments, and co-participating in their treatment. But professional discourses of supervision and choice limit patient responsibility and participation accomplishing an alternative relation of supervisory, controlling psychiatry/untrustworthy patient. In this section I explore the way that patients appropriate and reformulate the discourses that constitute relations of benevolent psychiatry/responsible, participatory patient. In reformulating the meanings of choice and responsibility, and benevolence, patients attempt to resist the plans, preferences and assessments of the professionals, thus disrupting psychiatric power.

1.1 Reformulating Choice: "I need a couple more weeks to make up my mind"

Professionals simultaneously found and limit patient choice in such a way that they retain control through formulations of fixed and limited choices. Further, "give it a try" consumerism may be deployed as a means of persuading reluctant patients but I raised doubts about the extent to which patients could decline a course of action preferred or desired by the professionals. In the extracts that follow the professionals are trying to persuade the patient to return to living in his flat, rather than with his parents, a course of action that is desired by the professionals but which the patient is reluctant to do. In the course of the interaction professionals' invocation of discourses of choice and "give it a try" consumerism are counterposed with an alternative formulation of the meaning of choice, deployed by the patient.

Colin is about to be discharged from the day hospital and attends the meeting with his parents, Mr. and Mrs. Epsilon. Mr. Epsilon has introduced the subject of where Colin is "staying" and the doctor takes up this topic. The extract below begins with her question to Colin, which, though framed as a request for confirmation, suggests she is seeking an explanation (Queensgate is where Colin has a supported accommodation flat).

Meeting 13 (main meeting) : Colin (notes only)
72 Dr. N.: don't you want to live at Queensgate Colin
73 Colin: I get more support at home
74 Dr. N.: you'd have your own place be independent
75 Colin: if I had a full time job
76 Dr. N.: well you can't keep it as back-up
77 Colin: I prefer to live with my parents
78 Basil (HSW): I'm concerned hes been staying at his parents and the viability of that
79 we're not giving him the support because hes not there
80 Dr. N.: should we encourage him to go back
81 Basil (HSW): its up to Colin
82 Dr. N.: but you're not helping because hes not there why don't you give it
83 another try
84 Mrs. Epsilon: hes high on the list for a place of his own
85 Dr. N.: is that going to work out
86 Mrs. Epsilon: I don't know I get the feeling its the people moving in and out of
87 Queensgates
88 Brian (PN): its quietened down now its fairly stable
89 Basil (HSW): stable
90 Colin: I need a couple more weeks to make up my mind

Colin provides a justification for living at home rather than at the flat, however the doctor counters "support" with "independent" suggesting that Colin would be more autonomous if he lived in the flat and implying, perhaps, that needing support from your parents is overly-dependent. In response Colin counterposes the doctor's understanding of independence, having "your own place" (line 74) with an alternative one, "a full time job". In making living at the flat conditional on a full-time job, something which is not likely at present, he is placing it in an indefinite future. The doctor completely ignores the notion of a full-time job but Colin's reformulation of independence elicits a stronger response in terms of a warning that he cannot live with his parents and keep the flat, inferring that a decision needs to be made. And Colin gives her a decision, framed as a preference.

But it is not simply a matter of Colin making a choice when his preference does not concur with that of the professionals. Now the practicability ("viability") of Colin living with his parents is raised as a matter of concern suggesting that there is some unnamed problem associated with this, followed by the notion that he will have as much, if not more, support (from a professional) if he does live on his own, "we're not giving him the support because hes not there" (lines 78-9). Dr. North reiterates Basil's argument followed by consumerism, "why don't you give it another try" (lines 82-83). As in the previous chapter this works to suggest that Colin *can* choose (even though he has already chosen the professionals' dispreferred option), and need not do it if he has tried (or on this case tried again) and does not like it. And once again it is an attempt to persuade the patient to comply with the professionals' advice. Colin's mother also enters the conversation here and brings in a new element which covertly suggests that Queensgate is not a real "place of his own" (line 84) but more like a transit camp, "its the people moving in and out of Queensgates" (lines 86-7). In the process Mrs. Epsilon frames Queensgate as the problem rather than Colin. The psychiatric nurse and housing support worker join forces to counter the implication that Queensgate is a problem and undermine Mrs. Epsilon's attempt to support Colin. At this point, possibly feeling under pressure to give the professionals the answer they are seeking, Colin defers agreement, "I need a couple more weeks to make up my mind", thus warding off, at least temporarily, the need to comply and resisting the professionals' desired plan for him.

In the next extract the professionals continue to press Colin to agree to their preferred plan. In the intervening discussion between the previous extract and the one below, the doctor has changed tack and attempted unsuccessfully to elicit the support of Colin's parents. This extract takes up where the doctor is turning back to Colin with a direct question about "Queensgate", signalling that she is continuing to pursue the professionals' preference that he live in the flat. And, given that Basil has undermined Colin's objection in terms of "support" and Mrs. Epsilon's regarding "people moving in and out" (previous extract, lines 79 & 89), the doctor's question at line 99 presents a problem for Colin.

When Colin does not provide any objections to Queensgate, the doctor reiterates the consumerist discourse of "give it a try", explicitly elaborating that he still has a choice but if he does not act that choice will no longer be available, the inference being that it should be an *informed* choice and, by implication, that the choice Colin has made is not an informed one (lines 101-102).

99 Dr. N.: is there anything wrong with Queensgates
100 Colin: no
101 Dr. N.: why don't you give it a try for a month and then make up your mind
102 otherwise you'll lose it and then you'll have no choice
103 Mr. Epsilon: I'd rather Colin was independent but what do you do if he wants to
104 come home
105 Dr. N.: give it a try Basil can't help if hes not there
106 Colin: can I give it a couple of weeks
107 Dr. N.: of what [.] thinking [.] what [.]
108 Colin: well I sort of I haven't put in my mind what I want to do
109 Dr. N.: why a couple of weeks
110 Colin: because I'm getting better all the time

Under even more pressure to agree to this persuasive argument of choice and consumerism, Colin recirculates his previous strategy of deferring agreement, "can I give it a couple of weeks" (line 106). This time the doctor confronts this response with a series of direct questions; note the number of pauses here indicating that she is expecting an explanation from Colin which he is very slow to provide, "of what [.] thinking [.] what [.]" (line 107). The final pause suggests that she will wait until she gets an answer. The doctor's reference to "thinking", sandwiched between two questioning "what"s, appears to be reorienting to Colin's previous claim that "I need a couple more weeks to make up my mind" (previous extract, line 90), and it seems to be uttered as a result of Colin's silence and as a means to press him for an answer. But it also provides an opening for Colin to recirculate his claim, this time formulated rather oddly, "I haven't put in my mind what I want to do". When the doctor presses him further, questioning the idea that thinking will take "a couple of weeks", Colin brings in the notion of improving health, "I'm getting better all the time" (line 110). This response works in a number of ways; it is a positive self-assessment of his health which carries the covert suggestion of positive treatment, but it also provides a good justification for deferring agreement and support for a reformulation of what choice means.

Therefore, the professionals have a particular plan for Colin, living at the flat, which Colin resists. They deploy a number of persuasive arguments in terms of "independence", "support", and "help" he will receive if he concurs with their plan (lines 74, 79 & 105). But the chief means through which they attempt to solicit his agreement is the employment of discourses of "choice" and "give it a try" consumerism (lines 82-3, 102 & 105). The professionals, therefore, are attempting to persuade Colin to do something which he is reluctant to do.[1] And it is not a simple matter of choice between two options when the patient does not choose the one desired by the professionals. The doctor instigates a series of direct questions to Colin (lines 99, 107 & 109) in the second extract which accomplish control of the talk (Scheff 1968) and attempt to secure Colin's compliance. As such, the doctor can be said to be 'doing' power here.

However, accomplishing psychiatric power through control of the talk does not achieve agreement. Colin employs a number of arguments to resist the desired plan, for example discourses of parental "support" (line 73), and reformulating the meaning of "independent" (line 75). However his main strategy is deferring agreement through the appropriation and reformulation of the discourses of "choice" and "give it a try" consumerism. The themes of "I need a couple more weeks to make up my mind" and "can I give it a couple of weeks...I haven't put in my mind what I want to do", (lines 90, 106 & 108) reformulate the meaning of choice from a simple informed choosing between two options to notions that choice requires thought, thought takes time, and the better he feels the more able he will be to think about it and make a decision. Thus "choice" is no longer about giving something "a try" but about giving it considerable thought.[2]

Therefore Colin appropriates and reformulates the professional discourses of choice and consumerism to effectively resist professionals' attempts to gain compliance to their

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[1] The same sort of response to patients' reluctance was deployed in the extracts in chapter three, section 2.5 when Diane, Tony, and Robin are similarly persuaded.

[2] Given that CPA meetings are convened every three to six months, and that patients usually only see the doctor once between CPA meetings, the practical effect of reformulating the meaning of choice in this way is to defer agreement, or more likely disagreement, to a time and place outside of the meeting and, in particular, outside of the doctor's domain.

desired plan for him. By effective I mean simply the practical effects in terms of where Colin lives and who decides. As such, this localised everyday resistance temporarily disrupts psychiatric control and is not insignificant (Moore 1988). But this kind of resistance is unlikely to impact upon broader power relations; in drawing on the professional discourse of choice, Colin also reinforces the notion that patients have choices (Kingfisher 1996). Moreover Colin's disruption of psychiatric control does not free him from power but, rather, further enmeshes him in governmental power. In effect, Colin has momentarily extended the limits of governmental psychiatry in terms of his capacity to be a "choosing individual" which is more consonant with Rose's (1989: 228) conception of governmentality. In the following section, I explore patients' appropriations and reformulations of responsibility, which similarly disrupt psychiatric control of decision-making and assessments of patients.

1.2 Reformulating Responsibility: "I worry about the long term effect" and "sorting what I'm thinking"

There are a number of ways in which professionals invoke and assign patient responsibility. Benevolent psychiatry requires a patient who is responsible for bringing their problems and needs to the attention of professionals, and seeking and taking professional advice. In particular, patients should be responsible for taking their medication and keeping appointments, activities they are not allowed to forget. But professionals retain ultimate responsibility for patients' mental health and the extent of responsibility is limited by discourses of supervision. In this section, I discuss reformulations of responsibility deployed by patients to resist the doctor's assessments and preferred plans.

The first extract are taken from the meeting for Diane, a community patient, who attends the meeting with her husband George Yellow. One of the main topics discussed during the meeting is why Diane does not take her medication and the necessity for Diane to take her medication has been framed by the doctor in terms of "forget"ting, thus assigning it as Diane's responsibility.[3] The doctor has suggested that Diane has the wrong attitude ("so really its your attitude that you've got to think about", text not included here). But the reason for Diane having the wrong sort of attitude to her medication has been left

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[3] Parts of this extended discussion are in chapter three, sections 2 and 3.

unexplicated. The extract below begins with the consultant moving to provide a reason; it is about what Diane "believes" (lines 555, 559 & 563). A number of inferences are founded in this sequence. Firstly, "you've gotta" is articulated twice (line 554) lending the discourse an imperative quality which reinforces the notion that it is Diane's responsibility. Responsibility here is assigned in terms of trusting and believing the professionals, "you've got to trust" and "really believe" (lines 554-5). Secondly, the use of "people" at line 555 deprofessionalises the "help"; it positions the professionals as general caring sorts of people who want to help and have Diane's best interests at heart (see previous chapter, section 1). Thirdly "help" is juxtaposed with "poison".

Meeting 2 (main meeting): Diane
554 Dr. N.: because I think its a matter of trust really you've gotta (.) you've got to
555 trust the people trying to help you and really believe they're trying to
556 help you [not]
557 Diane: [oh] I do believe that=
558 Dr. N.: =poisoning you when this happens because its not its not poison but if
559 you beLIEVE its poison then you're not going to want to take it=
560 Diane: =yes
561 Dr. N.: so y'know I think you need to to to just discuss it and see
562 Diane: yeah
563 Dr. N.: what you really belie::ve (1.6) do you sometimes think maybe this is a
564 bit of poison [they're giving you]

Within this short sequence the doctor employs "believe" three times and each time it is emphasised (lines 555, 559 & 563), and "poison" four times (lines 558 twice, 559 & 564). In this psychiatric context, beliefs are not necessarily a matter of personal ideas and convictions, but rather are potential candidates for being judged as part of the "grammar of schizophrenia" (Coulter 1991: 161); professional judgments may be made regarding whether a patient's beliefs are harmless or delusional .[4] Thus beliefs may be invoked by professionals to denote something as unbeliev*able* and thus delusional and psychotic. In designating "poison" as a belief, and contrasting "people trying to help you" with "not poisoning you", Dr. North is ascribing to Diane a delusional belief; the belief that

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[4] For example, the community centre runs a group called "living with your beliefs" which is specifically for patients whose hallucinations and delusions are not entirely controlled by their medication.

professionals would poison their patients is bizarre, unbelievable and thus delusional. In this way the doctor foregrounds an understanding of schizophrenia, in terms of delusional beliefs, as an explanation for why Diane does not take her medication. Diane interrupts Dr. North at line 556 to attempt to confirm that she has the right kind of beliefs but the doctor is mid-way in producing a contrast structure between a rational belief (that people are trying to help Diane) and a delusional one (poisoning her). In ignoring Diane's response and attempt at affirmation at line 557, the doctor continues to control access to the talk (Scheff 1968; Mehan 1990) until she has completed her assessment.

The next extract follows on from the previous one. Having founded her explanation in terms of a delusional belief, in the next extract Dr. North provides an opening for Diane in the form of a request for her to confirm the doctor's explanation. But instead of the preferred response Diane resists the doctor's formulation and presents an alternative interpretation, interrupting the doctor to do so. What makes this alternative framing so effective is that Diane draws on the notion of "poison", introduced by the doctor, to reformulate the explanation in terms of poisoning her own body, the long term effects of taking medication.

565 Diane: [no no I don't] I just think to myself (1.6) I worry about the long term
566 effect of tablets and injections (0.7) y'know what its doing to my body
567 do you know what I mean doctor?
568 Dr. N.: ye::s=
569 Diane: =I worry about the long term effect thats all
570 Dr. N.: well but you can find out about the long term effect I mean when
571 Sarah could get you some information from the pharmacy and things
572 like that I mean you can (.) ask questions
573 Diane: yes
574 Dr. N.: and you can be told the answers
575 Diane: yes
576 Dr. N.: y'know you maybe you need to find out more about it
577 Diane: yes
578 Dr. N.: um but its its been around for a long time I mean with this
579 medication that you're o::n so that people do know the long term
580 effects its not a mystery

581 Diane: yeah
582 Dr. N.: yeah::

Diane reformulates poison from a delusional belief into a legitimate and rational concern, "I worry about the long term effect...what its doing to my body" (lines 565-6). Whilst the doctor has positioned Diane as delusional, Diane has re-positioned herself as someone who is aware of and concerned with her health. After initial hesitation (the holding response at line 568) Dr. North launches into a long sequence which avoids giving Diane any explanation of what the long term effects might be. Dr. North places responsibility squarely on Diane again, it is her responsibility to find out, "you can find out" (line 570), "you can (.) ask questions" (line 571), and "you can be told answers" (line 574). Diane is repositioned, this time as someone who has not asked, has not bothered to find out about something that "people do know", and thus as worrying unnecessarily and acting without knowledge. The doctor undermines Diane's claim that she is concerned with her health somewhat, by suggesting that Diane has been rather foolish, but Diane has successfully shifted the discourse from the realm of delusional belief to one of legitimate concern. And, while the doctor has used this as an opportunity to further impress upon Diane where her responsibilities lie, there is also a sense here that the doctor does not really want to deal with this topic in the meeting beyond assigning responsibility; that is, it could be argued that she spends quite some time *not* telling Diane what the side-effects are.

Therefore, the doctor is attempting to assign responsibility to Diane for taking her medication through exhorting her to trust and believe in the professionals. In the course of doing so, Diane's past behaviour of not taking her medication is explained in terms of an ascription of pathology/delusional belief. Such an ascription may decrease the degree of Diane's irresponsibility in the past but not her untrustworthiness. The doctor ignores Diane's affirmation of having the right kind of belief and evaluates Diane's claim that she worries about the long-term effects of medication. In turn, Diane interrupts the doctor (West 1984) and initiates her own interpretation of why she does not take her medication (lines 566-7) (Burman 1995). Diane's interpretation resists a potentially damaging assessment; the reason why she does not take her medication is not down to a delusional belief but a reasonable and legitimate concern for her health. It is a formulation that the doctor can only partially counter, rather than dismantle, by claiming that Diane is worrying unnecessarily and acting without knowledge.

The effectiveness of Diane's interpretation comes from her appropriation and reformulation of the professional discourse of responsibility which exploits a tension between medication having therapeutic effects and having adverse side-effects. In the process the meaning of responsibility as trusting and believing in the professionals and responsibility for taking her medication, is transformed into a more wide-ranging self-responsibility for general long-term health, a framing which pits one responsibility (for taking medication) against another (for long-term health). In this way, Diane is drawing on a dominant discourse and thus, like Colin in the previous section, ultimately reaffirms the discourse that patients should be responsible for their mental health. However, the practical effects in terms of overturning a psychiatric ascription of delusional beliefs carries significance for Diane's past, present and future (un)trustworthiness and (un)believability. Once again Diane's resistance is formulated within and draws upon benevolent psychiatry/responsible patient relations but it temporarily resists psychiatric power to ascribe (a feature of) pathology and in so doing disrupts a controlling psychiatry that takes ultimate responsibility for an untrustworthy patient; it is Diane who is taking responsibility over the longer term regarding the costs (rather than benefits) of medication for her health.

However, the meaning of a reformulated responsibility for mental health varies according to the context and purpose for which it is deployed and it can be mobilised pre-emptively rather than in response to a professional assessment. In the next extract Matthew, another patient, provides an alternative reformulation of responsibility to further a course of action which, it becomes clear, is dispreferred by the doctor. Matthew utilises the discourse of "help" to dispute the therapeutic effect of medication and reframe responsibility in terms of self-help and self-understanding in order to pursue a request for psychotherapy. Moreover one of the professionals forms a temporary covert alliance with the patient to resist the doctor's assessment and plan. Matthew is a community patient who attends the meeting alone. The first extract occurs very near the beginning of the meeting. The doctor is questioning Matthew about his medication and Matthew interrupts the doctor's second question with a response which appropriates the discourse of "help" to negate the benefit of the medication.

Meeting 3 (main meeting) : Matthew (**** denotes name of medication)

5 Dr. N.: so did they did they help you? (0.9) have you been taking [them]?
6 Matthew: [um] I don't
7 feel the medications helping me at all
8 Dr. N.: you don't think any of the medications helping you (0.6) well what
9 about these these **** tablets do you think (.) think they did anything?
10 Matthew: not really
11 Dr. N.: so tell me what you're taking now in the way of medication

The doctor responds with a partial repeat, "you don't think any of the medications helping you" (line 8) which challenges the believability of Matthew's claim, heightened by the use of the extreme formulation "any" which is emphasised (Mellinger 1995). While perhaps a certain medication might not be "help"ful, she implies that a claim of "any" is unbelievable. Framing her question in this way appears to be an attempt to elicit a modifying response from Matthew. However, again, Matthew's response is not forthcoming forcing Dr. North to frame yet another more specific question together with another extreme formulation "anything" (line 9). Matthew reconfirms his prior claim, but it is modified ("not really") and the doctor moves into a series of direct medical questions which enable her to take control of the talk (Scheff 1968). Having done so she presents him with a fixed 'Catch 22' sort of choice; either he is feeling better or he is not, which takes him back to the "stra::nge (.) thoughts and feelings" (lines 47-8). It has been set up in such a way that Matthew can only respond in the positive (or risk being discredited), which he does initially at line 51.

47 Dr. N.: um (2.9) well because you see um you did have stra::nge (.) thoughts
48 and feelings at one time didn't you >when I saw you in< July::: um you
49 said you were feeling a lot better:: so do you feel differently now do
50 you or do you still feel you're doing OK:::
51 Matthew: um I'm doing a lot better than I was (.) um (1.0)
52 Dr. N.: ye::s (1.3) so but you see (1.7) wouldn't that perhaps be due to to
53 having the the medication

54 Matthew: naah I don't think so=
55 Dr. N.: =°well what do you think it's due to°?
56 Matthew: sorting out my head sorting what I'm thinking
57 Dr. N.: you're thinking yourself into being better
58 Matthew: yes
59 Dr. N.: °I see° (4.8) ((sound of papers rustling))

But when Dr. North moves to link feeling better with "having the medication" and invites Matthew to agree with her explanation (lines 52-3), he explicitly denies that this is the case, "naah I don't think so" (line 54). Dr. North pursues Matthew's denial by requesting an alternative explanation, which I would suggest is probably in order to give her sufficient purchase to undermine his claim. Matthew places the reasons for "doing a lot better" inside himself with self as the agent of change rather than the medication or the professionals, "sorting out my head sorting what I'm thinking" (line 56). The doctor's rephrasing of what he has said may well be another challenge to the believability of his claim but it is not effective: Matthew reconfirms the claim and the doctor is stumped. The long pause and rustling of papers suggests that the doctor does not want to engage in a discussion about self-healing versus medication.

Therefore, Matthew has appropriated the psychiatric discourse of "help" to undermine the therapeutic effectiveness of his medication. The discourse of "sorting what I'm thinking" suggests that self-help is what makes you better, and the notion of self-help suggests a responsibility for his own mental health in terms of a self-healing which runs counter to professional formulations of patient responsibility in terms of seeking and taking professional advice, and taking the medication the professionals prescribe. Moreover, this formulation of help and responsibility stops the doctor in her tracks. While in the previous sections patients' reformulations were mobilised to resist professional plans and assessments, Matthew's reformulation of help and responsibility appears to be pre-emptive. As the discussion continues a reformulation of responsibility as self-help and self-healing is turned towards a request by the patient for psychotherapy. The extract below runs directly on from the previous one. After a long pause and much rustling of papers, Sarah, the CPN, fills the silence with a reference to Matthew's last CPA. In filling the silence, Sarah provides another opening for Matthew. She names the medication as an "issue" with a history as a disclaimer to forward the inference that Matthew was persuaded to "stay on" it. Notice also that Sarah has read Matthew's pre-emptive interactional moves as related to furthering a cessation of his medication. But Matthew interrupts Sarah, using the history to introduce a new agenda, "one to one" therapy (line 63).

60 Sarah (CPN): yes I think we had this discussion when we had the CPA meeting in
61 April (1.0) with Dr. South then you wished to come off all medication
62 that was the issue but we convinced [you to stay on it]
63 Matthew: [yeah I wanted one] to one
64 Sarah (CPN): sorry?
65 Matthew: I think I wanted one to one with someone
66 Dr. N.: well you've had an assessment by the psychotherapist by Louise and
67 and you didn't seem to know what it was all abou:::t and it never got
68 off the grou:::nd (.) um (2.3) ya I mean she theres a letter here from
69 Louise so you she wanted to see you November '96 and she said she'd
70 written to you befo:::re but you you hadn't kept the appointment or
71 somethi::ng and then she arranged another appointment for you:: and
72 you didn't come and you didn't get in touch with he::r (1.3) um
73 Matthew: I was in a bad way then y'know
74 Dr. N.: ya well what kind of >wha'd'you wah'd'you< mean by one to one? what
75 d'you think you want to talk abou::t (1.0) because you would've had
76 quite a bit of talking in the day hospital wouldn't you?
77 Matthew: I didn't really use the time when I was there I don't think I really um
78 (2.3) the time in the day hospital when I was in the day hospital I
79 wasn't well (0.9) tuned in to what I was feeling (1.4) I wasn't

The doctor re-enters the conversation with what could be termed a chronicle of failed opportunity. Two three-part lists are sandwiched either side of documentary evidence. The initial three-part list of "you've had an assessment by the psychotherapist...and you didn't seem to know what it was all abou:::t and it never got off the grou:::nd" (lines 66-8) founds the claim that Matthew has already had this opportunity but it was a complete failure because of his inadequacy. The middle item in the list is particularly damning and provides the explanation as to why it was unsuccessful and whose fault this was;

Matthew's not knowing "what it was all abou:::t" suggests that he was insufficiently aware to benefit from psychotherapy. The second three-part list provides an actual chronology which again suggests that Matthew has had this opportunity and failed to take it up, "you hadn't kept the appointment or somethi::ng and then she arranged another appointment for you:: and you didn't come and you didn't get in touch with he::r" (lines 70-2). In this chronological list, the psychotherapist is depicted as going to some efforts to see Matthew while Matthew inexplicably did not bother, or was not able to attend or contact the therapist.

The documentary evidence sandwiched between the two three-part lists provides weight to the doctor's claims, "theres a letter here from Louise...she wanted to see you in November 96" (lines 68-9), founding the claim that Matthew has had this opportunity already, it was a complete waste of time, and it was all his fault. As such it is a strong indictment of Matthew and counter to his claim that he "wanted one to one". However, rather than denying what the doctor has claimed, Matthew responds with a justification which firmly places those actions in the past , "I was in a bad way then" (line 73), thus providing an alternative interpretation. Not only does this provide a justification for his past failure but it also carries with it the implication that this past should not be used as an indicator of his future capabilities. As such it attempts to undermine the relevance of his past behaviour for the present discussion.

Matthew's justification and denial of relevance leaves the doctor floundering ("ya well what kind of >wha'd'you wha'd'you<", line 74) and her response suggests that his counter has been (at least partially) effective. It forces the doctor towards a slightly different line of questioning which nevertheless pursues the notion that psychotherapy is a waste of time. She frames a question to Matthew which challenges what he is asking for and why he thinks he wants it, "wah'd'you< mean by one to one? what d'you think you want to talk abou::t" (lines 74-5). The question subtly infers that he does not know what he is talking about and presses Matthew to provide a convincing justification. The pause suggests she is waiting for an answer but when he does not respond the doctor formulates another example of an opportunity Matthew has already had, "quite a bit of talking in the day hospital " (line 76). This time it is not a failed opportunity but one which suggests he has already had therapy so why should he need more. But Matthew recirculates and elaborates his previous explanation which ignores and circumvents the, potentially more difficult, first half of the doctor's question.

But this merely prompts the doctor to reiterate the first part of her question. The next extract follows on again from the previous one. In repeating her question, the consultant also attempts to undermine, to some extent, what Matthew is asking for. Her use of "one to one as you put it" (lines 80-1) suggests that Matthew is using pop psychology terminology, it is not the correct word, and once again implies that he does not know what he is talking about. It is also clear by this point in the discussion that the doctor does not agree with or want to grant Matthew's request for therapy. Moreover, in the next extract it appears that Matthew is trying to bring pressure to bear to get what he wants but he does not want to talk about whatever he wants to talk about with the doctor.[5]

80 Dr. N.: OK but you haven't actually said what it is you think that one to one
81 as you put it will do for you
82 Matthew: well I just need to get a lot of things out of my system
83 Dr. N.: like what?
84 Matthew: disturbing thoughts
85 Dr. N.: can you tell me about them?
86 Matthew: um sexual abuse (1.7) um (1.2) schizophrenia (1.4) things about my
87 parents (1.9) (   )
88 Dr. N.: they're a lot of different things that you're ju::st (.) °sort of (.) >putting
89 all< to°gether can you explain a bit about that?
90 Matthew: I had a nervous breakdown when I was seven (1.2) and I didn't deal
91 with it (1.8) so over the years my thoughts have just got worse and
92 worse
93 Dr. N.: and what what is this about sexual abuse?
94 Matthew: that's what caused my er breakdown when I was seven
95 Dr. N.: and who from who was the sexual abuse from
96 Matthew: my father (8.5)
97 Dr. N.: I mean is this something that was discussed in the day hospital Sarah?
98 Sarah (CPN): well we discussed that didn't we Matthew
99 Matthew: I don't remember

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[5] Given that Matthew gets "one to one" of sorts in outpatients with the doctor, he is also, to some extent, indirectly undermining her expertise.

Matthew provides a general reason at line 82, "I just need to get a lot things out of my system", which works in a number of ways. Firstly, it founds the inference that he has "a lot of things" that he needs to talk about while at the same time keeping it sufficiently vague to prevent the doctor undermining his claim. Secondly it carries the same sort of connotations to the reformulation of help and responsibility accomplished earlier in the meeting. Now responsibility for mental health is formulated in terms of self-understanding with the help of the professionals. But this is not help in the form of medication or advice from the professionals. Rather it reformulates the professional version of help to mean help to help yourself. And it brings a problem and need to the attention of the professionals but at the same time suggests that these particular professionals cannot meet that need. However the doctor pushes to elicit more information at line 83, and again at line 85. Finally Matthew names in a list of "sexual abuse", "schizophrenia", "things about my parents" and something, unfortunately, inaudible on the tape (lines 86-7). This is a shocking move on Matthew's part which has been forced by the doctor; a claim of sexual abuse in itself is disquieting and schizophrenia is rarely named in meetings, even by the professionals.

The doctor immediately attempts to undermine Matthew's claim by, again, suggesting that he does not know what he is talking about. In a series of increasingly direct questions (lines 89, 93 & 95) she attempts to take interactional control and elicit sufficient information to undermine Matthew's claim and his request for therapy. However, Matthew provides a rationale which places the explanation for schizophrenia in his childhood and links his claims together. The very long pause (8.5 seconds) suggests that Dr. North is stumped again; she cannot undermine what Matthew is claiming without dealing with the topic and it seems that she does not want to deal with it, at least not in the meeting. She responds, then, by attempting to off-load the problem onto Sarah (line 97). But Matthew refuses to engage with Sarah; his avowal of forgetting here appears to be deployed to obstruct this line of questioning (Lynch & Bogen 1996) and thus force the issue back to the doctor.

In the following extracts I trace the effectiveness of Matthew's resistance in terms of achieving a dispreferred referral for therapy. The extract below begins with the doctor appearing to concede to Matthew's request for therapy. I noted in the previous extract that the doctor did not want to engage with the topic of sexual abuse and now she avoids naming it, it is "the problem" (line 148). The resolution is presented as a fixed choice between the psychologist, "Lucy Oran::ge", and "living with your beliefs (.) grou::p" (lines 153 & 157). However it becomes clear that the beliefs group is the preferred option in the fixed choice as Dr. North goes on to reiterate that it is a "group" seven times (lines 156, 157 twice, 160, 162, 163 & 165).

146 Dr. N.: but now you're saying you want something different um (.) yeah?
147 Matthew: yeah=
148 Dr. N.: =what you had hasn't solved the problem and now you want something
149 different (.) °yeah OK° (0.6) well perhaps I think theres two avenues
150 because I'm not very clear and I don't think the CPAs the right place to
151 have a proper discussion because y'know >we're supposed to be talking
152 about< care plans not sort of trying to (0.9) find out what your
153 problems a::re um so (.) its either that you see Lucy Oran::ge um and
154 she will have that discussion with you and then she will (.) suggest
155 somethi::ng so I think we could go for tha:::t or the other alternative
156 would be to ask Alan Purple because he he runs a group and it could be
157 a group situation and its called living with your beliefs (.) grou::p and
158 that that could possibly be helpful for you has that been discussed?=
159 Sarah (CPN): =um
160 Dr. N.: the possibility of that group?
161 Matthew: no I've never heard of it
162 Dr. N.: you've >never heard of< it well what d'you think of joining a grou::p is
163 that something (1.0) you you would like to do? a (.) therapy group
164 Matthew: I don't mind
165 Dr. N.: uha (.) well its a group=
166 Sarah (CPN): =I can talk to you about that
167 Dr. N.: mm where people talk about (.) y'know the sort of beliefs that are
168 troubling them y'know trouble troublesome beliefs and how to live
169 with them (.) and I think that might be a possibility mightn't it=
170 Sarah (CPN): =mm (3.3) well maybe when you come for your next depo Matthew
171 because you always seem to be rushing to college (.) you might come a
172 bit earlier and we could spend about half an hour discussing it

The fact that the doctor keeps repeating this aspect of the group gives the appearance of elaboration and providing more information without actually doing so and effectively continues to press this option despite Matthew being non-committal, "no I've never heard of it" and "I don't mind" (lines 161 & 164). However, it now becomes clear why the doctor did not appear to want to give Matthew's claim credence and why she is not really elaborating on what the group is. The "living with your beliefs" group is specifically run for people whose hallucinations and delusions are not fully controlled by their medication; in effect the 'beliefs' that patients 'learn to live with' in this group are delusional beliefs. Thus in introducing the beliefs group and framing it as the preferred option, the doctor is also intimating that Matthew's claim about sexual abuse is a delusional belief.

However Sarah re-enters the conversation here and exerts influence on which option is finally taken. In placing discussion with Matthew in the future, it carries the covert implication that she could be managing the discussion out of the doctor's domain. In effect, she is placing Matthew's commitment to the beliefs group as a matter between her and Matthew, and deferring it to some time in the future, thus helping Matthew *not* to make a commitment to it in the meeting.[6] It is suggestive that Sarah could be forming a covert alliance with Matthew. But Dr. North presses on with her 'sell' of the beliefs group, now providing another elaboration which has a similar effect to her previous reiterations of "group". Her use of "troubling", "trouble", and "troublesome" "beliefs" (line 168) allows the doctor to continue to press this preferred option whilst providing little additional information. In the process Matthew's claim of sexual abuse is reframed as "troublesome beliefs", a depiction which is sufficiently vague to cover over the difference between troubling memories and delusional beliefs and thus avoids engaging with Matthew over the veracity of his claim.

The CPN's response, followed by a pause (line 170) suggests little enthusiasm for this option. She goes on to elaborate on her previous suggestion, once again placing Matthew's commitment into her domain and the future. Note also that Matthew is repositioned here from someone with "troublesome beliefs" to a busy college student, "you always seem to

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[6] All decisions agreed in the meeting are written up in the care plan document and reviewed at the next CPA.

be rushing to college" (line 171). After this the doctor changes the subject but later in the meeting she returns to the topic. In the next extract the effect of Sarah's intervention and alliance with Matthew is reflected in the doctor's re-ordering of the options. Whilst in the previous extract the beliefs group was the preferred option, now the psychologist is presented as the first option with the beliefs group relegated to a back-up option.

277 Dr. N.: alright well I think in that case really um we should continue (.) with
278 with the care plan perhaps other than chan just saying that you could
279 see the psychologist and if the psychologist (.) can't (1.9) give you the
280 help you want then maybe Alan Purple and the living with your beliefs
281 group (.) so shall we just go through the care plan

The statement that they will "continue (.) with the care plan...other than...just saying" appears to be covertly referring to the issue of medication raised early on in the meeting and implies that an assessment for therapy is the only concession the doctor is going to make. As such, Matthew's early linkage between medication and therapy could have been a means for "striking a deal". Now the beliefs group is subsumed under the psychologist in a syllogistic framing, "if the psychologist (.) can't (1.9) give you the help you want then..." (lines 279-80). The emphasis on "want" indicates that this is what he, not she, wants and together with the deployment of "help" draws on and re-establishes benevolent psychiatry and participatory patient. Notice also how the whole endeavour is now surrounded by doubt, "perhaps", "could", "maybe" (lines 278 & 280), which could be read in a number of ways: that the doctor is signalling her reluctance; that the referral is not likely to be successful; or, in the case of "maybe" that Sarah is not likely to refer Matthew to the beliefs group. My reading of Sarah's intervention as a covert alliance with Matthew to resist the doctor's preferred plan is supported by the doctor's re-ordering of the options.

Therefore Matthew is attempting to achieve a referral for psychotherapy. In what appears to be a pre-emptive move, rather than a response to a professional plan or assessment, he mobilises and exploits the psychiatric discourse of "help", to negate the therapeutic effectiveness of the medication. Help and responsibility are no longer about professional dispensation and limited patient responsibility but about helping patients to acquire the (self-)knowledge to help, heal and understand themselves, a much more wide-ranging formulation of responsibility for mental health. Matthew's naming and interpretation of the links between childhood, schizophrenia and sexual abuse lead to a temporary interactional standstill. It is noteworthy, therefore, that the doctor does not refuse his request outright. It becomes clear that the doctor is attempting to undermine Matthew's request for therapy by forwarding a number of justificatory arguments for not referring him. By turn she suggests that therapy is a waste of time because of failed opportunities in the past, that it is not necessary because he has already had therapy at the day hospital and, finally, that he does not know what he is talking about thus attempting to undermine notions of self-understanding.

The doctor also attempts to accomplish and reaccomplish control through direct questioning and controlling access to and the distribution of talk (Scheff 1968; Mehan 1990), using partial repeats to challenge the believability of Matthew's claims (Mellinger 1995) and positioning herself as more knowledgeable (Burman 1995). In turn Matthew resists the doctor's control of the interaction. For example, he sets the agenda on the ineffectiveness of medication and request for therapy (Burman 1995), selectively ignores the doctor's questions (Scheff 1968), interrupts the doctor and the CPN (West 1984), defends claims that have been challenged (Mellinger 1995) and initiates his own interpretations (Burman 1995) (lines 55, 72 & 78, & 91-6). As such the doctor and Matthew are producing power and resistance through the turns of talk. It can be said that the doctor does not have full control of this meeting and her attempts to reaccomplish control are not always effective. However, it is also the case that it is the substance of Matthew's reformulations of help and responsibility and his interpretations that create trouble for the doctor and thus disrupt psychiatric power. In turn, the CPN's covert alliance with Matthew assists him in attaining a referral for therapy. Through managing the discussion about the beliefs group out of the doctor's domain and thus undermining this option, the CPN also subverts the doctor's assessment and preferred plan for Matthew.

Once again, achieving a course of action which runs counter to the doctor's assessment and preferred plan is not insignificant. As such, Matthew temporarily disrupts the power of the doctor both to control the interaction and, with the aid of the CPN, to control decision-making about his future treatment, in this case access to psychotherapy.

However, not only do Matthew's reformulations reinforce dominant discourses of psychiatric benevolence, patient responsibility and participation, but they are also firmly situated within the "psychotherapeutics" of self-help and self-understanding that characterise governmentality and the management of the self (Rose 1989: 227).

In summary, patients appropriate and reformulate professional discourses of choice and responsibility deployed to resist the plans, preferences and assessments of the professionals. Patients employ the framework of benevolent psychiatry/responsibile, participatory patient to disrupt professional control of decision-making and patient participation, and ascriptions of pathology. While these are 'everyday forms of resistance' (Scott 1985; 1990) at the local level, which are unlikely to impact upon broader power relations, they are significant (Moore 1988) for their temporary disruption of professional power and their practical effects (for example, where Colin lives, whether Diane is trustworthy and believable, and whether Matthew gets psychotherapy). As such these reformulations are directed against a more controlling psychiatry. But patients ultimately reproduce dominant discourses (Kingfisher 1996) that patients have choices and should be responsible for their mental health.

Professionals and patients accomplish control and resistance through the turns of talk (Mellinger 1995) and professionals do appear to have the interactional advantage, particularly in terms of controlling access to and the distribution of talk (Scheff 1968; Mehan 1990) which was accomplished in all the three meetings discussed, particularly through direct questions and interactions between professionals. Doctors also, at times, use partial repeats to challenge the unbelievable responses of patients (Mellinger 1995) and position themselves as more knowledgeable (Burman 1995). However, these interactional moves are not always effective in (re)accomplishing professional control and patients resist in a variety of ways, for example, interrupting the professionals (West 1984), defending claims that have been challenged (Mellinger 1995) and initiating their own interpretations (Burman 1995).

Professionals do not directly refuse patients' requests or force patients' agreement to preferred plans. Rather, they attempt to go through patients and negotiate decisions with them and, when they are unable to elicit their compliance, professionals do concede to dispreferred options. Moreover, patients can produce reformulations which professionals avoid engaging with, as occurred in Diane's framing of the adverse effects of medication and Matthew's formulation of self-healing; features which it is difficult to account for entirely in terms of the interactions themselves. Therefore broader legislative and rights discourses appear to be subtly in play within these interactions. The professionals' concessions are a further playing out at the local level of the wider legislative framework which produces the uncertain limits of professional compulsion and patients' rights, and which specifies patient involvement in their treatment (Jones 1980; 1993; DoH&WO 1993; Jones 1994). And media and public concerns regarding 'dangerous' patients may account for professionals' reluctance to engage with patient formulations which run counter to the therapeutic benefits of medication. In effect, there appears to be an increased potential for negotiation at the local level, rather than outright conflict (Jones 1980;1993), and resistance to the controlling aspects of psychiatric power which is temporarily disruptive. However, as patients resist psychiatric control, they become further enmeshed in a more productive power of the choosing, responsible well-managed self (Miller 1986; Rose 1986a; 1989).

In this section, I have explored instances of patients' resistance to professionals' plans and assessments and the interactional moves and persuasive talk through which professionals attempt to (re)accomplish control and forward their preferences. I have argued that patients are effective in terms of the practical outcomes for themselves and in disrupting the controlling aspects of psychiatric power. In the following section I turn to a major means by which professionals reassert power in response to patient resistance through (re)ascriptions of pathology in the intra-professional post-meeting.

2. Reasserting Psychiatric Power: The Post-Meeting and Discourses of Pathology

The post-meeting, after patients have departed, is an intra-professional event which affords professionals the opportunity to discuss what has occurred during the main meeting. In this respect the post-meeting is a "hidden transcript":

> ...discourse that takes place "off-stage"...elaborated among a restricted "public" that excludes - that is hidden from - certain specified others. (Scott 1990: 4 & 14).

Hidden transcripts usually contain "practices and claims...that cannot be openly avowed" (Scott 1990: xii) and, in the case of post-meetings, provide occasions to reframe, undermine or counter any discourses established during the meeting. In this section I draw on two post-meetings for patients whose resistance has already been discussed above, Diane and Matthew, and trace how psychiatric authority is reasserted. Both Diane and Matthew accomplished effective resistance during their main meetings; Diane's reformulation of responsibility was left to stand at the end of her meeting; and Matthew's reframing of help and responsibility was instrumental, with the CPN's assistance, in achieving a referral for an assessment for therapy despite the doctor's disapproval. In both meetings, the doctor ascribed a pathological feature to the patients in terms of delusional beliefs which Diane overturned and the CPN in Matthew's meeting undermined. In this section I discuss professional imputations of pathology as part of the "hidden transcript" (Scott 1990: 4) of post-meetings and the means by which professionals reassert power in response to patient resistance.

2.1 Re-establishing Pathology: "she just doesn't believe theres an illness" and "still psychotic"

In Diane's meeting she resisted and reformulated the reason why she does not take her medication; it is not due to a delusional belief about her medication being poison but a reasonable and legitimate concern for her long-term health. In this way Diane reformulated the meaning of responsibility for her mental health in order to counter a potentially damaging ascription of delusional beliefs, and one which has implications for her past, present and future trustworthiness and believability. Now the professionals discuss her and the main meeting amongst themselves.

The extract below begins near the start of the post-meeting and the problem of Diane's medication-taking behaviour is reintroduced by Sarah, the CPN, drawing on a very generalised version that Diane does not take her medication ("she's not good at taking things", line 645). This provides an opportunity for Dr. North to selectively draw upon discourses from the meeting to reinforce her definition of the problem. The doctor begins by invoking Diane's husband as someone who "knows her quite well" (line 646); George knows that Diane does not take her medication but he does not necessarily know what is best for her, reflecting the tenor of the meeting. Diane not taking her medication is presented in the first instance as wilful but inexplicable, "for some reason she just doesn't (0.8) want to take anything" (line 647).

Meeting 2 (post-meeting) : Diane (**** indicates name of medication)
645 Sarah (CPN): shes shes shes not good at taking things
646 Dr. N.: well I think her husband (.) knows her quite we::ll and she she really
647 (1.0) for some reason she just doesn't (0.8) want to take anything I
648 mean I think she just doesn't believe theres an illness and all that or
649 y'know she didn't in the past (.) because it was a cycle that repeated
650 itself every year but I suppose the different thing is that (.) I think
651 people have got to know her a bit better and maybe shes trusting
652 people more

However the doctor immediately proceeds to her evaluation: Diane lacks insight into her illness, "she just doesn't believe theres an illness" (line 648). Belief is reintroduced but this time it is not associated with poison but the whole "illness" and, in a 'Catch-22' manner, if she does not believe she is ill then this in itself is evidence of illness. Moreover, this lack of insight is inscribed over a long past in an extreme formulation that attributes it as the cause of Diane being a revolving door case, "because it was a cycle that repeated itself every year" (lines 649-50). The theme of "she just doesn't believe theres an illness" situates the reason why Diane does not take her medication firmly back in the pathological realm. In effectively resisting the discourse of poison as delusional belief, Diane has forced the doctor to formulate an alternative discourse of pathology in terms of lack of insight. It is a discourse which, because it is not voiced in the public domain, the patient does not have the opportunity to counter.

But Dr. North tempers her definition reinvoking trust to suggest optimism for the future; Diane may have lacked insight into her illness in the past but trusting "people" suggests the possibility for change. Nevertheless the definition of why Diane *did* not take her medication is due to her lack of insight into her illness, overturning Diane's reformulation of concern for her long-term health. Thus Diane's resistance now becomes encompassed within pathology; "she just doesn't believe theres an illness" can encompass anything Diane says about taking her medication, including her carefully reformulated discourse about the "poison"-ous effects of medication. Therefore a discourse of pathology, that the patient lacks insight into her illness, is invoked and deployed by professionals in the post-meeting to redefine why Diane does/did not take her medication. It counters Diane's alternative reformulation without having to engage with it, and re-establishes a (redefined) imputation of pathology. As such it is a means for reasserting professional authority in an "off-stage" (Scott 1990: 4) context where the patient has no opportunity to counter it.

In Matthew's post-meeting his resistance meets the same fate. Matthew's resistance to the consultant effectively gained for him an assessment for therapy, with the covert assistance of the CPN, and against the preference and assessment of the doctor. Matthew appropriated the discourses of help and responsibility, reformulating them as self-help, self-healing and self-understanding. The doctor responded to Matthew's claim of sexual abuse with an intimation of pathology in terms of delusional belief but the CPN's alliance effectively downgraded the beliefs group option preferred by the doctor, thus undermining her assessment. Unfortunately, I was unable to audiotape Matthew's post-meeting because the consultant asked me to turn off the tape recorder as soon as he had left the room. This in itself is indicative of the amount of tension generated within the meeting which was palpable when Matthew produced his list of "sexual abuse (1.7) um (1.2) schizophrenia (1.4) things about my parents". But I stayed in the post-meeting while the consultant and the CPN discussed Matthew and made notes about what had been said as soon as the meeting ended. What follows is an extract from my fieldwork diary. [7]

Meeting 3 (post-meeting) : Matthew (fieldnotes only)
Dr. North and Sarah discussed Matthew's request for therapy and Dr. North said it was a "waste of time", "he has had therapy before and stopped going". The doctor said that as he had requested therapy they would have to put him forward for psychological assessment but her tone and manner supported her statement that it was a waste of time. She said to Sarah that she thought he was "still psychotic" and Sarah agreed. The doctor raised the question of child abuse and was fairly dismissive suggesting that he had "probably made it up".

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[7] I have used italics to differentiate fieldnotes from audiotape transcription and notes taken within meetings but quotation marks indicate verbatim speech.

While this fieldnote entry lacks the detail of Diane's audiotaped post-meeting, it is clear that the doctor is reasserting her definition of Matthew and assessment of his claims. What she says supports my earlier readings of sequences in the main meeting which suggested that the doctor's chronicle of failed opportunity was inferring that referring Matthew for therapy was a "waste of time". As such this is quite a damning moral judgment, and completely undermines Matthew's reinterpretation that he was "in a bad way" in the past, which carried with it the notion that he was capable of change for the better in the future. Here this becomes doubtful, at best. Unlike Diane, whose past lack of insight into her illness is contrasted with the possibility of a more optimistic relationship with the professionals in the future, Matthew's past behaviour becomes an indicator of likely future behaviour; if he "stopped going" before then he will do so again and thus referring him for therapy is a "waste of time".

The doctor's assertion that psychiatric professionals have to respond to patients' requests suggests that she is orienting to and incorporating broader legislative concerns and "rights" discourses here, thus acknowledging the wider constraints of "the new legalism" (Jones 1993: 197). At the same time she makes it clear that this is contrary to her assessment of what should be done. My reading of the doctor's avoidance of the sexual abuse topic (thus not giving Matthew's claim credence) and the reasons for her preferred option of the beliefs group, is also confirmed; her assessment is that he is "still psychotic" and "probably made it up". Thus in the post-meeting the consultant reasserts professional authority by reaffirming her assessments and definitions. Her assessment that Matthew is "still psychotic" has the same effect as Diane "doesn't believe theres an illness". If Matthew is "still psychotic" then anything he has said, about medication, therapy or sexual abuse, becomes pathological and Matthew's reformulations of self-help and self-understanding are effectively undermined. Once again, re-establishing an imputation of pathology off-stage, this time much more directly than in the main meeting, places it out of bounds of contestation by the patient. And, given the covert alliance formed between Sarah, the CPN, and Matthew, the doctor is also reasserting authority over the other professional.

The doctor's discourses of pathology bear a resemblance to Goffman's (1968) analysis of the fate of patient resistance in the asylum where disapproved actions/interactions were assigned a psychiatric cause and uncooperative behaviour was viewed as evidence of pathology. As such, Diane and Matthew's reformulations related to medication could be construed as uncooperative behaviour. Certainly, effective patient resistance in these local encounters appears to elicit an imputation of pathology, or rather a reascription of pathology. However in the cases above, we cannot say that this is a straightforward exercise in repression. The patients were effective in disrupting psychiatric power within these meetings and, in Colin and Matthew's cases, resisted the professionals' control over decision-making, achieving a professionally dispreferred practical outcome which the professionals can undermine but cannot undo.

But professional ascriptions of pathology are an effective means of reasserting professional power. If a patient lacks insight into their illness or is psychotic, then whatever discourses they have deployed within the main meeting are undermined in such a way that professionals can ignore them. In this respect, the post-meeting is a powerful institutional practice which enables professionals to reassert their authority through discourses of pathology. It is also an indicator of broader power relations which specify, for example, who stays in the room after the 'official' meeting has ended, who writes in, holds, and has access to files about the patient etc.. In other words, who has the last word. In effect:

> The capacity of dominant groups to prevail - though never totally - in defining and constituting what counts as the public transcript and what as off-stage is...no small measure of their power. (Scott 1990: 14).

In addition, professionals' background understandings of schizophrenia are a resource in accomplishments and reaccomplishments of power. It is not the case that these patients' claims and beliefs are treated in the way any 'ordinary' person's would be. For example, notions that someone was not taking their medication because they believed it was poison, or that they had made up a claim of sexual abuse would probably be a final option when all other possible explanations had been explored, rather than a first option. Moreover, explanations in terms of lacking insight or psychosis would not even be readily available for patients with a diagnosis of neurosis, although they could become options. As such, professionals' background knowledge that these particular patients have a diagnosis of schizophrenia, and associated understandings, are readily available for foregrounding within interactions to assess and undermine patients' claims and interpretations. In other words, any claim by patients which runs counter to professionals' assessments and preferred plans is a potential candidate for being judged as part of "the grammar of schizophrenia" (Coulter 1991: 161), and this "grammar" is a ready resource for the reassertion of professional authority.

It is also noteworthy that professional ascriptions of pathology, which are relatively carefully formulated in face-to-face interactions with patients (a belief that the medication is "poison", a suggestion that Matthew attend the "living with your beliefs (.) grou::p") are more "openly avowed" off-stage (Diane lacks insight into her illness, Matthew is psychotic) (Scott 1990: xii). In this way, professionals strongly reassert their authority to make such ascriptions but in a domain where patients cannot counter them.

The discussion of professionals' and patients' accomplishments of power and resistance suggests that points of resistance occur in the psychiatric control of patient participation and responsibility and points of reassertion of professional authority occur in the institutional practice of post-meetings and reascriptions of pathology, which draw on background understandings of schizophrenia. Therefore accomplishments of power and resistance in local encounters largely occur without recourse to gender understandings. However, gender understandings can be mobilised as a resource for reaccomplishing professional authority. In the final section I explore the way that gender understandings are deployed as an occasional resource in response to patient resistance.

3. Gender Understandings as an Occasional Resource for Countering Resistance

There has been little evidence to support Chesler's (1974) contention regarding the power psychiatry wields over passive and pathologised female patients. Patients have accomplished resistance through reformulations of dominant discourses of choice and responsibility. And professionals have deployed various persuasions and dissuasions, again without invoking gender understandings. Moreover, discourses of pathology were ascribed without reference to gender, and in response to patient resistance. However, this is not to say that professionals do not draw on gender understandings to reassert their authority. In this section, I explore the way that professionals invoke understandings of femininity, but not masculinity, as an occasional resource that is deployed when useful and overridden when not.

3.1 Gendering, Degendering, and Regendering: "frightened lady", "everybody likes to do things" and "its just hard being a single Mum"

In the extracts below, professionals explicitly invoke gender understandings and make them relevant to the activity at hand, that is countering patient or carer resistance and reasserting authority. But professionals may also degender their argument in response to a patient and carer's invocation of a gendered category which has been deployed to resist the professionals' plans.

In the first extract I return to Diane's post-meeting. Her main meeting has been concerned with two main topics: why she does not take her medication and an attempt to persuade her to attend activities at the community centre. Diane has resisted the professionals' persuasions regarding activities through not giving them a definite agreement. In the previous section a reascription of pathology was effective in countering Diane's reformulation of responsibility in relation to medication and reasserting professional authority. But it is less so in connection with Diane's resistance to attending activities. In the extract below the doctor moves to a different discourse that draws on gender understandings. The extract begins with Sarah, the CPN, formulating a contrast between "building" and "badger" to characterise her relationship with Diane, followed by an extreme formulation of what will happen if she does the latter, "she won't agree to anything otherwise" (line 668). The notion of not agreeing to "anything" has the potential to encompass both problems: why she does/did not take her medication and why she has not agreed to attend activities. But the doctor goes on to suggest that it is not just a question of what the professionals do, it is also about Diane herself.

Meeting 2 (post-meeting): Diane

664 Sarah (CPN): mm and I've been building up the relationship with her

665 Dr. N.: mm

666 Sarah (CPN) she doesn't want you to sort of badger her
667 Dr. N.: yes
668 Sarah (CPN) she won't she won't agree to anything otherwise=
669 Dr. N.: =no but shes also a very I think shes a very frightened lady isnt she
670 Sarah (CPN): yes
671 Dr. N.: shes very frightened
672 Sarah (CPN) yes there was a virus that she asked me a lot of questions about °what
673 if this what if that°
674 Dr. N.: mm

The doctor invokes an explicit gendering to position Diane as "a very frightened lady" (line 669). Now it is not just a case of gaining the trust of someone who lacks insight into their illness, it is a gendered problem: dealing with a woman who is "very frightened". This discourse undermines anything Diane has said during the main meeting while continuing the note of optimism about her future relationship with the professionals. Diane's concern about her medication and reluctance to attend activities now become responses generated by extreme fear. As such it is a discourse that can be deployed to explain any behaviour or discourse which runs counter to the professionals' assessments and plans. The explicit orientation to "lady" suggests that a gender understanding is relevant to the activity of undermining patient resistance and reasserting professional authority whilst maintaining that Diane can and should be helped. Gendering fear appears to enhance the notion of a person who is frightened of anything and so refuses everything, but can be helped. As such a "frightened lady" invokes different connotations from, say, a frightened person or a frightened man.

The doctor solicits Sarah's agreement to this ascription, which she gives but the doctor reiterates her claim suggesting that she wants more than a simple agreement. Sarah provides an example of an instance when Diane was "very frightened", "there was a virus she asked me a lot of questions about". Thus the notion of fear and "anything" can encompass literally anything Diane does or says. Whilst under Diane's formulation of concern for her health, asking about a virus could be construed as an entirely legitimate question, now it is an example of her fear. Therefore the discourse of "frightened lady" completely undermines Diane's resistance enabling the professionals to reassert their authority.

However it is not the case that professionals routinely deploy gender understandings in this way. In the next extract it is the patient (and carer) who mobilise a gender understanding to resist the professionals' plans and the doctor who attempts to re-establish control and forward her desired plan through degendering her argument. The extract below is taken from a meeting for another community patient, Christine, who attends the meeting with her small son, Simon, and her mother, Anne Green.[8] This extract occurs very near the beginning of the main meeting and begins with Dr. North introducing the topic of "activities". She provides an opening for Christine to talk about activities, although the extreme formulation "anything" and intimation of doubt ("I don't know if", line 391) implies that Christine may not have much, if "anything" to say on the subject.

Meeting 1 (main meeting) : Christine (**** denotes name of medication)

391 Dr. N.: so I don't know if you've got anything you want to say about that
392 Christine: well I'll try and come to more of the events at Hillcrest I think
393 Dr. N.: uha you'd like to do that=
394 Christine: =because that was your advice to me last time I saw [you]
395 Dr. N.: [yes]
396 Christine: and I think that's a good idea but er I've only just got my car on the
397 road again so=
398 Dr. N.: =uha
399 Christine: ((to Simon)) come and sit on Mummys knee
400 Anne: and Simon of course can he come along to these things?=
401 Claire (CPN): =well Simon can't go to the (   )
402 Dr. N. : no I thought maybe that he could come to the social group but it
403 seems like that that thats not so:: I was wrong there

Christine's answer infers that she has good intentions but may not succeed and covertly hints at possible obstacles. When the doctor presses for a more positive response, Christine suggests that it is what the doctor thinks she should do, "that was your advice" (line 394). But this is followed by the disclaimer, "I think thats a good idea but..." (line

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[8] Anne Green is designated as Christine's official carer.

396) which wards off any suggestion that she is disagreeing with the doctor or being difficult/negative about activities while founding a practical complication, "I've only just got my car on the road again", which excuses any lack of activity between when she last saw the doctor and the present time. The doctor encourages Christine to continue and at this point she brings in Simon, her son, explicitly positioning herself *as* a mother, "come and sit on Mummy's knee" (line 399). That this is oriented to the interaction, rather than incidental, is supported in two ways. Firstly I noted in my fieldwork diary that Simon was settled on Anne Green's lap at the time. Secondly, Anne uses it as an opportunity to resist the professionals' plan by bringing in Simon, as if the professionals had forgotten him, "and Simon of course" (line 400). As such, Christine's invocation of the category of mother, "Mummys knee", covertly infers that the activities could be a problem *because* she is a mother with a small child. At this point the doctor is forced to admit that Simon cannot go to the social group, an admission of error that she has some difficulty making, "that that thats not so:: I was wrong there" (line 403). The doctor then turns to Mrs. Green.

408 Dr. N.:	um OK Christine what about you Mrs. Green what do you think (.) we
409	should be doing (1.0) um to help Christine
410 Anne:	well first of all I want to say that since Christine came back from
411	holiday and (0.9) it was like a normal thing really because coming back
412	from holiday gets you down anyway (.) because °she did enjoy herself
413	she did have a good time°=
414 Dr. N.:	=ahnn
415 Anne:	and she does take em she doesn't (.) change doesn't go too well with
416	her=
417 Dr. N.:	=ahnn
418 Anne:	so obviously she took a bit of time to settle (.) um (1.8) the medication
419	I think you gave her in actual fact is too much medication I think it
420	heightens her symptoms I think as opposed to °helping°
421 Dr. N.:	uhnn
422 Anne:	um possibly the effect of the **** is OK but (.) her **** I feel (.) is too
423	much
424 Dr. N.:	uhnn
425 Anne:	because when she was in Ireland and she missed out a week (2.0) her
426	mental (0.9) state was very °much better than usually°

427 Dr. N.: I see
428 Anne: so thats what I reckon (0.9) I know she was on holiday and I know
429 things were different (1.2) and obviously its not quite the same as
430 being at home but (1.3) in herself and even my sisters family noticed
431 the difference and I I think her **** is actually too high perhaps the
432 effect might even be (0.8) [( )]
433 Dr. N.: [OK]

The doctor has made it clear that the discussion is about activities but Mrs. Green uses the opportunity to raise a different agenda. Anne Green begins with two explanations of why Christine is "down"; she has just come back from holiday which is a normal thing to be down about, "coming back from holiday gets you down anyway" (line 411-2), and it is part of Christine's personality, she does not like change.[9] Mrs. Green moves from this general assessment to launch a resistance to Christine's level of medication. In a contrast between "heightens" and "helping" (line 420) she founds the claim not only that the medication is "too much" but it makes Christine worse rather than better. Like Matthew, she appropriates the professional discourse of "help", to negate the therapeutic effectiveness of the medication. This is followed with a justificatory example of an instance when Christine did not take it, "when...she missed out a week (2.0) her mental state (0.9) was very °much better than usually°" (lines 425-6). The three-part list of "I know she was on holiday and I know things were different (1.2) and obviously its not quite the same as being at home (1.3) but..." (lines 428-30) works as a disclaimer which appears to be a pre-emptive warding off of potential counters from the doctor whilst founding her claim regarding the deleterious effects of the medication. She finishes with an independent witness, "even my sisters family noticed the difference" (lines 430-1) and a reiteration of her claim that the level of medication is too high.

The next extract follows on from the previous one. Dr. North ignores everything Mrs. Green has said and reorients the conversation back to activities, "but what about the activitie::s" (line 433). Mrs. Green produces another disclaimer, very similar to Christine's earlier one, in which she infers that she has nothing against the activities per se, "I think

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[9] This appears to be referring back to Christine's claim at the very start of the meeting that she is "drudging on" (text not included here).

the activities are a good thing but..." (lines 435 & 437) while reconnecting Christine to Simon.

433 Dr. N.: [OK] now but what about the activitie::s (.) what do you think we
434 should be doing (.) [to help Christine with with]
435 Anne: [I think the activi] [ties are a good thing]
436 Dr. N.: [the activities]
437 Anne: but I don't think its very realistic to tell Christine to come to all these
438 activities (0.7) when Christines got Simon and Simons not allowed to
439 (0.6) come (0.6) I know shes got the childminder two days a week and
440 thats °very helpful° ( )
441 Dr. N.: well but Christine wants to go to the activities and I think Christine (.)
442 from what I gather gets bo:::red and fed u:::p so I mean everybody likes
443 to get out of the house and do things

Anne Green suggests that the professionals do not understand the realities of Christine's life as a mother. Notice also how she is interrupting the doctor to get control of the talk. Christine, then, has positioned herself as a mother and made it relevant to the issue at hand. And Mrs. Green is drawing on implicit understandings about activities associated with members of the category mother (Sacks 1972) in order to resist the doctor's plan that Christine should attend activities at the community centre. The doctor signals her disagreement, ("well but" line 441) and in a neat counter draws on the specific, "Christine wants to go to the activities...Christine...gets bo:::red and fed u:::p" (lines 441-2), and a general extreme formulation, "everybody likes to get out...and do things" (lines 442-3). Invoking what Christine "wants" suggests that Mrs. Green does not understand what Christine likes to do. It also infers that the professionals are not being unrealistic; rather they are acting in Christine's best interests based on what she wants and what anyone would want. Therefore, the doctor explicitly degenders the argument; it is not about being a mother, it is about what "everybody likes...to do". So in this case the patient and her carer have drawn on the gender category of "mother" and associated understandings to resist the doctor's plan and the doctor has degendered the argument, "everybody", in order to counter that resistance.

However, when it is useful, the doctor invokes those same gender understandings in the same meeting. In the final extract below, the meeting is coming towards a close and the doctor reintroduces the topic of medication. Her argument consists of a series of disclaimers, "I do understand what you're saying Mrs. Green...but...", lines 765-6, ">you're obviously very helpful< to her but...", lines 768-9, "I'd like to cut it down as we:::ll (.) but...", lines 771-2, and "Simon's a lovely boy um (.) but...", line 775). The disclaimers work to portray the doctor as "understand"-ing, to ward off any notion that Mrs. Green is not sufficiently "helpful", that the doctor would like to reduce the medication as much as she would, and that it is no reflection on Simon or his behaviour. She frames her counter in terms of normality; "recovering from her time in hospita::l" (line 770) drawing on notions of convalescence rather than on-going mental illness. And "its just hard being a single Mum" draws on a general notion of (normal) single Mum's; it is hard because they are alone, do not have a partner to help them, again a "normal" difficulty.

765 Dr. N.: about the medication I do understand what you're saying Mrs. Green
766 that you think (.) Christine is on too much medication but I I think we
767 have to be very ca::reful because (.) Christine (1.0) is is having to look
768 after Simon and I think (0.9) um it is (0.8) y'know >you're obviously
769 very helpful< to her but I think it is quite ha:::rd for Christi::ne (.) um
770 and I think she really is still recovering from her time in hospita::l (0.5)
771 so I think that we've got to go very carefully with the medication I'd
772 like to cut it down as we:::ll (.) but I just don't think (0.9) we're there
773 yet >I don't think the time is right< (.) just yet to start cutting it dow::n
774 (0.9) because I think Christine is y'know finding it quite hard really
775 (0.9) I mean Simon's a lovely boy um (.) but its just hard being a single
776 Mum [isn't] it really?
777 Anne: [that's right]

Whilst the doctor's counter is very carefully framed with disclaimers and what might be called 'normality' arguments, there are a number of covert references to Christine's position as a mother with a mental illness who is looking after a small child, "we have to be very careful" (twice lines 766-7 & 771). Thus woven into the argument are warnings which carry covert implications of potential danger for Simon if Christine's medication is reduced. Also, the notion that "Christine is...having to look after Simon" (lines 767-8) infers that this is something of a burden for Christine. Dr. North's carefully constructed counter to Mrs. Green's resistance over Christine's medication ends with an invitation to Mrs. Green to agree, which she does.

Therefore the patient, carer and doctor deploy the category of mother and related understandings associated with members of this particular category (Sacks 1972): such as notions that young children accompany their mothers to whatever activities they are engaging in; that mothers' responsibilities are such that they cannot easily get involved in activities if their children cannot accompany them; and that mothering is particularly arduous if the mother does not have a partner. These explicit orientations to the category of mother, and associated understandings are, therefore, also an explicit orientation to gender: "images of women are linked to images of mothering" (Ochs 1992: 337). This gendered category is made relevant to the activities at hand: resisting the professionals' plans that Christine should attend activities at the community centre and countering Anne Green's resistance to Christine's level of medication. However, the doctor also explicitly degenders the argument, positioning Christine as like "everybody" else, as a means for countering Anne Green's resistance and forwarding her preferred plan. The doctor's overriding and subsequent (re)invocation of gender is pragmatic and designed for the particular activity at hand. As such gender understandings are an occasional resource.

Therefore, gender orientations and understandings of professionals are an occasional resource that can be invoked and deployed when useful for countering patient and carer resistance and overridden when not. That it is an occasional rather than consistent resource is supported by the doctor degendering the argument to counter Christine and Mrs. Green's invocation of "mother" and associated understandings. As such, Diane is gendered ("frightened lady") and Christine is by turns gendered ("Mummys knee"), degendered ("everyone"), and regendered ("single Mum") within the same meeting and according to the activity at hand. Thus professionals deploy gender understandings as an occasional resource to counter patient (and carer) resistance, to reaccomplish authority, and it is feminine, not masculine, genderings that are deployed in this way.

This initial discussion of professionals' orientations to feminine genderings to counter patient resistance suggests a more complex picture than that proposed by Chesler (1974). The psychiatrist has (re)asserted authority over patients, and drawn on gender understandings to do so, but Diane and Christine cannot be depicted as passive victims; the discourses of "frightened lady" and "its just hard being a single Mum" are invoked to counter their resistance and reaccomplish professional authority. Moreover, the professionals appear to be as ready to degender patients as they are to gender them, as in "everybody likes to do things". Furthermore, whilst Diane is gendered she is also pathologised in a similar way to patients who are not gendered, as in Matthew's post-meeting. And while being a Mum becomes an important understanding for resisting a reduction in Christine's medication, it is difficult to interpret this as any form of gender conformity given that at other times the professionals de-maternalise her. In this respect, far from motherhood being perceived as necessary for mental health (Chesler 1974) it is framed as a burden; Christine is "having to look after Simon".

Conclusion

Psychiatric power is resisted and reasserted within local encounters between professionals and patients. Patients appropriate and reformulate professional discourses of choice and responsibility to accomplish resistance to professionals' plans and assessments. Themes of "I need a couple more weeks to make up my mind", "I worry about the long term effect", and "sorting what I'm thinking" draw on the relation of benevolent psychiatry/responsible, participatory patient to disrupt psychiatric control of patient participation and responsibility. Choice is reformulated from an informed choosing between limited options to something that requires time and thought. And responsibility takes on a number of alternative meanings: responsibility for long-term health or for self-healing and self-understanding, which run counter to professional discourses of limited patient responsibility. The discourse of "help" is appropriated by patients, particularly in relation to the therapeutic effects of medication, and reformulated in negative terms and/or as self-help. And, on occasions professionals may form temporary covert alliances with patients to assist their resistance to another professional's plan or assessment.

These localised 'everyday forms of resistance' (Scott 1985; 1990) are unlikely to impact upon broader power relations; in appropriating and reformulating dominant discourses, patients ultimately reproduce these discourses (Kingfisher 1996), reaffirming notions of choice and responsibility. However, they are significant in terms of the practical effects for patients' lives and on-going treatment (Moore 1988), and for the temporary disruption of psychiatric authority to control decision-making and make assessments. But I have argued that these small resistances and disruptions should not be viewed as empowering patients. Rather, reformulated discourses of choice and responsibility extend the scope of self-regulation, thus enmeshing patients further in governmental power (Miller 1986; Rose 1986b; 1989).

Professionals and patients accomplish power and resistance turn-by-turn within interactions. Overall professionals do have the interactional advantage: controlling access to and the distribution of talk, particularly through direct questioning of patients (Scheff 1968; Mehan 1990); using partial repeats to challenge unbelievable claims (Mellinger 1995); interrupting (West 1984); and positioning themselves as more knowledgeable (Burman 1995). However, these strategies are not always effective. In turn, patients also interrupt the professionals; defend claims which have been challenged (Mellinger 1995); and initiate their own interpretations (Burman 1995). But professional concessions to dispreferred actions, and reluctance to engage with topics which undermine the benefits of medication, are indicative of broader discourses coming into play at the local level. In particular, the ambiguous limits of professional compulsion and patients' rights and involvement, produced in wider legislative and rights discourses (Jones 1980; 1993; DoH&WO 1993; Jones 1994), seem to be played out in local encounters in terms of professional concessions. And avoidance of talk about the adverse effects of medication or self-healing indicate some awareness on the part of professionals of broader concerns regarding 'dangerous' community patients. Moreover, professionals do incorporate wider legislative and 'rights' discourses into the interactions; concessions to dispreferred options are justified in terms of *having* to respond to patients' requests.

However, professional imputations of pathology are an effective means of reasserting professional authority in response to patients' resistance. The post-meeting is an institutional practice which enables such reassertions and is a "hidden transcript" whereby professionals can make more explicit (re)ascriptions than in face-to-face interactions with patients, and in an "off-stage" context where patients do not have the opportunity to counter them (Scott 1990: 4 & 14). As such, broader discourses which specify this sort of institutional practice are a powerful determinant of who has the last word. Discourses of pathology, such as "she doesn't believe theres an illness" and "still psychotic" re-establish psychiatric authority to make assessments and undermine any discourses patients have deployed during the main meetings. Furthermore assessments that patients lack insight into their illness or are psychotic draw on professionals' understandings of schizophrenia which are an available resource for (re)accomplishing authority over these particular patients. Professional (re)ascriptions of pathology in response to patient resistance bear similarities to Goffman's (1968) analysis of psychiatric responses to uncooperative behaviour in the asylum. They also suggest that disruptions of psychiatric power are only short-lived. However, while patient resistance is small-scale, localised, and temporary, it does disrupt professional control over decision-making and in such a way that, despite professional reassertions of authority, professionally dispreferred decisions are made that cannot be undone.

Localised disruptions and reassertions of professional power can also involve the explicit deployment of gender understandings but they are an occasional, rather than consistent resource. Themes such as "frightened lady" and the category of "mother", and associated gender understandings, make gender relevant to the activity of countering patient/carer resistance and reaccomplishing professional authority. But at the same time, professionals will explicitly override the same kinds of gender understandings to counter resistance to a preferred plan, as in "everybody likes to do things". This occasional deployment of gender does not accord in a straightforward way with traditional feminist accounts of psychiatry enforcing gender conformity and pathologising passive female patients (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992). Rather, gendering is a response to resistance, patients are pathologised without recourse to gender understandings, and motherhood is framed as a burden. However, professionals do draw on gender understandings to reassert authority and it is understandings of femininity that are mobilised in this way.

This chapter has discussed where points of resistance occur at the local level in professional control of patient participation and responsibility, and points of reassertion of psychiatric authority in the institutional practice of post-meetings, where reascriptions of pathology are accomplished. Local encounters between professionals and patients involve considerable negotiation in which the meanings of participation and responsibility are reformulated and professionals sometimes concede to dispreferred courses of action. In these negotiations, professionals' understandings of schizophrenia are a resource for (re)ascriptions of pathology and thus reaccomplishments of psychiatric authority. However, gender, in terms of certain understandings of femininity, is an occasional resource deployed when useful to the activity at hand and overridden when not. In the next chapter I extend the focus on gender through an examination of intersections between professionals' gender understandings, discourses of autonomy and purpose, and schizophrenia. I consider the way that professionals' genderings and understandings of personhood inform talk about restoring patients' lives.

Chapter Five

Restoring Lives: Intersections Between Femininity and (Masculine) Personhood, Schizophrenia, and Discourses of Purposes and Autonomies

Introduction

Chapter four explored the way that patients appropriate and reformulate professional discourses of choice and responsibility to resist the assessments and preferred plans of professionals, and disrupt psychiatric control. These localised resistances ultimately reaffirm dominant discourses but they are not insignificant for patients' practical on-going treatment. An important means for reasserting psychiatric authority in response to patient resistance occurs through the institutional practice of post-meetings where ascriptions of pathology are deployed in an "off-stage" (Scott 1990: 4) context and draw upon professionals' understandings of schizophrenia. Notions of femininity may also be deployed as an occasional resource for undermining patient resistance and reasserting authority. I concluded that local encounters involve considerable negotiation in which professionals may concede to dispreferred courses of action but professionals' understandings of schizophrenia and occasional feminine genderings are resources for reaccomplishing professional power.

This chapter focuses more closely on professionals' gender understandings through consideration of professional/patient discussions about restoring patients' lives. I begin with a comparison between feminist literature on women/gender and schizophrenia (Chesler 1974; Al-Issa 1980; Warren 1987; Barnes & Maple 1992) and Rose's (1989) account of contemporary psychiatry in terms of re-making individuals back into purposeful and autonomous beings (Rose 1989). I raise questions about the relationship between professionals' understandings of gender and schizophrenia and restoring patients' lives to purpose and autonomy within local encounters.

In the first part of the chapter, I discuss meetings for four patients who are framed as insufficiently purposeful. I argue that professionals position women as "women" and draw on associated understandings of femininity to formulate particular meanings of purpose and autonomy. "Women" are problematised in terms of home, loneliness and emotional dependence and encouraged to do something independent from home and significant others and in the company of other "women", thus interweaving purpose and independence. In contrast other patients are depicted as practically dependent or in need of emotional support, but not emotionally dependent. And these patients are accorded autonomy in terms of self-regulation over how they spend their time, a different understanding of independence than that encouraged for "women". I suggest that it is not safe to assume that masculinity is necessarily irrelevant to professionals' ascriptions of self-regulating autonomy, arguing that professionals' understandings should be characterised as (masculine) personhood reflecting that the indexing of "people" is likely to be underpinned by a background understanding of masculinity. Throughout I include discussion of the ways that patients' past and present experiences are resources within clinical encounters, shaped according to the activity of restoring lives and in relation to understandings of femininity and (masculine) personhood.

Finally, I consider the way that professionals' assumptions about schizophrenia inform notions of purpose and autonomy. Purposeful activities for patients have a filling-in-for-the-real-thing quality which suggests a partial and delimited restoration. I conclude that contemporary psychiatry is more concerned with restoring patients lives in local encounters than gender conformity, however professionals' understandings of femininity and (masculine) personhood intersect with schizophrenia to differentiate and delimit restoration to purpose and autonomy. In this respect notions of activity, emotions, dependence and independence taken on a plurality of meanings as they are associated with these understandings.

Feminist literature on gender/women and schizophrenia suggests that psychiatry holds a double standard of mental health for women and men. Clinicians are said to view mentally healthy women as less independent and more emotional, submissive and passive than mentally healthy men or adults, gender unspecified (Broverman et al 1970; Smyth & McFarlane 1985). One of the central claims of feminist writers has been that psychiatry pathologises gender deviation and seeks to help women come to terms with their female role, including marriage and motherhood, thus enforcing gender-role conformity (Chesler 1974; Al-Issa 1980; Warren 1987; Barnes & Maple 1992). It has been claimed that gender understandings continue to permeate contemporary psychiatry; the person being assessed is "always a gendered subject" and is likely to be assessed on the performance of gendered tasks (Busfield 1996: 114; 1989). However, gender may have become less salient as psychiatry has extended out of the hospital into the community; Allen (1986) argues that social coping in the community does not require adjustment to gender-role.

In contrast, or in addition, feminist researchers have emphasised that schizophrenia may be the product of the stress, oppression and traumas women experience in their daily lives, particularly in their roles as housewives and mothers (Al-Issa 1980; Warren 1987; Barnes & Maple 1992). However, there is little consideration of how the meaning of experiences are formulated interactively and intersubjectively. As such, the meanings of patients' experiences are likely to be negotiated and shaped within encounters between psychiatric professionals and patients (Barrett 1988), and interpreted in the light of professionals' understandings of schizophrenia (Scheff 1966; Rosenhan 1973). Moreover those understandings, according to Szasz (1976), are likely to be informed by notions of femininity, in terms of incompetence, dependence and unemployability, for both women and men.

However, Rose (1989) suggests a different conception arguing that contemporary psychiatry seeks to re-make individuals back into purposeful, autonomous subjects:

> ...the rationale of psychotherapies - and this applies equally to contemporary psychiatry - is to restore to individuals the capacity to function as autonomous beings in the contractual society of the self. Selves unable to operate the imperative of choice are to be restored through therapy to the status of a choosing individual. Selves who find choice meaningless and their identity fading under inner and outer fragmentation are to be restored, through therapy, to unity and personal purpose. (Rose 1989: 227-8).

But it is not evident from Rose's analysis what kinds of gender understandings are produced within the psychiatric project of restoring lives.

In contrast to Rose, the feminist literature above suggests that psychiatric notions of purpose and autonomy are likely to be shot through with gender differentiated understandings of what constitutes purposefulness and autonomy in terms of notions of (in)dependence, emotionality and activity. Alternatively, Szasz's account is suggestive that restoration may be partial and feminised. But it is not apparent from the literature how patients' experiences are played out in relation to understandings of gender and schizophrenia. The literature raises questions about the relationship between professionals' understandings of gender and schizophrenia and the restoration of patients' lives in local encounters. Do psychiatric professionals enforce gender conformity or restore lives to purpose and autonomy? Do understandings of femininity and masculinity inform what it means to be purposeful and autonomous? How are the past and present experiences of patients negotiated in relation to restoring patients' lives? And how are understandings of schizophrenia relevant to these aspects of professional/patient interactions? I use extracts from CPA meetings to discuss these questions focusing on the intersections between professionals' understandings of gender and schizophrenia, and discourses of purposes and autonomies. And I explore how professionals' understandings of gender, personhood and schizophrenia are played out in negotiations and decision-making about patients' future activities.

1. Restoring Women's Lives: Interweaving Discourses of Purpose and Independence

Discussions about "activities" are one of the main features of CPA meetings: what activities patients have or have not been engaged in since the last meeting, and what activities they should do in the future. As such, activity talk is the cornerstone of these meetings, for example:

Meeting 1 : Christine
388 Dr. N.: °uhum (.) OK° (1.0) OK well I think (.) the main thing is for this
389 meeting (0.7) to for us all to get our heads together and see (.) what you
390 should be doin::g (1.0) um y'kno::w? in the way of all these activities
391 that (0.9) might be helpful to you? (1.1) um

Meeting 10 : Natalie (notes only)
38 Dr. S.: now in terms of ways to occupy you during the day Erica do you have
39 any thoughts

Activities are framed as being therapeutic for patients ("helpful" line 391), filling their time and keeping them busy ("occupy" line 38). Psychiatric professionals are specifically concerned with *day*time activities (line 38) suggesting that people should not be at a loose end particularly during the day.[1] Purposeful activity, in this initial framing, is therapeutic, fills the patient's time, keeps her/him busy, and takes place during the day. But when patients' biographical details and professionals' gender understandings come into play, purposeful activity, or the lack of it, takes on a number of different meanings. In this section I discuss meetings for two patients who are framed as insufficiently purposeful, looking at the discourses deployed to frame the problem and the proposed solution.

1.1 Problems of Home, Loneliness and Dependence: "shes stuck in the house", "she doesn't have any friends" and "she does get dependent"

In the extracts below, professionals invoke and shape patients' biographies and experiences to support the problem that they are insufficiently purposeful. In the process, certain understandings of home and friendship are accomplished which position these patients as lonely and dependent. Christine and Diane are both community patients. Christine has a young son (Simon) and attends the meeting with him and her mother (Anne Green). Diane is married to George, and she and George attend the meeting together. The first extract comes from Christine's meeting where the doctor frames a question to Jane, the community support worker, which suggests that she is seeking information about what sort of "things" Jane does with Christine. But Jane uses the opening as an opportunity to introduce a problem. The CSW begins by framing Christine's problem as not having any adult friends. Her "lack" (line 2) suggests a deficiency, she should have friends, and the contrast between "Simon" and "friend" (line 3) infers that it is adult friendship that she needs, that small children are not friends, and that a friend would enable Christine to do things "without Simon".

Meeting 1(pre-meeting) : Christine

1 Dr. N: you do things do you?

2 Jane (CSW): ye::s but I've I've (0.8) felt that she has a lack of friends y'know that's

3 the sort of thing she'd like to do without Simon (0.7) with a friend she

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[1] This is suggestive that professionals are drawing on the assumption that 'normal' people are occupied during daytime. In this sense activities also stand in, in some way, for what 'normal' people do during the day.

4 says she finds it difficult making °friends°

At the same time Jane positions herself as a professional friend rather than a real friend. The problem of lacking friends is supported by verbatim reporting, "she says" (line 3), which not only adds veracity to Jane's claim but also sites the problem firmly within Christine. Later in the pre-meeting the professionals go back to the problem of Christine's "lack of friends", shaping it further, together with a proposed solution. The extract below begins and ends with an ascription of Christine as "dependent". Dr. North begins with the claim that Christine is "dependent" on Jane (line 315) which is not "helpful", and ends with the suggestion that she is "dependent" on "me::", a state of affairs that is "not very healthy" (line 329-30). Christine's dependency on the professionals is framed as untherapeutic, unhealthy and, it would seem, inappropriate when it involves the consultant. Between these ascriptions of dependency the professionals shape the problem of Christine's lack of purposeful activity to support the proposed solution at lines 312-3, coming "here" to meet a "wider group of people", that is, Christine should come to professionally organised activities at the community centre.

312 Dr. N.: well I would suggest that we use the childminder and and Jane as
313 well if you're happy to be used that way to to get Christine to come
314 here because that way she meets a wider group of people otherwise she
315 just becomes dependent on you:::=
316 Jane (CSW): =mm yeah=
317 Dr. N.: =which isn't very (.) helpful=
318 Jane (CSW): =no thats right=
319 Claire (CPN): =and she gets out of the house because I think shes stuck in the house
320 and (1.4) y'know its a lovely house its a nice area but there is just no::
321 (1.7) ( ) so she just sits and broods ( )
322 Dr. N.: no well its obviously not good for anyone much less someone with a
323 mental illness to be sitting at home with a young chi::ld I mean its its
324 (1.1) y'know I think quite difficult for for absolutely healthy young
325 Mums=
326 Claire (CPN): =thats true=
327 Dr. N.: =to be (.) isolated like that (0.8) um so I think anything that gets her in
328 with a group of people I think is good because otherwise she she she

329 does get dependent >I mean the fact that< she rings me:: its not very
330 healthy ...but y'know she seems not to have (.) anyone e::lse to tur::n to

The CPN's suggestion that Christine is "stuck in the house" (line 319) and "just sits and broods" (line 321) is shaped by the consultant into "sitting at home with a young chi::ld" (line 323) and "isolated" (line 327). The doctor's contrast between anyone, someone, and Mums works up the vulnerability and isolation of Christine, thus justifying the necessity of getting her out of the house and to the community centre. The notions that it is "not good for" and "quite difficult for" are vaguely formulated but are sufficient to found the inference that if it is not healthy and beneficial for "anyone", and quite hard even for healthy Mums, then it is even more so for "someone with a mental illness". Notice also that age is made salient here; in flagging up "young child" and "young Mums", youthfulness appears to increase the sense of vulnerability on both sides. A gendered category appears to be invoked here to infer associated understandings about the normal difficulties faced by young mothers, such as stress and isolation, and thereby amplify the problematic status of Christine's situation.

Therefore Christine's problem is that she is dependent on the professionals, stuck at home, has no friends, and the situation is made worse by the fact that she has a young child. She is insufficiently purposeful in that she just sits at home with her son and broods. The invocation of a generalised pathology ("mental illness") in combination with the category of mother facilitates a contrast with normal difficulties as a means of amplifying the problem and making the proposed solution more necessary. This solution, that she should attend activities at the community centre with "a group of people" (lines 313 & 326), will get her out of the house, give her something to do without Simon and provide an opportunity to meet people, make friends and thus be less dependent on the professionals. The inference is that Christine's dependence is not just practical but also, and mainly, emotional in that she needs a friend not just to do things with but "to turn to" (line 328). In this way Christine's dependency and lack of purposeful activity are linked together to inform the problem and the solution. In framing the solution for Christine in terms of getting out on her own (without Simon) and becoming less dependent, what constitutes purposeful activity is gaining some independence; independence *is* the purpose.

In the next extract I turn to Diane's meeting where different biographical details are shaped towards the same kind of problem and the same proposed solution. In this extract the professionals are discussing Diane in the intra-professional post-meeting and the extract begins, once again, with the CSW (Betty this time, not Jane) framing the problem as lack of friends, "she doesn't have any friends" (line 745). The proposed solution is also coupled with the problem; loneliness and lack of friends would be ameliorated if Diane were to "come to the meeting" (line 746), a reference to a professionally organised activity at the community centre.[2]

Meeting 2 (post-meeting) : Diane
745 Betty (CSW): shes said shes quite lonely because she doesn't have any friends (.)
746 which is why I wanted her to come to the meeting=
747 Dr. N.: =mm
748 Betty (CSW): I haven't been able to persuade her but I'll try:::
749 Sarah (CPN): and he does taxi work doesn't he so he must be out for long hours
750 Betty (CSW): yes I mean hes actually out of the house quite a lot
751 Sarah (CPN): mm and shes just at home cleaning=
752 Betty (CSW): =yeah (4.0) cleaning seems to be the focus of her life
753 Dr. N.: °yes well its not healthy is it° (1.2) well if you could make a start to get
754 her=
755 Betty (CSW): =I'll try
756 Dr. N.: to do something in the community then (.) it would be

Sarah, the CPN, and Betty, the CSW, continue to shape the problem of loneliness by bringing in Diane's husband George and the type of work he does, magnifying her loneliness by the amount of time she spends at home alone. Not only does she not have any friends, she does not even have her husband for company, producing a picture of extreme isolation. In addition, George being "out of the house" (line 750) for "long hours" (line 749) is contrasted with Diane who is "just at home cleaning" (line 751). While Christine was just sitting at home with a small child, Diane is just at home cleaning, a similarly purposeless domestic activity. Thus professionals in both meetings establish that patients' lives should not revolve solely around home, housework and childcare.

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[2] Getting Diane to this activity appears to be an on-going project of professional persuasion, suggesting some reluctance on her part, "I haven't been able to persuade her but I'll try" (line 748).

Moreover, while Christine and Diane may be occupied during the day, with childcare and housework respectively, these activities are characterised as at best insufficiently purposeful, and at worst psychologically unhealthy.

After a brief digression Dr. North reintroduces the problem. While Christine is stuck at home because she has a small child, and the doctor draws on a generalised pathology and the gendered category of mother to amplify the problem, the cause of Diane's problem is shaped rather differently. Betty has just suggested that if she cannot persuade Diane to go to the community centre she will continue to visit her at home but Dr. North signals her disagreement and reiterates what is "important" in a contrast between "doing something outside the <u>home</u>" and "you coming i::n" (lines 779-80 & 782).

779 Dr. N.: but um I do think y'know its the the doing something outside the
780 <u>home</u> thats [impor]tant
781 Betty (CSW): [it is]
782 Dr. N.: rather than you coming i::n y'know (1.1) I think thats where the <u>fear</u> is
783 the fear I mean in her home shes at ease
784 Betty (CSW): yeah
785 Dr. N.: but the fear is (1.0) going out >because I mean she was sort of< phobic
786 for years wasn't she >sort of real< agora<u>pho</u>bia (.) its a psychotic
787 agoraphobia I think she felt people were=
788 Betty (CSW): =paranoid=
789 Dr. N.: =°ye::s >talking about her or something°< so um:: I think if you can
790 get her to <u>break</u> <u>that</u> the fear that if she goes out they're going to to to
791 talk about her because shes <u>I</u>rish or not like her because shes <u>I</u>rish

Dr. North continues with another contrast between "ease" at home and "fear" of going out together with a sequence of psychiatric terminology. In a three-part list of psychiatric naming, "fear" of "going out" is quickly worked up from "sort of phobic" to "real agoraphobia" to "psychotic agoraphobia" (lines 785-7) so that Diane not going out becomes framed as irrational and pathological. The consultant goes on to provide an explanation that draws on an earlier narrative of a reported conversation supplied by Betty (text not included here). Diane's ethnicity, being "<u>I</u>rish", becomes the cause; her pathological fear of leaving her home is underpinned by a pathological fear of racism.

Such a framing presents the problem in such extreme terms that getting Diane out of the house becomes vital for her mental health. Whilst the aim to "break that the fear" is perhaps a rather harsh means to cure a pathology, it has been introduced here by the consultant to add force and weight to the necessity of getting Diane out of the house and is a direct response to the other professionals' suggestion that it may not be possible to persuade Diane to do so.

Diane's biography has been invoked and shaped to add force to the necessity of restoring her life to purpose. In this case, the doctor ascribes a specific kind of pathology and a category of ethnicity to amplify the problem and the necessity of the proposed solution. But these different biographies are shaped towards the same problem. Like Christine, Diane is stuck at home, engaged in purposeless domestic activity, and does not have any friends. And it is the same proposed solution, to do something at the community centre. The professionals' concern regarding dependency is less acute with Diane than with Christine. Nevertheless, in the next extract Diane is framed as dependent on her husband (rather than the professionals). Betty has just raised the possibility that it could be George who does not want Diane to go out without him, a very different discourse to the one raised regarding Diane's pathological fear of racism. The doctor draws on Betty's suggestion to position Diane as dependent.

705 Dr. N.: its hard for him to (0.7) to to sort of see her as independent he
706 doesn't really want to (5.0) but I think once a week maybe they could
707 both manage that

In framing George as unable to see Diane as "independent", together with the notion that they could "both manage" once a week (line 707), this sequence positions Diane as dependent on George, George as dependent on Diane being dependent on him and the need for Diane to be more "independent" (line 705). In this way, getting Diane out of the house and to the community centre includes the notion that Diane should do something independent from her home and husband; the purpose of the activity is to get her out of the house, do something without her husband, meet people and make friends, and be less dependent on her husband - and breaking her pathological fear of racism adds weight to these restorative moves.

The themes of "stuck at home", "lacks friends" and "dependent" position these patients as insufficiently purposeful and autonomous even though their biographical details are drawn on and shaped in different ways to support the problem. Therefore, patients' experiences and individual histories are resources which professionals draw upon and shape interactively within meetings. It is noteworthy that all the extracts in this section occurred in an intra-professional pre-meeting or post-meeting. Thus professional accounts of patients' experiences, replete with ascriptions of pathology, are largely part of the professional "hidden transcript" (Scott 1990: 4); in these cases what counts as a valid experience is established amongst the professionals in a context where patients are unable to contest the professional version. And the professionals' authority to decide the meaning and import of these experiences is determined by the powerful institutional practices of pre- and post-meetings. The discourses related to home, domestic activities and dependency are suggestive that professionals' background understandings of femininity could be operating here. In the following section, I trace the way that professional notions that Christine and Diane should do something at the community centre are shaped towards a specific activity which explicitly positions these patients as "women" and makes understandings of femininity relevant to the activity of restoring lives and particular notions of purpose and autonomy.

1.2 Independence and Friendship in the Company of Other Women: "its just all women"

Up until now the actual activity/environment proposed for Christine and Diane has been formulated in very broad terms, "anything that gets her in with a group of people" (Christine, lines 327-8) and "something in the community" (Diane, line 757). But the professionals have a particular, preferred environment in mind that is one of several suggested to Christine but the only suitable environment for Diane. Professional understandings of home, friendship and (in)dependence inform and feed into the preferred environment for their proposed solution to the problem. The first extract is taken from Christine's meeting. Laura, the ASW, has just suggested that Christine could attend the beliefs group and Christine has counterposed Laura's suggestion with the notion of stimulation, "I would like some stimulation" (text not included here). The extract below begins with Anne Green introducing "computer classes" (line 737) in response to

Christine's invocation of "stimulation". However, this suggestion is ignored by the professionals who instead raise "womens group".

Meeting 1 (main meeting) : Christine

737 Anne: I thought you were going to do some (.) computer classes
738 Christine: oh yeah at night school yeah
739 Laura (ASW): on Friday Claire is going to visit on Fridays
740 Claire (CPN): and also on Fridays the womens group (.) which is on Friday morning
741 that is very popular
742 Laura (ASW): I think you'd enjoy that
743 Claire (CPN): the womens group (.) would you be interested in that?=
744 Christine: =yeah I would I would be yeah I would be interested yeah >it doesn't
745 mean I'd have to come< every week does it
746 Claire (CPN): I don't think so I think y'know its its sort of reasonably o::pen (.) but
747 obviously thats something you'd have to discuss with whoevers
748 running it
749 Christine: yeah
750 Claire (CPN): and from week to week they have different topics that they cover and
751 guest speakers come in and (.) they do some interesting topics
752 Christine: thats right and you can socialise at the same time can't you?
753 Claire (CPN): yeah its a very good group yeah very good

Women's group is framed as pleasurable, "you'd enjoy that" (line 742) and stimulating, "different topics", "guest speakers", and "interesting topics". The notion that it is "very popular" and "very good" (lines 741 & 753), suggests not only that it is beneficial for women but women who go agree. The amount of discursive effort put into selling this group to Christine presents women's group, a gendered environment, as particularly suitable for Christine. The solution of "womens group", therefore, explicitly positions Christine *as* a 'woman' and makes this the most salient feature about her (Edwards 1998). Moreover, despite the way women's group is formulated for Christine, it becomes clear that its salience is not stimulation but rather that it is a *women's* group. The following extract is from Diane's meeting and consists of Betty, the CSW, selling the women's group to Diane. Betty's approach consists of four inter-related parts which present women's group as an undemanding and safe environment for a woman.

Meeting 2 (main meeting) : Diane

273 Betty (CSW): right its only an hour and a half
274 Diane: right
275 Betty (CSW): its only half ten to twe::lve
276 Diane: yeah
277 Betty (CSW): its not a lo:::ng=
278 Diane: =yeah
279 Betty (CSW): sort of session (0.8) and by the time you arrive and have a cup of tea a
280 cup of coffee its ten to eleven=
281 Diane: =yeah=
282 Betty (CSW): =so really and then we have a little break and have another cup of
283 coffee
284 Diane: yeah
285 Betty (CSW): so really in total y'know and its a very sort of gentle group=
286 Diane: =yeah
287 Betty (CSW): er you're not under pressure to do anything er and someone comes
288 along from the college to talk about make-up (.) someone came last
289 week to talk about nai::ls
290 Diane: yeah
291 Betty (CSW): so its that kind of group um theres about (1.9) eight or nine women
292 and you will kno:::w some of them from the ward
293 Diane: yeah
294 Betty (CSW): and its all its just all women >its nothing< its very relaxing and I
295 don't think you'd feel pressured or or um=
296 Diane: =no
297 Betty (CSW): um (.) uncomfortable in any way

Betty's 'sell' of the women's group is accomplished in four three-part lists. Firstly she presents the women's group as not requiring very much of Diane or her time, "its not a lo:::ng ...sort of session (0.8) and by the time you arrive and have a cup of tea a cup of coffee its ten to eleven...and then we have a little break and have another cup of coffee" (lines 277-283). In moving from the length of the session to a chronology of coffee breaks, the women's group is presented as a short amount of time that is not much to ask of Diane and little will be required of her beyond drinking coffee, thus founding the notion that it is undemanding. In the second list, Betty builds on the notion that it is undemanding by linking it with beauty activities, "you're not under pressure to do anything er and someone comes along from the college to talk about makeup (.) someone came last week to talk about nai::ls" (lines 285-289). The first item in the list, "you're not under pressure", forms a bridge between the previous list and depictions of the sort of activities involved. In the third list Betty presents the women's group as an environment specifically for *women*, "theres about (1.9) eight or nine women and you will kno:::w some of them from the ward...and its all its just all women" (lines 291-4). The small numbers, the fact that Diane will "know some of them", and the emphasis that it is only women works to suggest that it is safe and undemanding *because* it is "just all women".

The final list reiterates and expands the notion that the group is undemanding, "its very relaxing and I don't think you'd feel pressurised or or um...um (.) uncomfortable in any way" (lines 294-7). Therefore, women's group is undemanding because it takes up little time and little is required beyond drinking coffee, because it is about beautifying activities, because it is a safe, women-only environment. Women's group in this formulation is for the kind of 'woman' who cannot manage to do very much, if anything, and who feels happiest and safest with other women. Nothing is required, just for Diane to be there. It is a small step from home to women's group. Therefore each discursive 'sell' of the women's group is furnished with constituent parts that are aimed to appeal to the particular woman concerned. But what is most salient, and what traverses both depictions is that it is a group with women for women. And whilst these women may have different biographical details and predilections, they are women who need to do something outside the home, make friends and be more independent and the best place for that is a professionally organised activity that is "just all women".

The four themes explored so far, "shes stuck in the house", "she doesn't have any friends", "she does get dependent" and "its just all women" suggest that psychiatric professionals are drawing on understandings of femininity in their decision-making regarding patients' futures in terms of their purposefulness and autonomy. Being stuck at home, friendless and dependent is framed as insufficiently purposeful while doing something outside the home, independent of significant others and in the company of other women is framed as the solution. In this way, purposeful activity and a certain understanding of independence are interwoven and feminised. But there is little sense in these meetings that women are being assessed on the performance of gendered tasks per se (Busfield 1989; 1996), nor that psychiatry is enforcing gender-role conformity (Chesler 1974; Warren 1987) in any straightforward or traditional way. In fact traditionally feminised tasks such as childcare and housework are deemed insufficiently purposeful, if not downright psychologically unhealthy, supporting Allen's (1986) contention that social coping in the community does not require adjustment, in any simple sense, to gender-role.

However, Busfield is right to the extent that the patient is "a gendered subject" (1996: 114), or rather, these patients are feminised subjects. The gender thinking of psychiatric professionals positions women as "women", informing what constitutes lack of purpose, what purposeful activity should consist of and what kind of independence "women" should be restored to. Moreover, while contemporary psychiatric understandings eschew the idea that 'a woman's place is in the home', home becomes, paradoxically, a problematic place for women: somewhere where they engage in purposeless activities and a place they need to get away from. Furthermore, when the meaning of patients' histories and experiences are analysed as interactive accomplishments, rather than pre-given, it is apparent that they are shaped according to the activity at hand. Different biographies and experiences, such as "single Mum" with a "mental illness", "Irish" patient with "psychotic agoraphobia", can be shaped and informed by understandings of femininity to support the same problematisation and the same proposed solution.[3] Furthermore, much of this work occurs in an intra-professional domain where professionals have the authority to decide what patients' experiences mean and in a context where patients do not have the opportunity to contest these professional versions.

Thus re-making individuals back into purposeful and autonomous subjects (Rose 1989) is informed by professionals' understandings of femininity. However, from the analysis so far it is not apparent whether professionals also make understandings of masculinity relevant to discussions about patients' activities, nor what kinds of understandings are accomplished and to what effect. In the next section, I discuss meetings for two patients who are also framed as insufficiently purposeful. I explore a different professional

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[3] This includes the meanings of experiences related to motherhood and housework which are constituted interactively and according to the activity at hand.

formulation of autonomy which, I argue, is informed by an understanding of personhood which is not explicitly masculinised. And I raise issues about whether a background understanding of masculinity could be operating.

2. Restoring People's Lives: Understandings of Personhood and Ascriptions of Autonomy

There has been a tendency in feminist writings on gender and schizophrenia to focus chiefly or wholly on women. The result has often been a reliance on an implicit comparison or assumed knowledge about men (Busfield 1996) while leaving the interrelationships between femininity and masculinity largely unexplored. For example, while Chesler (1974) claims that men who are passive and dependent are likely to be diagnosed schizophrenic, it is women who are the focus of her account. As I have argued above, in contemporary psychiatric encounters women are explicitly positioned as "women" in talk about restoring patients' lives and understandings of femininity inform what it means for "women" to be purposeful and autonomous. In this section I discuss two further meetings where patients are framed as insufficiently purposeful and I examine the way the biographies and experiences of these patients are shaped towards framing the problem(s) and the proposed solution. In these meetings professionals' understandings of a generalised person are informing a different understanding of purpose and autonomy to that constituted for "women". And it is likely that professionals' understandings of masculinity are operating as a background relevance.

2.1 Problems of a Difficult Relationship, and Home and Dependence Revisited: "he'll need some support" and "dependent on us feeding you"

This section focuses primarily on meetings for two patients. As in the previous section, I trace the way professionals invoke and shape the patients' biographies to frame them as insufficiently purposeful. However, understandings of a difficult relationship for one patient, and home and survival for the other, position these patients in ways that suggest that professional notions of dependence and sociability can take on a number of different meanings. Tony is a community patient and has recently ended a long-term relationship with another patient. Henry is a patient at the day hospital who is about to be discharged into the community. They both live alone and attend the meetings alone. In the first extract the professionals are discussing with Tony the recent break-up of his relationship with Wendy, another patient. The extract begins and ends with "all his time taken up" (lines 144 & 150), an extreme formulation which is sandwiched either side of a narrative of how Tony used to be before he took up with Wendy. The solicitation of Tony's agreement problematises the situation with Wendy as Tony's framing rather than a professional one.

Meeting 6 (main meeting) : Tony

144 Martin (CPN): I think Tony's time's all taken up by Wendy isn't that right (.) its its
145 become (.) a a problem in a sense for him (.) and I think that time when
146 he said y'know he was pleased to break up with her if he felt he can get
147 time for himself its a pity before I knew him so many years that
148 although he was quite ill at ti::me but when he LIKES to believe he has
149 his own routine and go out on his own and do things and it seems now
150 all his time taken up by Wendy's sort of (.) y'know um preoccupations

Martin, the CPN, provides a contrast between a before, when Tony had "his own routine" and went "out on his own and do things" (line 149), and a recent state of affairs when "all his time taken up" with Wendy's "preoccupations" (line 150). The assessment is warranted by how long the CPN has known Tony, "so many years". In a three-part list, Tony is framed as formerly purposeful, independent and active "he has his own routine and go out on his own and do things" (lines 148-9), even when he was "quite ill" (line 148). This contrast sequence suggests that Tony used to be purposeful and independent, is no longer so, but he is not to blame, it is Wendy's fault. In the next extract, the professionals go on to discuss what the future role of those involved in Tony's care should be. The first point to note is the sheer number of professionals involved with Tony, four plus the consultant. Tony is positioned as someone who requires necessary but understandable support; again it is not quite his fault it is because of the "relationship".[4] Additionally, it would seem to be emotional support that he needs because of the "area" it is related to.

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[4] The consultant also appears to be reluctant to accord Tony and Wendy's association the status of a relationship; she pauses before using the term (line 170) and then moves to using "that area" (twice lines 171-2). This reluctance is suggestive that, perhaps, the doctor is subtly inferring that it was not a 'real' relationship in some way.

169 Dr. N.: I think y'know Tony will need some suppo::rt because um
170 its not been easy and its been quite a long (0.7) relationship so I think
171 Kathryn Maroon can continue maybe to support you (0.6) in that in that
172 area and along with Lucy cos Lucys been involved in that area too but I
173 think that leaves Celia Beige and Martin to discuss (.) your your own
174 needs

However, despite the number of professionals involved, and Tony's need for (emotional) support there is no discourse of dependency invoked here. He may need the professionals for emotional support but he is not dependent on them. The need for emotional support arises out of his biographical circumstances and is reasonable given those circumstances, a difficult association with a preoccupied co-patient. Thus Tony is not positioned as dependent in the way that Christine was in the previous section.[5] In the next extract, the professionals begin to formulate a solution to the problem which they frame initially in broad terms. The extract begins with the consultant introducing the notion that "activitie::s" are central to the care plan and consist of more than one activity. Tony makes the claim that "I do go out everyday anyway" (line 253), an extreme formulation that attempts to found the claim that he is sufficiently active.

250 Dr. N.: uhn OK so shall we start >sort of making< the care plan so lets say the
251 heading activitie::s and you say that social group would be one activity
252 (1.7) um
253 Tony: I do go out every day anyway
254 Dr. N.: where do you go to
255 Tony: local towns (.) like Crick or Farrington [or Borley]
256 Dr. N.: [what you just] wander around
257 the sho::ps
258 Tony: yeah
259 Dr. N.: but wouldn't it be better to do something (1.5) more purposeful and
260 with other people
261 Tony: yeah

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[5] Christine *could* be framed in the same way as Tony; her need for emotional support could also be understandable given that she is a single mother living alone with a small child. However, Christine is positioned as overly dependent on the professionals and needing someone "else to turn to".

A short interrogation by the doctor enables her to quickly differentiate between aimless activity ("just wander around the sho::ps" lines 256-7) and "something (1.5) more purposeful and with other people" (lines 259-60). Purposeful activity is overtly formulated as the solution for Tony, but has not yet been given any substance, and this activity should involve contact with others. The doctor solicits Tony's agreement to this formulation, which he gives. Therefore Tony's problem is that he has been embroiled in a long and difficult association with another patient. He is insufficiently purposeful in that Wendy takes up all his time but it is not his fault. He used to be independent and purposeful and his need for emotional support is understandable given the situation, but he is not emotionally dependent. And the proposed solution is that Tony should do an, as yet, vaguely formulated "something more purposeful" and do it "with other people".

In the following extract, I turn to Henry's meeting. Henry's problems are formulated in much more extreme terms than Tony's and ones that bear similarities to discourses deployed in the meetings for Christine and Diane. In the extract below, the professionals are discussing the arrangements for Henry's discharge from the day hospital, along with potential problems and how they will be addressed. Henry himself has introduced the main problem at the start of the meeting (Henry: "I still have a problem going out on my own", text not included here) which threads through the whole of the meeting. The extract begins with the consultant listing off what needs to be done to "help" Henry with his "problems and difficulties" (line 72), writing in the file as she talks. In a three-part list, the last item of which is itself a three-part list (Jefferson 1990), Henry's problems and thus professional intervention is framed as "help maintain your mood help you get out so you don't get trapped in the house...help you get out for shopping doctors appointments and collecting prescriptions" (lines 75-77).

Meeting 9 (main meeting): Henry (notes only)

72 Dr. S.: ... list of problems and difficulties... how are you in your spirits and
73 your mood
74 Henry: at the moment I would say not bad
75 Dr. S.: we need to help maintain your mood help you get out so you don't get

trapped in the house... help you get out for shopping doctors appointments and collecting prescriptions ((Dr. South writes in the file))... need to encourage you to socialise a bit

The first point to note is that "getting out" has two components: a general sort of getting out so that Henry is not "trapped in the house", and a specific "getting out" as a means of survival. Secondly, the notion that he should "socialise" implies general contact with others, in a similar fashion to Tony. The qualifier of "a bit" implies they do not expect very much of him and/or he is not likely to be very sociable. In this initial framing then, the problems are implied by, and incorporated into, the proposed solutions. Henry is insufficiently purposeful in two respects. He is "trapped in the house", unable to go out, and he is also insufficiently purposeful at the most basic level of necessities for living, an even more extreme depiction. And the proposed solution is framed in terms of psychiatric help and encouragement; Henry should "get out" in a general way, "get out" for basic necessities, and "socialise a bit", and the professionals will "help" and "encourage" him to do this.

The problem of Henry being "trapped in the house" has a very similar resonance to Christine and Diane being "stuck in the house" and, in particular, his problem of "getting out" appears to be the same as Diane's, that is, based on fear. However "stuck" and "trapped" are not necessarily synonymous and can convey subtly different meanings. For example, "stuck in the house" implies that Christine and Diane remain there when they could and should be doing other things, as in 'I was stuck indoors all day because it was raining'. But "trapped" suggests a way in but no way out, a lack of means of escape. In this sense then, being "stuck" implies a lack of volition which being "trapped" does not. The subtle difference in meanings are elaborated and differentiated in this context according to the solutions attached to the problems. So for Diane the solution is to "break that fear" conveying the sense of prising her out of the house, much like a clam from a shell, and for Christine it is to get her in with a group of people, the implication being that if she has something better to do she will not stay at home all the time. But for Henry it is a matter of help and encouragement to enable him to escape, at least in order to get what he needs for survival.

However, the psychiatric nurse goes on to frame the problem in terms of dependence. In the following extract, the doctor has just referred again to the problem of collecting doctors' prescriptions. The extract begins with Lynne, the PN, asking a direct question to Henry in a rhetoric of argument construction of "if you got a taxi" then "what would happen" (line 98). This question incorporates a proposed solution to the problem but Henry resists this proposal implying a distinction between what might work on an occasional basis but not as a general solution, "regular basis" (line 99), together with the vaguely formulated claim that it is "not appropriate".

98 Lynne (PN): what about if you got a taxi somewhere what would happen
99 Henry: I don't feel I could get a taxi on a regular basis its not appropriate
100 Lynne (PN): in what way [.]
101 Henry: if I get a taxi shopping I think and taxis to get prescriptions and go to
102 the chemist its the expense really
103 Dr. S.: : it wouldn't have to be for everything ((checks how often he would
104 need to get prescriptions))... Michael can you talk to Dr. Beta so he can
105 have his prescription for as long as possible
106 Lynne (PN): you could get one when you go shopping at Tescos... it would give
107 you some independence... on a weekly basis otherwise you're going to
108 be dependent on us feeding you I thought it might give you some
109 control over it

However, Lynne challenges Henry's claim and demands an explanation. The pause at the end of line 100 suggests that she is waiting for Henry's answer. Eventually he provides a three-part list of the things he would have to use taxis for, "a taxi shopping...and taxis to get prescriptions and go to the chemist" (lines 101-2). The list items work up the extent to which he would have to take taxis, thus supporting and justifying his previous claim that it is "not appropriate" because of the "expense" (lines 101-2). In this way, a strategy for getting out that could be used occasionally becomes, by sheer volume of what "regular" would entail, impractical. But the doctor undermines Henry's implied claim regarding volume and impracticality, "it wouldn't have to be for everything" (line 103), followed by a practical suggestion of how the volume of taxi rides can be decreased. Having dispensed with two parts of Henry's list ("prescriptions" and "the chemist"), Lynne takes up the third part, shopping, and reiterates her proposal. This time she provides a justification in the form of a strong and evocative contrast between "independence" and "control" on one hand and extreme dependence on the other, "otherwise you're going to be dependent on us feeding you" (lines 107-9). In depicting Henry's situation as one of such severe dependence, his very life depends on it, the PN has formulated a strong counter to Henry's resistance. However, despite the severity of Henry's dependence, it is of a specific practical nature related to everyday acquisitions of food and medicines, rather than the more internal emotional dependence associated with Christine and Diane.

Therefore the formulations of "all his time taken up" and "trapped in the house" position Tony and Henry as insufficiently purposeful, but in very different ways. Tony has been embroiled in a difficult relationship and his lack of purpose is not his fault. The difficulty of his association with Wendy is deployed to support professional assertions that Tony needs support and to do something more purposeful, while at the same time excusing him of blame for this state of affairs. Henry cannot get out of the house but professional plans to remedy this situation meet with resistance from Henry which in turn elicits a discourse of dependence from one of the professionals.

Nevertheless there are some commonalities. Tony will "need some support" but he is not dependent, and Henry is practically, rather than emotionally dependent, he is "dependent on us feeding you". There is no sense that either patient needs someone "else to turn to"; despite the fact they both live alone this aspect of their biographies is not made relevant to the discussions. And both patients should have contact with other people implying a general sociability but they are not framed as having a "lack of friends" or "lonely". Furthermore, "home" is not problematised and associated with domestic activities in the way it was for Christine and Diane; Henry in particular and Tony could be framed as "just at home", but they are not. Thus different understandings of dependence and sociability from those associated with "women" are formulated by professionals for these patients suggesting that some kind of unexplicated background understanding could be operating here. In the next section, I trace the way professional solutions to Tony's and Henry's lack of purposeful activity are played out in the course of the interactions, and in such a way that a particular understanding of independence is constituted and accorded to these patients in terms of a self-regulating autonomy which differs from professionals' understandings of independence for "women".

2.2 Autonomy: "he'll do what he wants to do"

The proposed solutions have been formulated in very general terms for Tony ("something more purposeful and with other people") and in very basic terms for Henry ("help you get out" and "encourage you to socialise a bit"). However, as professionals go on to furnish these solutions with more detail, a particular understanding of independence feeds into the direction that the discussions take. The first extract is taken from Tony's meeting. Doctor North is suggesting to Tony a range of purposeful and sociable activities organised by the professionals at the community centre. But Tony directly and emphatically resists each of the doctor's suggestions, "no" (lines 272, 274 & 287). However, despite the doctor pursuing some of these refusals, her response in terms of her amusement and laughter (lines 273, 277, & 283 twice) is very different from the sort of professional responses to patient resistance discussed in the previous chapter. It suggests that it is acceptable for Tony to refuse.

Meeting 6 (main meeting) : Tony

270 Dr. N.: so what about (.) theres a relaxation group Tuesday isn't there does that
271 sound like your thing? relaxation? (4.9) °no° sports?
272 Tony: no
273 Dr. N.: sports group? h h h h h
274 Tony: no
275 Dr. N.: why not?
276 Tony: well=
277 Dr. N.: =can you swim? ((still sounding amused))
278 Tony: no I can't swim
279 Dr. N.: you can't swim?
280 Tony: no
281 Dr. N.: how did you manage not to learn? at school didn't they make you
282 Tony: I stayed away from sport
283 Dr. N.: h h h h I don't think I believe you um alright so no sport er h h we're
284 running out of things [living]
285 Martin (CPN): [the Drop] In the Drop In do you do you like the
286 Drop In
287 Tony: no I've been there before

In allowing, and even encouraging, Tony's resistance to all these professionally organised activities, the doctor appears to be reinforcing and colluding with his resistance. As such, an independence of spirit/will is implicitly accorded to Tony in the professional's responses. The next extract consists of the doctor 'selling' another activity to Tony, this time "computers". The initial introduction of "computers" by the doctor has met with no interest from Tony but she presses on. The extract begins with a piece of flattery from the doctor, "you have a good brai::n Tony" (line 343). The first point to note here is the sheer amount of effort that goes into 'selling' this activity to Tony. Working with computers is framed as an activity for "people" (lines 350, 352, 357 & 361), together with a number of mechanical metaphors, "tune it up", "really riveted" (lines 345 & 352), mirrored by Tony's "sparked" (line 358), which could suggest that she is covertly masculinising the activity (Hopper & LeBaron 1998).

343 Dr. N.: you have a good brai::n Tony?
344 Tony: its a clapped out brain now
345 Dr. N.: no well you've got to tune it up again and start using it (1.9) I'm
346 surprised that computers don't (0.8) interest you (4.4) no? (2.5)
347 Tony: I might
348 Dr. N.: ah ah well how about [looking at tha::t cos]
349 Martin (CPN): [you see Downs College] is
350 Dr. N.: Downs College has got courses for sort of introducing people to
351 computers (.) that you might get into that you might like it I mean
352 people get really riveted by by computers and (0.8) the web and all that
353 kindof stuff do you know anything about that?
354 Tony: no
355 Dr. N.: well y'know you you get into this (0.8) THING and you can read
356 noticeboards or y'know through this (0.7) internet and you can (1.4)
357 communicate with people through it and (1.0) stuff like that
358 Tony: you've sparked off a bit of interest=
359 Dr. N.: =ah h h h h h
360 Martin (CPN): good good
361 Dr. N.: no its its some people are really y'know into it its quite exciting for
362 them and it could be your thing cos I mean y'know its sortof

363 Martin (CPN): working on your own and [and]
364 Dr. N.: [ya]

Having positioned Tony as someone with "a good brain", his disinterest in computers becomes surprising, "I'm surprised that computers don't (0.8) interest you" (lines 345-6). Thus while the doctor seemingly gives Tony permission to refuse again, and an opening to do so, tying his intelligence to this activity is a tactic which is likely to elicit a more positive response. The doctor builds on her persuasion, with the help of Martin. In three three-part lists the doctor works up how "interesting" and suitable computers are. The first two lists present computers as interesting for other people and reasons for this, "people get really riveted by by computers and (0.8) the web and all that kindof stuff" and "you can read noticeboards...and you can (1.4) communicate with people through it and (1.0) stuff like that" (lines 352-3 & 355-7). The generalised list-completers in each list suggest that there are "many more relevant nameables" (Jefferson 1990: 68) thus increasing the extent and sense of interest.

Having established how interesting computers are for others, and why, and having elicited an even more positive response from Tony (line 358), the doctor finishes with another list which acts as a bridge from her depiction of others to Tony, "some people are really y'know into it its quite exciting for them and it could be your thing". Therefore, getting involved in computers is presented by the doctor in terms of interest bordering on passion, "interest" (line 346), "like", "riveted" (351-2), "get into" (lines 351 & 355) and "exciting" (line 361). This is combined with the notion of suitability which suggests that computers are "something" with purpose and "something" which could be purposeful for Tony, "it could be your thing" (line 362). The last point to note is Martin's interjection at line 363. He presents computers as an independent activity, something purposeful to do "on your own" (line 363). But this also carries the implication that computers are the "thing" for someone who is not good with people. "Something...with other people" (previous extract, lines 259-60) is reconfigured to other people at a distance; he can "communicate with people" (Dr. North, line 357) but "working on your own" (line 363).

Therefore the solution for Tony is an interest/passion in the activity of computers, an activity that is associated with "people" but partially worked up through the use of mechanical metaphors which could carry connotations of masculinity. Computers will be a purposeful activity for someone with a good brain who can communicate with other people, but at a distance. While Christine's mother raised the possibility of computer classes and Christine talked about stimulation, the professionals used the notion of stimulation to position Christine as a "woman", and frame the solution for Christine in terms of the company of other women. Yet despite Tony's disinterest and counter-claim of a "clapped out brain" the consultant goes to some lengths to frame the solution of computers in terms of interest and suitability; the discourses of "good brain" and "your thing" suggest that Tony has talents and he should engage in activities that use those talents. However, a certain understanding of independence is woven into the discussion. Not only is Tony encouraged to get involved in an independent activity, "working on your own", but his resistance elicits an implicit discourse of independence which is very different from that proposed for women. The notion of independence implied here is a sense of free will and self-government; Tony is allowed, even encouraged, to refuse to do what he does not want to do and thus the implication is that he will do what he wants to do and will not do what he does not want to do.

This covert framing of autonomy is explicitly invoked in Henry's meeting as it is juxtaposed with a discourse of dependence, and deployed to override it. In the following extract, Henry's meeting is drawing to a close. Henry has suggested that he is "apprehensive very about going out on my own" (text not included here) and the extract below begins with the doctor responding to Henry, whereupon the meeting suddenly takes a different turn. The doctor's acknowledgement of Henry's feelings suggests that she has listened to what he has said and she understands. This is followed by a sequence that undermines much of what has gone before. She presents a worst case scenario that conveys the notion that he will not be made to take taxis if he will not or cannot do so and that they would not let him starve; the CSW will provide the means for his sustenance if necessary.

Meeting 9 (main meeting) : Henry (notes only)

203 Dr. S.: I acknowledge your apprehension... if the worst comes to the worst

204 Jane can do the shopping I think you'd feel a bit less trapped indoors or
205 you don't feel that do we want to get you out more than you want to be
206 got out
207 Lynne (PN): but there may be times when he needs to go out
208 Dr. S.: I think Henry'll do what he wants to do

The doctor follows this worst case scenario with a contrast between her opinion ("I think") regarding his feelings about the problem of being "trapped indoors" and Henry's, perhaps different, feelings. It founds the inference that she is concerned about his feelings and problems but at the same time it suggests that there may be more than one way to see the problem; she thinks he would feel "less trapped indoors" if he took a taxi to get his shopping but perhaps he does not. Finally, the consultant frames a question that appears to be rhetorical in that Henry does not answer. While previously the doctor's opinion was juxtaposed with Henry's feelings, now an equivalence is founded in which what the professionals "want" is contrasted with what Henry "wants", "do we want to get you out more than you want to be got out" (lines 205-6). In this way, what Henry "wants" is given equal weight and value to what the professionals "want". As such it gives what Henry "wants" credence and provides tacit support for his resistance.

This reframing of equivalence occasions disagreement from Lynne who contrasts "want" with "needs". It is not a question of desires or preferences, but basic life sustaining needs. However the doctor's response to the PN explicitly accords Henry autonomy, "I think Henry'll do what he wants to do" (line 208). As in the discussion between Dr. North and Tony, the patient's resistance to the professionals' plans and suggestions elicits, this time an overt, discourse of autonomy. Henry is accorded a free will and self-government which shuts down resistance from the PN and in the process affirms Henry's resistance. Moreover, this ascription has the potential to undermine all the proposed professional solutions forwarded earlier in the meeting. However in the post-meeting the PN raises the problem and her disagreement again. She re-invokes her previous discourse of Henry's dependence on the professionals combined with an extreme formulation which infers severe lack of purpose and activity almost to the point of lifelessness, "hes so dependent on us and he won't do anything" (line 211). And once again the PN's resistance elicits an overt affirmation of autonomy, "yep but he won't do it if he doesn't want to do it" (line 212).

((Henry leaves))
209 Dr. S.: I think his mood has improved hes more spontaneous
210 Michael (CPN): its a good time to encourage him
211 Lynne (PN): hes so dependent on us and he won't do anything
212 Dr. S.: yep but he won't do it if he doesn't want to do it OK HONOS
213 ((consults small booklet)) I think he does still have some delusions
214 Lynne (PN): fear of going out
215 Dr. S.: but its much more vague now

This time, the discourse of dependence is explicitly counterposed with, and overridden by, a discourse of independence construed as autonomy; Henry will do what he wants to do and he will not do what he does not want to do. The doctor then shuts down the discussion, and the PN's disagreement, by abruptly changing the subject.[6] Lynne makes one more attempt to raise the subject at line 214 but the doctor frames Henry's "fear of going out" as not such a problem as it used to be, "but its much more vague now" (line 215). In working Henry's fear down, the suggestion is that it is not a severe problem, and that it will perhaps sort itself out and continue to get increasingly "vague". Thus Henry's fear of going out, which could be understood in very similar terms to that of Diane, is pathologised ("he does still have some delusions", line 213) but it is worked down rather than worked up to extreme pathology. As such this framing of his "fear" and the underplaying of its severity and importance is a consequence of the disagreements that have occurred during the meeting.

Therefore, while the solutions to Tony's and Henry's problems of insufficient activity are different, Tony should do something that uses his brain, Henry should just survive, they are both accorded an independence construed in terms of autonomy; whether implicitly inferred or explicitly stated, both patients will "do what he wants to do". And autonomy is accorded to them as the direct result of patient and professional resistance. These implicit and explicit ascriptions of autonomy, therefore, work to affirm patient resistance.

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[6] HONOS is the Health of the Nation Survey that has been incorporated into the CPA documentation.

However, this meaning of autonomy is not dependent upon resistance. In the last part of this section I look at an extract for a patient who is not framed as insufficiently purposeful, and who is not resisting the professionals' definitions and plans. Ian is an informal in-patient but one who is using the bed for "respite" (the doctor's term) and seems to come and go from the ward as he pleases. He attends the meeting with his mother, Mrs. Peach. The consultant is trying to establish "how much" Ian is on the ward and the extract below begins with Ian's reply which incorporates the claim that, even when he is there, he does not do "anything" (line 637). This extreme formulation, and introduction of what he does not do, orients the conversation to activities. Ian, assisted by Mrs. Peach, provides a three-part list of what could be termed leisure activities, or perhaps the kind of things an unemployed person might fill their time with, but certainly not professionally organised activities, "I just go round the charity shops listen to some sounds"/"comes round my house" (lines 639-40). The doctor summarises these activities as "so you do your own thing" (line 643).

Meeting 16 (main meeting) : Ian

635 Ian: I'm here normally sometime Monday most of the nights if I'm having
636 problems or um (.) a couple of the days I stayed but I don't do the
637 therapy occupational or anything
638 Dr. N.: no you do::n't so what do you do
639 Ian: I just go round the charity shops listen to some sounds
640 Mrs. Peach: comes round my house
641 Ian: come round me Mum's
642 Mrs. Peach: he has his therapy at my place h h h h h
643 Dr. N.: so you do your own thing
644 Ian: I do yeah
645 Dr. N.: so how does that fit in with the old care plan is that=
646 Ian: =I go to Kickstart and um
647 Dr. N.: uha so we'd better whizz through the old care plan hadn't we ((sound
648 of paper rustling))

Doing his "own thing" carries the sense both that Ian does things that are not connected with professionally organised activities, they are his things rather than the professionals' things, and that he does what he wants to do. As such this can be read as another variant of the autonomy discourse. When Ian agrees with this summary the doctor raises the care plan, suggesting not disapproval or insufficient purpose, but more the sense that the care plan requires certain official activities to be written into it and these "own things" are not the sort of thing you can write in a care plan. Ian certainly reads it this way and provides the doctor with an official activity, "Kickstart" (line 646), which seems to be sufficient for the doctor.

The extract from Ian's meeting suggests that while autonomy may be accorded to certain patients as a result of their resistance, it is not dependent upon it. Ian is playing by the rules, as it were, and providing the consultant with the kinds of responses she is seeking (for example, line 646). The phrase "so you do your own thing" encapsulates a sense of free-wheeling self-government that does not arise in meetings for patients who are positioned as "women". The extent to which these patients are self-governing, however, is not all-encompassing. Autonomy, as self-government only extends to notions of activities, that is, how these patients spend their time. One of the key components of Rose's (1989) concept of autonomy is that selves should be restored to "the status of a choosing individual" (pg. 228) but as we saw in chapter three, patient choice is severely limited, particularly when it comes to decisions regarding medication.[7] Thus, autonomy as self-regulation is itself differentiated; some patients are accorded self-regulation when it comes to how they spend their time, but not whether they take their medication.

Therefore, professionals formulate differentiated meanings of dependence and independence in their talk about restoring patients' lives. Tony is framed as needing emotional support and Henry as dependent on the professionals for his very survival, but neither is positioned as emotionally dependent. And independence for these patients is formulated in terms of a self-regulating autonomy over how they spend their time, they will "do what they want to do", "won't do what they don't want to do" and generally "do their own thing". Moreover, this understanding of independence is accorded regardless of the patient's level of (in)activity, as we saw in Henry's extreme case. In this sense, then, these particular patients are not to be *restored* to autonomy, they are accorded autonomy

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[7] I included extracts from Tony's meeting in chapter three where talk about choice and medication was discussed.

whether they are engaged in purposeful activity or not. Independence is disconnected from purpose.

However this presents a conundrum: if femininity is foregrounded and made relevant to restoring "women's" lives, what understandings are relevant to restoring these other lives that are not feminine? Remaining within the bounds of professionals' explicit orientations suggests that professionals' understandings of femininity are relevant to restoring patients' lives but understandings of masculinity are not.[8] However, resting upon such assumptions risks falling into the trap of privileging "the man as unproblematic or exempted from determination by gender relations" (Flax 1987: 629). And it is not clear that men are indeed "exempted" in professionals' talk about restoring patients' lives.

A number of potential relevancies might be operating here such as age, ethnicity, education, stage of illness/recovery and level of activity or previous level of activity. But these categories do not appear to be relevant. For example, age is made relevant to Christine ("young Mum"), and ethnicity to Diane ("Irish"), but neither is oriented to in Tony and Henry's meetings. Tony has "a good brain" but this is not relevant to proposals for Henry. Christine and Diane are pathologised, but Henry is too, although his "delusions" are downplayed, and Tony is "not all that <u>well</u>" (text not included in this section). They are all positioned as insufficiently active/purposeful and whilst Tony's previous purposefulness is made relevant in his meeting, it is not in Henry's meeting. Each patient therefore has singular details to their biography and situation but biographical details and experiences are made relevant, developed, or downplayed as professionals shape the problems and the solutions. Thus different biographies can be shaped towards the same problem and solution (Diane and Christine), towards different problems but the same solution (Tony and Henry), or very similar biographical details can be made relevant to different problems and solutions (Diane and Henry). Further, mechanical metaphors such as "tune it up" and "riveted", deployed in Tony's meeting to persuade him of the interest and suitability of the activity of computers, could be covertly

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[8] This stance could then be taken to support a long-held feminist view that man is the universal human being and there is only one gender, the feminine (e.g. de Beauvoir 1979). It could also support the view of feminist writers that psychiatry is particularly concerned with femininity and the gender conformity of women (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992), even if psychiatric understandings of femininity have changed.

indexing masculinity (Hopper & LeBaron 1998). But there is nothing intrinsically masculine in terms such as "tune it up" and "riveted" (Stokoe & Smithson, in press).

Discounting a range of other possible category terms increases the likelihood that an understanding of masculinity is informing the professional ascription of autonomy for these patients, but I cannot demonstrate unequivocally that this is the case. Professionals are making at least two understandings relevant to the activity of restoring patients' lives to purpose and autonomy: an understanding of "women" and related notions of femininity, and an understanding of a generalised person. However, while understandings of femininity are made overtly relevant, this does not necessarily or automatically mean that notions of masculinity are not relevant for professionals. Given that a range of other potential category terms do not appear to be relevant, it is likely, but not conclusively so, that a background understanding of masculinity could be informing professionals' formulations of dependence and independence for these generalised "people" - hence this understanding is best characterised as (masculine) personhood.

This raises the question of whether contemporary psychiatry continues to view mentally healthy women (and thus what women should be restored to) as less independent and more emotional than mentally healthy men or adults unspecified (Broverman et al 1970; Smyth & McFarlane 1985). But it is not necessarily the case that women are positioned as more emotional and less independent. Rather, emotion, dependence and independence take on a number of different meanings as they are associated with "women" and (masculine) "people". Thus when dependence is informed by understandings of femininity it takes on an emotional and internalised character: "women" "get dependent" and need someone "to turn to". Whereas emotions and dependence can be associated with understandings of (masculine) people but emotions are attributed to understandable external causes, "a long and difficult relationship", or dependence is associated with practical matters even when extreme, "feeding you". As such, it is not so much the case that the category of emotion is associated with femininity (Hekman 1990; Edwards 1997) but that emotion takes on different meanings in association with femininity and (masculine) personhood.

Professionals' understandings of femininity are also associated with concerns about loneliness and lack of friendship, ameliorated by the company of other women, whereas understandings of (masculine) people appear to elicit notions that patients should have "a bit" of general contact with "other people", notions that are undermined somewhat by ascriptions of autonomy. Moreover, while understandings of femininity are an occasional resource deployed to undermine patient resistance, as we saw in the previous chapter, it would appear to be the case that ascriptions of autonomy, informed by understandings of (masculine) personhood, work to affirm patient resistance.

However it is not that "women" should be less independent per se, rather independence is understood as independent activity away from home and significant others, whereas (masculine) personhood is associated with self-regulation over how patients spend their time. The differences turn on what dependence/independence mean to the professionals in the context of restoring lives, which take on a diversity and complexity when a discursive approach is taken to psychiatric understandings, particularly as they are played out within clinical encounters. A focus on language as interactive and productive enables a better understanding of the plurality of meanings of (in)dependence that are produced by professionals in the intersections between restoring lives and understandings of femininity and (masculine) personhood. It also suggests a more diversified picture than that presented by Rose (1989). Moreover, it is apparent that patients' experiences do not have pre-defined meanings but are shaped within interactions to support particular formulations of problems and proposed solutions, in association with notions of femininity and (masculine) personhood.

Having explored the way that professionals' understandings of "women" and (masculine) "people" inform what it means to be purposeful and autonomous, in the final section I turn to considering activities and the restoration of lives more generally. At the beginning of this chapter, I highlighted the way activities for patients are framed by professionals with a particular focus on keeping them occupied during the *daytime*. In the next section I explore this issue further in relation to professionals' understandings of schizophrenia.

3. Daytime Activities: Partial Restoration and Understandings of Schizophrenia

Rose's (1989) analysis of the "psychological sciences" could be taken to imply that all "fading" selves will be restored to "unity and personal purpose" (pg. 228). Or to put it another way, there is little exploration of what happens to selves who are not completely restored or restorable. There is also little consideration that the restoration project could be informed or delimited by individuals' diagnoses. As such, schizophrenia is regarded as one of the most severe disorders; for example DSM-IV (APA 1994) states that schizophrenia varies in its course but complete recovery is "probably not common" (APA 1994: 282). Miller (1986: 32) suggests that "when all else fails" individuals are "provided with just enough support to enable them to cope", but the analysis in the previous two sections indicates that contemporary psychiatry brings a number of different understandings to restoration/coping. In this section I explore whether restoration to purpose is not only informed by understandings of femininity and (masculine) personhood but also by professionals' understandings of schizophrenia.

3.1 Filling-In-For-the-Real-Thing: "its unlikely but perhaps in the future" and "this gentleman can't have paid employment because he has schizophrenia"

Professionals' concerns with daytime activities for patients appear to be drawing on the assumption that 'normal' people are occupied during the day and their proposed activities for patients are framed in terms of being therapeutic, keeping patients busy and filling their time. Activities therefore have a filling-in quality; they not only fill-in patients' time but also fill-in for 'normal' activities. But it is not apparent from the analysis so far whether the purposeful activities that patients are encouraged to undertake are steps on the way to fully restored lives or indicative of partial restoration. That is, do activities fill-in-for-the-real-thing and are these framings of purposefulness informed by professionals' understandings of schizophrenia?

There are many ways that "normal" people might occupy themselves during the daytime[9] but it is axiomatic in our society that purposefulness includes employment for healthy

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[9] For example, young people may be in further or higher education; elderly people who have retired from employment may be pursuing leisure activities; unemployed people may be seeking work; and those with the time, means and inclination may be engaged in voluntary work.

adults of working age who do not have independent incomes,[10] although this may now be an activity through which we "produce, discover, and experience our selves" rather than seek "financial advantage" (Rose 1989: 103). In this section, I focus on talk about employment to explore whether professionals' understandings of schizophrenia delimit restoration to purpose as Szasz (1976) has suggested, and in a similar way to the limitations of choice and responsibility discussed in chapter three. In the first extract, we return to Tony's meeting. Tony has been positioned as a (masculine) person by the professionals and implicitly accorded autonomy in relation to talk about purposeful activity. However, in the following extract the possibility of "work" is introduced. The sequence before this comprises a fairly long stretch of talk by Tony which, unfortunately, was inaudible. But from the doctor's response it seems that Tony has raised the issue of future employment. She begins with an extreme formulation and denial that he is expected to work, coupled with the suggestion that, anyway, it is his choice, ">nobodys expecting you to go out to work< not unless you yourself want to" (lines 232-3).

Meeting 6 (main meeting) : Tony

232 Dr. N.: °no:: (.) no >nobodys expecting you to go out to work< not unless you
233 yourself want to (.) u::m y'know but I mean >it wouldn't be (.)
234 something you just do you (2.8) you'd have to be fit for it° (3.4) so um
235 it doesn't sound like you're very fit Tony really not not to go to
236 wo::rk and all tha:::t (1.3) um and I think its unlikely perhaps (.) but I
237 mean y'know (1.0) °perhaps in the future°

However, the notion that it is Tony's choice works as a disclaimer as the doctor goes on to frame the decision in terms of fitness. The claim that "you'd have to be fit for it" along with the evidence that "it doesn't sound like you're very fit" (lines 234-5) is somewhat ambiguous in that it could be read that he is not in sufficiently good health or that he is not suited or not competent in a more vague and generalised way. Moreover, working is not just about going out to work but also now contains other vague and mysterious components, "and all tha:::t". Having established that Tony is not "fit" enough to go out to work at present, the doctor moves to the likely prospects for the future; the discourse of

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[10] For example, recently the government has put in place legislation to encourage single mothers to go into paid employment rather than stay at home with their young children and receive welfare benefits.

"its unlikely...but...°perhaps in the future°" (lines 236-7) defers the likelihood of Tony working to an indefinite future without discounting it completely.

Therefore the notion of paid employment is deferred to an indefinite future in a very similar way to questions regarding coming off medication altogether; in both cases the doctors appear to be working with a 'never say never but...' philosophy.[11] As such it is possible that the potential for the future, whether related to employment or medication, is informed by assumptions about the likely prospects for someone with a diagnosis of schizophrenia. This potential background relevance is rarely explicitly foregrounded but in the next extract paid employment is not only explicitly linked with schizophrenia but also with masculinity. The meeting is for Colin who is being discharged from the day hospital into the community and the extract is taken from the intra-professional pre-meeting. The professionals are discussing potential purposeful activities for Colin and the extract begins with Martin, the CPN, suggesting Saw and presenting it as "job training" (line 60). While Martin has framed the suggestion in terms of something Colin "needs", Dr. West reframes it as a question of preference and one that Colin does not prefer. The consultant's alternative suggestion of "Phil Grey" seems to be a reference to "Job Club" and suggests that she is going along with Martin's notion of job training. However, in a disclaimer that wards off any notion that it is Phil Grey's fault, the CPN founds the notion that Phil does not cater for people who are "not interested" and Colin is likely to be "not interested" (line 63).

Meeting 13 (pre-meeting) : Colin (notes only)
60 Martin (CPN): what about Saw... he needs some form of job training
61 Dr. W.: he doesn't like Saw
62 Dr. N.: what about Phil Grey
63 Martin (CPN): I'm not criticising Phil but if Colins not interested he'll just let him go
64 Dr. N.: ...
65 Martin (CPN): one of my clients went on the course... he needs some employment
66 prospects
67 Dr. W.: this gentleman can't have paid employment because he has
68 schizophrenia outpatients and support would be the best package

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[11] For example, in Dawn's meeting the notion of 'never say never' is explicitly invoked when she questions how long she will be on the medication: Dr. N. "no its not for life I never say for life".

Unfortunately there is some missing talk here, but the CPN goes on to reiterate his claim that Colin "needs some employment prospects". But this reiteration elicits a strong and damning counter from Dr. West who explicitly names and links together masculinity, schizophrenia and a negative framing of paid employment, "this gentleman can't have paid employment because he has schizophrenia" (lines 67-8). The notion of "can't" and "has" carries with it the implication that this is an ongoing state of affairs that is unlikely to change. The relevance of the links between masculinity, paid employment and schizophrenia are not elaborated but nonetheless carry inferences of an association between masculinity and paid employment which is discursively undercut by schizophrenia. As such it is an explicit depiction of the assumptions informing professionals' talk about the future prospects of patients.

Invoking schizophrenia to negate an association between masculinity and employment could be taken to support Szasz's (1976) claim that schizophrenia is feminised in terms of unemployability. However, while Colin is positioned as unemployable, this does not necessarily mean that he is feminised. Rather, Colin is positioned as a man with schizophrenia who therefore cannot have employment. Colin retains his positioning as a man but now he is a man with schizophrenia. Nevertheless, schizophrenia is made explicitly relevant to talk about employability and suggests that the extent of restoration is limited by professionals' understandings of schizophrenia. The doctor's contrast between "paid employment" and his preference, "outpatients and support", provides a strong distinction between full and partial restoration. Therefore, when the issue of paid employment is raised it is either deferred indefinitely or framed negatively and these discourses appear to be underpinned by professionals' background assumptions about schizophrenia.

Restoration of patients' lives is not only informed by understandings of femininity and (masculine) personhood. What it means to be purposeful and independent is also informed by assumptions about the likely prospects for someone with a diagnosis of schizophrenia which delimit the extent of restoration. Looking at the kinds of purposes proposed for patients, women's group, for example, is a professionally organised environment for being in the company of other women and making friendships, while independence from home and significant others only reaches as far as this professionally-made environment. Activities for (masculine) "people" are formulated in terms of interests and talents that are consonant with leisure activities, or at the extreme, simply survival. Thus daytime activities have a filling-in-for-the-real-thing quality. The kinds of purposes and autonomies delineated in psychiatric/patient encounters could be steps on the way to full restoration but there is a sense that this is not likely. Instead, the professional aim appears to be partial restoration that stands in for the 'normal'. In this way, professionals' background understandings of schizophrenia, made explicit in the last extract above, intersect with understandings of femininity and (masculine) personhood.

Conclusion

Psychiatric professionals' understandings of femininity and (masculine) personhood, subtly inform what constitutes lack of purpose, what purposeful activity should consist of, and what kind of independence patients should be restored to or accorded in case conferences. And background assumptions about schizophrenia intersect with these understandings to delimit the extent of restoration.

Professionals position women as "women" and draw on understandings of femininity in discussions about restoring "women's" lives. Themes of "shes stuck in the house", "she doesn't have any friends", and "she does get dependent" frame the problems for "women" in terms of home, loneliness, and (largely) emotional dependence. In turn a professionally organised environment/activity that is "just all women" will enable "women" to do something independent from home and significant others, and make friends in the company of other women. In this way gaining some independence, so construed, is the purpose; purpose and independence are interwoven. In contrast, discourses of "he'll need some support" and "dependent on us feeding you" attribute emotions to external causes (rather than internal) and dependence as practical (rather than emotional) for other patients. And these patients should have general contact with others rather than friendships. Furthermore, solutions to lack of purposefulness which are superficially very different are informed by a particular understanding of independence for these particular patients. They "will do what they want to do", an ascription of autonomy which suggests a free-will and self-government which is very different from the independent activity desired for "women". Moreover, autonomy is accorded regardless of whether these patients are purposeful or not; it is disconnected from purpose. And, while understandings of femininity are an occasional resource deployed to undermine patient resistance (as discussed in chapter four), ascriptions of autonomy appear to be invoked to affirm patient resistance, although they are not dependent upon resistance.

However, professionals' foregrounding of femininity in relation to restoring "women's" lives presents a conundrum regarding what understandings may be relevant to restoring other patients' lives. I argued that it is not necessarily the case that masculinity is not relevant (despite not being explicitly indexed in professionals' talk). Professionals appear to be drawing on the notion of a generalised person which may be informed by background understandings of masculinity, given that a range of other potential relevances can be discounted. Hence, this understanding is characterised as (masculine) personhood.

Patients' biographies and experiences are made relevant, developed or downplayed as professionals shape the problems and solutions. But different experiences can be shaped towards the same problem and solution, and similar biographical details can be made relevant to very different problems and solutions when understandings of femininity and (masculine) personhood come into play. The analysis suggests that experiences, including those associated with motherhood and housework, do not have pre-defined singular meanings but are formulated and reformulated interactively. Patients' past and present experiences are a *resource* in clinical encounters, shaped according to the activity at hand and in relation to understandings of femininity and (masculine) personhood.[12] In particular, the intra-professional post-meeting is a context in which professionals have the authority to decide what patients' experiences mean in a domain where they cannot be contested by patients.

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[12] In effect, the meanings of patients' experiences are likely to have been formulated, reformulated and shaped on many prior occasions both within the psychiatric context and outside of it. A range of other professionals and lay persons are likely to come into contact with the person before they arrive at the psychiatrist's door. During this phase the 'pre-patient's' experiences are likely to be an important resource in judging whether the person is a suitable candidate for psychiatric treatment (Goffman 1968; Emerson & Messinger 1977; Busfield 1989; 1996; Coulter 1991; Hak 1992).

However, it is not a case of assessment of performance on gendered tasks (Busfield 1989; 1996), nor enforcing gender-role conformity (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992) in any traditional or straightforward way. Neither is there a sense that all patients are feminised in terms of incompetence and dependence (Szasz 1976). Rather, professionals' understandings of femininity and (masculine) personhood subtly inform notions of purposes and autonomies within interactions. Moreover, contemporary psychiatry actively eschews traditional associations of women and home; home is framed as psychologically unhealthy and somewhere to be got away from, rather than the converse. However, in the process home becomes problematised for "women" in a way it is not for (masculine) "people". Viewing these understandings in terms of women being more emotional and less independent than men or adults (gender unspecified) is somewhat oversimplified (Broverman et al 1970; Smyth & McFarlane 1985) and underplays the plurality of professionals' understandings. Instead, emotions, dependence and independence take on a diversity of meanings as professionals go about the business of restoring patients' lives. Taking a discursive approach to these questions, therefore, is productive for elucidating the complexity of these meanings.

Contemporary psychiatric professionals are more concerned with restoring lives and coping in the community than gender conformity (Allen 1986; Rose 1989). But a focus on a local interactive context suggests that the psychiatric project of re-making individuals back into purposeful autonomous individuals is informed and differentiated by understandings of femininity and (masculine) personhood. Further, professionals' assumptions about schizophrenia are relevant when looking at restoring lives more generally. In particular the discourse of "its unlikely but perhaps in the future" defers employment indefinitely while the theme of "this gentleman can't have paid employment because he has schizophrenia" formulates an explicit association between masculinity and employment that is undercut by understandings of schizophrenia. Thus understandings of schizophrenia also inform what it means to be purposeful and independent. Daytime activities become partial restoration rather than steps on the way to full restoration and have a filling-in-for-the-real-thing quality.

In this chapter I have argued that understandings of femininity and (masculine) personhood intersect with assumptions about schizophrenia to inform, differentiate and delimit the psychiatric project of restoring patients' lives to purposes and autonomies. In particular, notions of dependence and independence, emotions and activity take on a complex of meanings in association with these understandings and assumptions. I also argued that experience is a resource shaped and played out in relation to femininity and (masculine) personhood, and according to the activity of restoring lives. In the next chapter, I extend the exploration of experience as an interactive accomplishment with a focus on discourses of care and negotiations of experiences between patients and significant others within psychiatric encounters. I consider the way that patients are located in interrelationship with significant others and experiences become complex resources for negotiating who is to blame for a particular problem and who should be the focus of professional intervention. And I examine how these interrelated experiences are formulated in relation to understandings of femininity and masculinity.

Chapter Six

Interrelated Lives: Experiences, Gender Relational Understandings and Attributions of Blame

Chapter five explored the way that professionals' understandings of femininity and (masculine) personhood inform the psychiatric project of restoring patients' lives to purpose and autonomy. Notions of independence for "women" are intertwined with those of purpose whereas (masculine) "people" are accorded an autonomy, construed in terms of a discourse of self-regulation over how they spend their time, regardless of level of purpose. I argued that this is not a case of enforcing gender role conformity, nor that women are simply construed as more emotional and less independent than men. Rather, emotions, activity, dependence and independence take on a number of different meanings. Further, patients' experiences are resources within interactions, informed by notions of femininity and (masculine) personhood and shaped according to the activity at hand. I suggested that professionals' assumptions about schizophrenia intersect with restoring patients' lives to delimit the likely degree of restoration: daytime activities become partial restoration.

This chapter extends the focus on gender understandings and experiences as interactional accomplishments through exploring how notions of 'care' and experiences between patients and significant others are negotiated in clinical encounters. I begin with a short discussion of literature on care as a gender issue (Banton et al 1985: Showalter 1987; Ussher 1991; Gorman 1992; Fisher 1997; Graham 1997), feminist literature on the relationship between schizophrenia and women's experience (Al-Issa 1980; Warren 1987; Barnes & Maple 1992) and analyses of problems and troubles in psychiatric/therapeutic settings (Emerson & Messinger 1977; Buttny 1990;1996). I go on to draw on CA/DA work on membership categories, standardized relational pairs and attributing blame in talk (Sacks 1972; 1974; Watson 1978; Edwards & Potter 1992). I raise questions about how 'care' and experiences between patients and significant others are played out in clinical interactions, and in relation to gender understandings and schizophrenia. In the first part of the chapter I focus on the way care and carers are framed within interactions. I argue that professionals draw on membership categories and standardized relational pairs of mother-father, husband-wife (Sacks 1972) to gender carers and locate them in interrelationship with patients. Carers' experiences of care are interactional resources, shaped, interrelated with those of patients and gendered to accomplish problematisations, blamings and excusings. Care is framed as helping and not hindering professionals' plans for patients; professional care takes precedence and professionals know what is best for patients. Professional discourses appear to draw on, but do not necessarily reinscribe, notions of caring as a traditionally feminine activity to frame masculine care in more positive terms than feminine care.

In the second and major section of the chapter, I trace reconfigurations of definitions of trouble through the course of two meetings for patients who are in relationships with significant others. I discuss how paired relational categories, such as boyfriend-girlfriend, mother-child, wife-husband, which are also gender categories, are invoked and deployed by professionals, patients and others, to accomplish definitions of relational troubles. I argue that parties to trouble are gendered in particular ways to give sense to definitions and to blame and excuse. Drawing on the notion of gender as an omnirelevance (Garfinkel 1967) and "transportable identity" (Zimmerman 1998: 90), I argue that gender relational identities, having been made relevant by participants, are transported across subsequent stretches of talk as an unrestated relevance. On this basis I suggest that complex and contradictory understandings of femininity and masculinity are produced as troubles, blamings and excusings are accomplished. However, a preponderance of negative understandings are linked with femininity (e.g. submissive, frightened, dependent, selfish, using) to accomplish an association between femininity, blame and changeability. Concomitantly and relationally, positive attributes are associated with masculinity (awareness, honesty, caring, responsible), or negative understandings are reconfigured or extenuated, to accomplish excusings and attributions of unchangeability.

I argue that the notion of women's experience is more complex than the traditional feminist literature has conceived. Rather than having intrinsic meaning, experiences are complex and fluid resources (re)configured, interrelated and gendered within interactions and according to the activity at hand. Finally, I suggest that schizophrenia is not applied as a label within these discussions, nor does it produce an individualisation of trouble or automatically relieve those close to the patient of blame. Instead, generalised notions of 'mental illness' may be deployed, much like any other experience, to blame and assign wrongdoing or to excuse and allocate victim status. I conclude that professional understandings of femininity and masculinity, not schizophrenia, inform definitions of trouble, blame and change.

A traditional feminist approach has viewed women's experiences, particularly as mothers and housewives, as productive of mental distress, including schizophrenia (Al-Issa 1980; Warren 1987; Barnes & Maple 1992). This view suggests that (women's) experiences have intrinsic meanings which are reflected in language. However, the previous chapter has detailed the way that patients' experiences, including those related to motherhood and housework, are resources in clinical encounters, negotiated and shaped within interactions and informed by professionals' understandings of femininity and (masculine) personhood and assumptions about schizophrenia. The previous chapter focused on the individual biographies and experiences of patients, but in the era of community care patients are rarely leading atomised individual lives, rather they are surrounded by significant others. Many, but not all, patients have a "carer"; someone who is officially recognised and designated as the person who cares for the patient.[1] Carers and significant others attend CPA meetings and have to be taken into account in interactions and professionals' plans.[2] Thus professionals have to contend with carers and significant others and, in turn, these significant others come within the scope of professional discussion and consideration.

The general view appears to be that carers are an economic and emotional 'good'; people who take much of the caring burden off of professional services (Gorman 1992). Community care has also been framed as a gender issue. Women are said to bear the burden of care, confining them to a traditional caring role (Banton et al 1985; Showalter 1987; Ussher 1991; Gorman 1992); community care is a "euphemism for an under-resourced system which places a heavy burden...on individual women" (Gorman 1992: 14). Moreover, it may be the case that male carers receive a different and more positive response from professionals than female carers (Gorman 1992; Fisher 1997). However, the literature on gender and community care has been accused of marginalising

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[1] A carer may be a relative or anyone close to the patient who is willing and able to take on the role. Normally official carers are invited automatically to the patient's CPA meeting and the patient can also invite any other friend or relative s/he wishes to.

[2] An aspect that is clearly stated in the Code of Practice Mental Health Act 1983 (DH&WO 1997).

the experiences of both patients and male carers (Graham 1997; Fisher 1997). And, as with the feminist literature on women and schizophrenia, there is little consideration of the way the experiences of carers are formulated within interactions with professionals. There is some evidence that professionals' understandings of carers' experiences may be important in professional decision-making about admitting a patient to hospital (Barrett 1988; Jones 1993), but it is not apparent how notions of care are generally understood within clinical encounters, nor how discourses of care may be gendered.

Further, it is not clear how professionals' understandings of patients (and their experiences) may be constituted in relation to those of carers and significant others. The interrelated nature of patients' lives and the requirement for professionals to take carers and significant others into account in their interactions and plans suggests a potential for relational understandings. As such, a "personal trouble" can be reframed as a "relational one, and vice versa" (Emerson & Messinger 1977: 124). In therapeutic/psychiatric settings, problems become the object of professional scrutiny, evaluation and possible redefinition (Buttny 1996). It has been suggested that a psychiatric diagnosis individualises relational and social troubles (Chesler 1974; Davis 1986; Warren 1987), relieving those close to the patient of blame (Emerson & Messinger 1977; Warren 1987), however, in CPA meetings professionals are dealing with the ongoing troubles of patients living in the community with significant others and it may not necessarily be the case that significant others are always and automatically the victim. Emerson & Messinger's (1977) framework suggests that the meaning of trouble, the attribution of blame and the proposed solution are interactional processes. But we do not know how experiences between patients and significant others may be drawn upon and shaped within contemporary psychiatric interactions to define troubles and allocate blame, nor how gender understandings may be relevant to these activities.

Sacks' (1972; 1974) work on membership categories and membership categorization devices may be useful here.[3] Membership categories are common sense equivalent kinds

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[3] For example, in Barrett's (1988: 277) analysis, the understanding of the psychiatrist that the carer, as a mother and a nurse, was "caring in spite of the difficulties" was crucial in obtaining admission to hospital for her son. While Barrett does not explore the relevance of membership categories such as "mother" and "nurse" for the activity at hand (a psychiatric decision on whether the patient was sufficiently unwell to be hospitalised), it is suggestive that professionals may draw on membership categories such as "mother" as resources within interactions.

such as mother or husband (Sacks 1972; 1974; Antaki & Widdicombe 1998; Silverman 1998). Membership categorization devices (MCD's) are collections of categories that go together, for example, the MCD 'family' includes mother, father, child etc. (Sacks 1972; 1974). If one category from an MCD is used then another category from that MCD may also be relevant, what Sacks (1972: 219) calls the "relevance rule", e.g. mother is relevant given the use of child and vice versa. Categories within a collection may also be paired relationally in "standardized" ways, e.g. husband-wife, parent-child (Sacks 1972: 37). People not only draw on common sense knowledge about activities associated with members of particular categories, e.g. babies cry, but also a whole range of characteristics and features that might be expected of particular category members and relational pairs.

Membership categories can be deployed to accomplish many different kinds of interactional tasks. For example, a paired relational category "constitutes a locus for a set of rights and obligations concerning the activity of giving help" (Sacks 1972: 37), and membership categories can be deployed to negotiate and attribute blame in talk (Watson 1978, Potter & Wetherell 1987). As conversation and discourse analysts have demonstrated, blamings are one of the social actions that people accomplish in talk (e.g. Austin 1962; Watson 1978; Atkinson & Drew 1979; Edwards & Potter 1992). Moreover, when blame is attributed to one person, it can also excuse someone else as Edwards & Potter (1992) demonstrate in their analysis of Chancellor Lawson's resignation and Margaret Thatcher's response. It might be thought that if anyone is to be framed as a problem by professionals during meetings then the most likely candidates would be patients themselves, by dint of being patients. But the inclusion of significant others in professional discussions widens the scope for framing problems or troubles in relational terms, and for drawing upon the experiences of significant others as well as patients to do so.

This discussion about care, experience and relational troubles raises questions about how 'care' and experiences between significant others and patients are played out in the context of contemporary psychiatric case conferences, and in relation to understandings of gender and schizophrenia. What understandings of care are constituted in clinical interactions? How are experiences between patients and significant others formulated within interactions and in relation to gender understandings? How are troubles defined and blame allocated, and are understandings of schizophrenia relevant to these activities? I use extracts from CPA meetings to explore these questions, focusing on the way that patients are located in interrelationship with significant others and experiences become complex resources for formulating notions of care, defining troubles, allocating blame and deciding who should be the focus of professional intervention. I discuss how these interrelated experiences are framed in terms of gender understandings through the deployment of gendered membership categories and relational pairings.

1. Relational Understandings, Gender and Discourses of Care

I have suggested that community care as a gender issue should not be understood solely on the basis of who bears the burden of care and the experiences of women who do so (Banton et al 1985; Showalter 1987; Ussher 1991; Gorman 1992), but also in terms of how care, carers and their experiences are understood interactively within clinical encounters and how gender understandings may inform these discussions. In this respect, clinical encounters are an important site for producing and negotiating meanings of 'care', both in terms of how experiences of care are understood and for professional decision-making regarding future treatment for patients (Barrett 1988; Jones 1993). In this section, I discuss meetings for two patients whose carers are problematised by professionals, drawing out what 'care' means in this context, how carers' experiences and characteristics are shaped to support the problem, and the deployment of gendered membership categories and relational pairs to attribute blame for an unsatisfactory state of affairs.

1.1 The Mother is not Doing Enough: "the mother could be more helpful than she is"

The extracts in this section are taken from a meeting for a patient who has what could be termed a standard and traditional carer. Anne Green is the mother of Christine, a community patient, and they both attend the meeting along with Christine's young son Simon. However the extracts that follow are all taken from the intra-professional pre-meeting. In the first extract below the consultant explicitly frames Anne Green, "mother", as a problem in a sequence that begins and ends with "a bit of a problem" (lines 231 & 238). Sandwiched between these claims, the doctor provides evidence for the problematisation. Mother is depicted in terms of having an all-pervasive, behind-the-scenes influence over Christine, she is "the force behind (0.7) everything" (line 232). The extreme formulation, "everything", suggests that absolutely anything that is occurring can be attributed to "mother". This becomes even more problematic as "mother" is ascribed the wrong or, at best, grudging beliefs about Christine's illness. The problematic status of mother's disbelief about Christine's "mental illness" is predicated on the unexplicated assumption that the professionals know otherwise. And characterising this wrong belief as "deep in her heart" (line 233) suggests that it is deeply ingrained and strongly felt. The alternative ascription, "or if she believes it she believes it very grudgingly" (line 234), softens the preceding claim, but founds the notion that, either way, mother is a "problem".

Meeting 1 (pre-meeting) : Christine

231 Dr. N.: well I think theres a bit of a problem because I think honestly that the
232 kind of (1.8) force behind (0.7) everything is her mother and her
233 mother really still deep in her heart does not believe that Christines got
234 a mental illness or if she believes it she believes it very grudgingly and
235 I think she she doesn't really he::lp (0.8) um I think the mother could
236 help mo::re but I think the mother really is very ambivalent about (.)
237 encouraging Christine to be (0.9) y'know (1.0) under our sort of ca::re
238 (.) I think thats a bit of a problem
239 Claire (CPN): I I=
240 Dr. N.: =the mother could be more helpful than she is
241 Claire (CPN) : I agree I think the mothers quite a problem

Having established that mother is a problem, the doctor goes on to articulate the effect in terms of "help". As with the depiction of Anne Green's beliefs about Christine's illness, the degree to which mother does not help is worked down from not helping at all to the notion that she does help, but not enough. At the same time, mother's insufficient helpfulness is attributed to opposing feelings about the professionals' 'care' for Christine. This could be related to mother's wrong or grudging beliefs or a covert inference about Mrs. Green's attitude towards the professionals. Either way, the consultant founds the claim that mother has extensive influence over Christine, wrong or grudging beliefs about her illness and opposing feelings about professional care that prevent her from helping the professionals to help Christine. The doctor's reiteration that "mother" is insufficiently "helpful" (line 240) appears to be soliciting agreement from the other professionals and Claire, the CPN, not only concurs but strengthens the problematisation; mother is more than "a bit of a problem", she is "quite a problem" (line 241).

A number of inferences and attributions are founded in the doctor's problematisation. Firstly, that the role of carers is to help the professionals to care for the patient. Secondly, that the professionals, rather than the carer, know what is best for the patient. Thirdly, that mother is preventing, in some unspecified way, the professionals providing care for Christine; mother is to blame for whatever unsatisfactory state of affairs is pertaining. Finally, the problematisation is specifically gendered. In moving from "her mother" (line 232) to "the mother" (twice, lines 235 & 240, and mirrored by the CPN, line 241), Mrs. Green is not just a problem carer/mother but is a problem *as* a mother. Thus professional assumptions about the category of "mother", and associated activities expected of a member of that category (Sacks 1972; 1974) are incorporated into the doctor's assessment and add force to it; mother is not doing what mothers should do and that is to "help" those who are caring for her child. The problematisation of Anne Green is further enhanced in the next extract as the consultant formulates her understanding in relational terms. The doctor provides a depiction of mother that relies upon a specific contrast with father, although now her account moves back from the generic "mother" to "Mum" and "Dad", a move which personalises her assessment and suggests that she has personal knowledge. Her claim that she does not know Dad, mitigated by the fact that she has "spoken to him (.) a couple of ti::mes" (lines 278-9) works to suggest that she knows enough to make an assessment of him whilst reinforcing the notion that she *does* know what she is saying about Mum.

275 Dr. N.: I think Mum is (.) y'know I don't know Dad stays in the background so
276 we don't kno:::w
277 Claire CPN: mm
278 Dr. N.: what hes like (0.5) um (1.8) when I've spoken to him (.) a couple of
279 ti::mes and he seemed qui::et but sensible whereas Mum talks an awful
280 lot and is not always sensible and °often is very (.) lacking in good
281 sense° (2.0) so

The notion of Dad as a shadowy figure, "Dad stays in the background" (line 275), provides a strong contrast with the doctor's previous depiction of Mum as a "force" (previous extract, line 232). The doctor goes on to contrast Dad who is the strong, silent, reasonable type, "he seemed qui::et but sensible" (line 279) with Mum who is over-talkative, silly and nonsensical. In a three-part list which moves from "talks an awful lot" to "is not always sensible" to "often is very lacking in good sense" (lines 279-81), the list items work up Mum's lack of sense. In effect Mum is characterised in terms of the saying, 'empty vessels make the most noise'. The contrast between "sensible" Dad and "very lacking in good sense" Mum founds the relation of sense versus non-sense.

The doctor's depiction of mother in relational terms provides force to her assessment and problematisation; mother *becomes* nonsensical and thoroughly problematic through and in relation to father's sensibleness. The pause at line 281 followed by "so" leaves the other professionals to draw their own conclusions which the doctor feels no need to state. Whilst mother has been problematised and is to blame for an unsatisfactory state of affairs with Christine, it has not been made clear what it is exactly that "mother could help more" with. However, in the next extract the doctor specifies what mother should be doing more of, which draws on traditional assumptions of what mothers are for. The extract begins with the doctor's statement that "we could...discuss this endlessly...but" (lines 289-90) suggesting that the discussion has gone on too long and she wants to move things along. Now it becomes clear that what mother is not doing enough of is "caring for Simon", Christine's young son, and thus mother is to blame for the fact that "Christine can't do any of the things" (line 294-5).

289 Dr. N.: what I think what we need to do in this mee::ting because >we could
290 sort of discuss this< endlessly (.) um but what we need to do is say
291 look (.) these are the things you should be doing:: and what is going to
292 happen to Simon while you're doing them and Mums here so I think
293 we've gotta maybe get Mums commitment that she will (0.8) at least
294 help out in caring for Simon because otherwise Christine can't do >any
295 of the things< because shes gotta look after Simon

The "things" that Christine "should be doing" (line 291), are vaguely formulated but undoubtedly refer to professionally organised activities at the community centre. While Mum as a mother should "help out in caring for Simon", Christine's position as a mother is absent. The notion that "shes gotta look after Simon" conveys the sense that this is something of a burden and an impediment, an inference that also occurs in the main meeting.[4] Moreover, the claim that "she will (0.8) at least help out" (line 293-4) suggests that mother could be doing a lot more but this is the "least" she can do. Also, the problematisation and blaming of mother includes the notion that she must change her ways, "we've gotta...get Mums commitment that she will...help out" (lines 293-4).

Therefore the discourse of "the mother could help more" problematises Anne Green and draws upon gender understandings of the category of mother, and associated expectations and understandings regarding what mothers do in terms of caring for (grand)children and the obligation to "help" (Sacks 1972; Watson 1978; Potter & Wetherell 1987). This problematisation is enhanced by relational understandings of mother and father, non-sense/sense. In addition the problematisation of Anne Green is deployed to attribute blame to her; it is her fault that Christine does not attend activities at the community centre. In the process both Christine and Mr. Green are excused (Edwards & Potter 1992). Therefore Christine is located in interrelationship with her mother, and her mother with her father and these interrelationships are played out discursively to accomplish a problematisation and blaming in which professionals produce and make relevant gender understandings about mothers and mothering. Further, the professionals invoke and shape the beliefs, feelings and characteristics of Anne Green to support the problematisation and blaming.

In this account, 'care' is formulated as doing whatever is required to "help" the professionals care for the patient. As such, it is not so much a question of taking the caring burden off of the professionals (Gorman 1992) but rather of relieving the patient of a burden/impediment to enable the professionals to do more for Christine. However, in invoking the category of "mother" and associated understandings, the professionals are drawing upon a traditional notion of mothers as carers (Banton et al 1985; Showalter

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[4] The depiction of motherhood as a burden occurs when the doctor is countering Anne Green's resistance to the level of Christine's medication (see chapter four, section 3.1).

1987; Ussher 1991; Gorman 1992). Moreover, blame for the problem that Christine "can't do any of the things" is attributed to Anne Green so that she becomes the "wrongdoer", Christine the "victim" (Emerson & Messinger 1977: 130) despite the fact that Christine has "got a mental illness". In the next section, I explore the problematisation of another carer, this time the husband of a patient, where gender and relational understandings are also made salient but the apportioning of blame is less straightforward.

1.2 The Husband is Overdoing It: "her husbands become overprotective"

The professionals positioned Anne Green as a mother and made associated gender understandings about mothering relevant to problematising her as a carer. However, care is not understood solely in terms of insufficiency, nor does it necessarily rely upon associations with mothering. George Yellow is the husband of Diane, a community patient, and they attend the meeting together. As in the last section however, all the extracts below are from intra-professional discussions, this time in the post-meeting. The first extract is taken from a longer conversation regarding the problem of getting Diane out of the house (see previous chapter, section 1.1). Betty, the CSW, raises the possibility that it could be George Yellow who is the problem, initially framed in terms of insufficient encouragement.

Meeting 2 (post-meeting) : Diane
684 Betty (CSW): I'm not sure really that he encourages her to go out without him when
685 he said there oh shes not one for coffee mornings (1.4) um she did say
686 >to me once< oh George doesn't really like me to go out without him
687 Dr. N.: mm well I think hes overprotecti::ve I mean I think he is

The CSW's claim is supported by two contrasting verbatim reports of he says it is her, she says it is him. The first is a recirculation of something George has said during the main meeting and in response to Betty's attempts to persuade Diane to go the women's group. Betty's recirculation of George's discourse suggests that it is, in fact, Diane who does not like "coffee mornings" (a rather old-fashioned and perhaps trivialising term for women's group). However, Betty contrasts George's version with a reported conversation between herself and Diane which acts to counter George's version. The claim that "George doesn't really like me to go out without him" (line 686) suggests that George is a problem because he does not want Diane to go out, it is not Diane. Doctor North picks up Betty's problematisation of George and names it as "overprotective". The notion of "overprotective" changes the nature of the problematisation; it retains the idea that George is a problem but it reformulates what the problem is. The notion of "overprotective" suggests that George is *over*doing it; he cares for and protects Diane, he means well, but he is taking it too far. Thus George is still problematised but the problem is reframed from a negative characterisation to one that is more positive.

After a short interlude, the doctor returns to the problem of George which is presented in terms of further mitigation. The next extract opens with Doctor North invoking the membership category "husband" (line 699) which makes this category relevant to what follows and gives sense to it. She provides a series of mitigating factors which formulate George's experiences in such a way that the problematisation is worked down even further. This sequence begins with a reiteration of "overprotective" followed by "hes...not able to...let go:::", "he...sees himself as looking after her", and "he gave up his job...to look after her" (lines 700-702). The effect is to frame George as a good but misguided carer who is standing in the way of what is best for Diane but he cannot help himself. Giving up his job to look after her, the final part of the sequence, is a framing of George's experience which acts as a testament to his care, concern and self-sacrifice.

699 Dr. N.: I think her husband because she has been (1.6) really quite unwell over
700 over the years I think hes become overprotective and hes also (0.9) not
701 able to sort of (0.7) let go::: I mean he sort of sees himself as looking
702 after her he gave up his job really [to look af]ter her
703 Betty (CSW): [yes he did]
704 Dr. N.: so its hard for him to (0.7) to to sort of see her as independent

The invocation of the category of "husband" carries with it the inference of the relational pairing of "wife" and associated gender understandings; the force of George giving up his job to look after Diane works through the assumption that it is unusual for husbands to give up work to look after their wives, rather than vice versa. George may be a problem but he is framed as a worthy carer (Gorman 1992; Fisher 1997). Moreover this sequence also shifts the attribution of blame. The assessment of George is preceded by an accompanying assessment of Diane which suggests that she has been ill for a long time, "she has been (1.6) really quite unwell over the years" (lines 699-700). Now it is not simply that George "is overprotective" (previous extract, line 687), rather he has "*become* overprotective" (line 700, emphasis added) "because" (line 699) of Diane's long-term illness. The paired relation accomplished here is that of overprotective husband/chronically ill wife. The effect is to suggest that George is not to blame for this unsatisfactory state of affairs; he is wrong-headed and overdoing it but it is understandable given the situation, "so its hard for him" (line 704). In this way, blame is shifted away from George back to Diane and her illness.

Therefore the doctor problematises George Yellow through the discourse of "overprotective", but a series of mitigations downplays the extent of the problematisation, presenting George as a worthy carer whose behaviour is understandable. In a relational contrast between a caring, self-sacrificing husband and a chronically ill wife, gender assumptions about what might be expected of husbands and wives, who protects whom, who looks after whom, who gives up their job, shift the blame away from George and back to Diane; he is overdoing it but her illness is to blame. Thus Diane is a problem as well as George, Diane's illness is to blame for George being a problem, and George is largely excused (Edwards & Potter 1992).

The analysis of professionals' problematisations of carers suggests that 'care', in this psychiatric context, is not formulated in straightforward terms of taking the burden off of professionals (Gorman 1992). Rather, the formulations of "the mother could help more" and "her husbands become overprotective" suggest that carers do not always do what carers should (either not enough or too much) and therefore inhibit the treatment process and plans of the professionals. The role of community carers is framed in terms of helping the professionals to help patients and not impeding professional care. In the cases analysed here, that is construed in terms of taking a burden off of the patient or being less protective to enable patients to engage in professionally organised activities and be more independent. Moreover, carers are gendered within interactions in ways that draw upon but do not necessarily reinscribe caring as a feminine activity. Whilst 'care' is not formulated as the province of women, understandings of mothers and wives as traditional carers explicitly or tacitly inform professionals' definitions of the problem and attributions of blame for an unsatisfactory state of affairs; "mother could help more" but "its hard for him". In the process, and as a result of these gender understandings, George Yellow is framed in different and more positive terms than Anne Green (Gorman 1992; Fisher 1997).

Professionals' problematisations and blamings also deploy paired relational categories and associated understandings (Sacks 1972; 1974); mother lacks sense in relation to father being sensible, and is insufficiently helpful in relation to her mentally ill child burdened with a child of her own, and the husband is caring and self-sacrificing in relation to a chronically sick wife. In this way blamings and excusings are accomplished (Watson 1978; Edwards & Potter 1992); mother is blamed while father and Christine are excused and, through a series of mitigating factors, blame is shifted to Diane and her husband is excused. Thus problematisations are defined in relational terms in which the patient is not necessarily the "wrongdoer" and the carer the "victim" (Emerson & Messinger 1977: 130); in the case of Anne Green this relation is reversed whilst for George Yellow it is largely reinscribed. A generalised notion of "mental illness" or being "really quite unwell" is invoked and made relevant to the problematisations but in different ways and with different effects. Christine's "mental illness" is deployed to ascribe the wrong or grudging beliefs to mother in order to support the problematisation that she is insufficiently helpful. Whereas framing Diane as "unwell" works to shift George from wrongdoer to victim, in the way Emerson & Messinger (1977) suggest, and thus to excuse him of blame. Finally, included within these problematisations are intimations of who should change; Mrs. Green should change her ways and help to care for Simon, Mr. Yellow should let go, and Diane should be more independent.

Carers' experiences of care are resources within these interactions, invoked and shaped, understood in relational terms, and gendered to support problematisations, blamings and excusings. And this interactional work is largely accomplished in the "off-stage" context of intra-professional pre- and post-meetings where professionals' versions of carers' experiences are established in a domain where carers and patients do not have the opportunity to contest them, and problematisations and blamings can be "openly avowed" (Scott 1990: xii & 4). The discourses of care and problematisations discussed so far have focused on what Sacks (1972) calls standardized relational pairs, mother/father, mother/child, husband/wife. However, patients also have relationships with significant others, principally girlfriends/boyfriends, who play an important part in their lives. In the following section, I discuss professional problematisations of patients and significant others, tracing professionals' and patients' configurations and reconfigurations of relational understandings and attributions of blame. And I consider the extent to which gender can be construed as an omnirelevance (Garfinkel 1967) or "transportable identity" (Zimmerman 1998: 90) within these discussions.

2. Gender Categories, Experiences and Relational Troubles: (Re)Configurations of Problems and Blame

In their framework for analysing troubles as interactional processes, Emerson & Messinger (1977: 128-9) discuss two ways that "troubleshooters" may respond to relational troubles as conflict or deviance. If the trouble is responded to as conflict, the troubleshooter "adopts a stance of nonalignment" (pg. 128) whereas if it is deviance the trouble becomes defined in terms of a "wrongdoer/deviant" and "victim" (pg. 130) and the relational core of the trouble may be dissolved. Furthermore, a "deviant" is not only "morally condemned, but also...sided against" (pg. 131). It has been suggested that a psychiatric diagnosis (Emerson & Messinger 1977), particularly that of schizophrenia (Warren 1987), can dissolve the relational nature of troubles, defining the diagnosed party as deviant and excusing the other party of blame (Emerson & Messinger 1977). As such, relational and social troubles become individualised (Chesler 1974; Davis 1986; Warren 1987). However, the analysis in the previous section suggests that the fact that one party is a patient with a mental illness and the other a carer does not necessarily or automatically predefine who will be framed as wrongdoer and who as victim.

In this section, I explore relational troubles further through focusing on meetings for two patients who are involved with significant others as girl/boyfriends. In these meetings professionals, patients and others formulate and reformulate relational understandings to accomplish problematisations, blamings and excusings, and reconfigure parties to the trouble as wrongdoer and victim. Experiences between patients and significant others become complex resources shaped and reshaped to support contested definitions of trouble, blamings and who should be the subject of professional intervention. I consider what relevance understandings of schizophrenia, 'illness', and patient status might have for defining trouble and accomplishing blamings and excusings. And I draw on Garfinkel's (1967) notion of gender as an omnirelevance and Zimmerman's (1998: 90) more recent idea of gender as a "transportable identity" to argue that relational gender categories such as girlfriend and boyfriend, once invoked and made relevant to the interaction, do not necessarily have to be re-established turn-by-turn in order to continue to be relevant across a stretch of interaction.

2.1 Formulating Experiences and Configuring Problems: "he can be verbally abusive and physically intimidating...she doesn't feel confident enough" and "him as the patient not her as the patient"

In this section, I discuss how experiences between patients and significant others are formulated by professionals in relational terms which are gendered. And I explore how these experiences are deployed to provide an initial definition of the nature of trouble, and associated blamings and excusings. As Buttny (1990: 231) demonstrates in relation to couple therapy, "telling problems" also involves allocating blame and responsibility. I focus on meetings for Natasha and Ian. Natasha is a community patient who is in a relationship with Laurence, who is also a patient. She lives alone in supported housing and attends the meeting alone. Ian is an informal in-patient, although he is using the bed for "respite" (the doctor's term) and when he is not in hospital, he lives with his girlfriend and carer, Harriette. However Ian has refused to allow Harriette to accompany him to the meeting and instead attends with his mother, Mrs. Peach. The first extract is taken from Natasha's main meeting. The preceding discussions have focused primarily on Natasha's pregnancy. The extract below begins as Dr. South is coming to the end of reading out a report sent by Celia Beige, Natasha's housing support worker, who is unable to attend the meeting. Celia's report introduces the relationship with Laurence as a problem for Natasha, "her relationship with her boyfriend continues to cause concern for Natasha" (lines 301-2). However, flagging this section of her report as "areas of conCERN" (line 301) suggests that it is a problem for the professionals as well as Natasha.

Meeting 12 (main meeting) : Natasha

301 Dr. S.: areas of conCERN (1.3) her relationship with her boyfriend continues

302 to cause concern for Natasha on an occasional basis at times there can
303 be a few problems (.) he can also be verbally abusive and °physically
304 intimidating° (1.1) she has said she would like the relationship to end
305 but doesn't feel confident enough to finish it as in the past when she
306 has tried (.) to hes been intimidating and persistent

However, the report downplays the extent of the problem, it is intermittent rather than constant, whilst also hinting that there are other problems that the author is not naming. The nub of the problematisation is formulated within the report in relational terms. The membership category "boyfriend" is explicitly invoked here and coupled with "her relationship" (line 301) sets up and makes relevant the paired relation of boyfriend/girlfriend. This is followed by characterisations of Laurence which are sandwiched either side of an assessment of Natasha, which is presented as a verbatim report of what Natasha herself has said. Thus Laurence is abusive, intimidating and persistent ("verbally abusive and °physically intimidating°" and "intimidating and persistent", lines 303-4 & 306), and Natasha is insufficiently confident and in the relationship against her wishes ("she would like the relationship to end but doesn't feel confident enough" lines 304-5).

In this way, the report quickly moves from an initial formulation of the relationship as the problem to one in which both parties to the relationship are problematised, although one more than the other. The categories of girlfriend/boyfriend makes a gendered relational pairing relevant to the definition of the problem and provides sense to the experiences that are formulated: he is an abusive, intimidating and persistent boyfriend in relation to an insufficiently confident girlfriend who is in the relationship against her wishes. There is also an initial intimation of blame in Celia's report (Buttny 1990); both Natasha and Laurence are to blame for the unsatisfactory state of their relationship but the blaming is mitigated for Natasha, she has at least tried but is daunted by Laurence's response. Thus experiences between Natasha and Laurence are formulated in gendered and relational terms to support a definition of trouble in which Laurence is allocated the role of wrongdoer, Natasha as victim (Emerson & Messinger 1977).

However, in Ian's meeting an initial formulation of relational conflict is quickly reconfigured in a way which attempts to dissolve the relational nature of the trouble to position one party as deviant (Emerson & Messinger 1977). The extract comes from early on in the pre-meeting and begins with the doctor formulating the relationship between Ian and Harriette as a problem and the problem as being one of "conflict" between them. However, sandwiched either side of this problematisation are intimations that Harriette could be more to blame for this "conflict" than Ian. The claims that "shes (.) got all these ideas about Ia::n" and "she...wants to (2.4) be in charge of treating him almost" (lines 19 & 23-24) suggest that Harriette's ideas and behaviour are somehow inappropriate.

Meeting 16 (pre-meeting): Ian

19 Dr. N.: she shes (.) got all these ideas about Ia::n and yet (0.5) hes not very
20 (1.0) WE::lcoming of these ideas is he
21 Erica (ASW): no °not really°
22 Dr. N.: I think thats the problem of their relationship is (1.4) founded on this
23 conflict I mean she sort of wants to (2.4) be in charge of of treating him
24 almost=
25 Erica (ASW): =°yeah° (1.1) but his violence is there anyway (3.5) she she doesn't (2.0)
26 trust him to to tell us um (1.4) °whats° (1.2) its actually lost sight of
27 the fact that >that you know< its him as the patient and not her as the
28 patient (1.2) um (.) what I've suggested to her is that we have (   )
29 about it
30 Dr. N.: HA h well that sounds a good idea yes=
31 Erica (ASW): =as part of his care plan h h h h h h h h

The notion of "all these ideas" tacitly conveys a sense that Harriette's ideas are foolhardy, further warranted by the fact that they are not acceptable to Ian. And the inappropriateness of Harriette being in charge of treating Ian is predicated on the unspoken assumption that this is the role of the professionals, not Harriette. This initial formulation, therefore, presents the problem as conflict, but also intimates that Harriette is to blame for the "conflict" in the relationship. But at line 25 Erica counters the doctor's framing with a reconfiguration; Ian is violent, he is violent regardless of whatever Harriette does, and he is untrustworthy, "°yeah° (1.1) but his violence is there anyway (3.5) she...doesn't (2.0) trust him to...tell us um (1.4) °whats° (1.2)" (lines 25-26). Erica's reconfiguration explicitly problematises Ian and attributes the blame to him, excusing Harriette. The notion of "his violence" not only situates the violence as belonging to Ian but also potentially masculinises it (Hopper & LeBaron 1998). This sequence is left unfinished but there is also an intimation here that the professionals are only hearing Ian's side of the story and may not know what is really going on. Further, as Erica appears to be speaking on behalf of Harriette, the inference could be that it is the doctor who does not know.

This is followed by an ambiguous claim about who is the patient. The ambiguity lies in *who* has lost sight of who is the patient. Framed as "its", it could be Harriette (who is behaving like a patient), the professionals generally, or it could be a covert criticism of the doctor's formulation of the problem. However, this sequence founds the inference that Harriette is behaving like or is being positioned as a patient but Ian is the patient, not Harriette. Further, Erica's invocation of the gendered pronouns "<u>him</u>...not <u>her</u>" (line 27), produces a relational understanding in which the gender identities of the parties may be relevant. As such, this framing introduces a number of potential relevancies for the talk; that Ian and Harriette should be understood as a relational pairing, that this pairing is gendered, that the assignment of patient status has become blurred, that Harriette could be a potential patient, but that she should not be the patient in this relation where Ian has already been assigned that status. However, the doctor's exclamation at line 29, "<u>HA</u>", appears to use the ambiguity of Erica's statement to infer that Harriette may not be the patient but perhaps she should be; Harriette is tacitly positioned as a potential patient. In response Erica attempts to reinforce her previous claim regarding who is the patient ("as part of his care plan", line 31). The doctor's exclamation and Erica's laughter are similarly ambiguous; they could signal amusement at playing with the reversible identities of patient and carer and/or be a sign of some tension between them over their opposing interpretations.

The gender pronouns "its <u>him</u>...not <u>her</u>" are invoked to emphasise the patient status and gender of one party to the trouble in relation to the non-patient status and gender of the other and are deployed to claim that someone (although it is not made clear whom) has been wrongly reversing the patient/non-patient relation. This claim is occasioned within the interaction in response to the doctor's framing of Harriette as the problem and as part of redefining Ian as the problem: it is "his violence" and it is "<u>him</u> as the patient". The assigning of patient status *and* the gender pronouns are made relevant to Erica's redefinition; while Harriette may be controlling, have foolhardy ideas and want to be a co-colleague, when reconfigured in relational terms that are gendered he is violent and he is the patient, she is the non-patient. Thus, patient status in combination with a masculine identity accomplishes the allocation of Ian as wrongdoer and Harriette as victim. Erica has attempted to dissolve the relational nature of the trouble and position Ian as deviant.

Therefore, professionals deploy paired relational categories (Sacks 1972; 1974) such as boyfriend/girlfriend, and other relational understandings such as him/her, patient/non-patient, to accomplish definitions of the nature of trouble. Gender understandings are produced and made relevant to problematisations through the invocation of gender categories and pronouns so that Natasha is an insufficiently confident girlfriend in relation to an abusive and intimidating boyfriend, and Ian is a violent and untrustworthy masculine patient in relation to a feminine non-patient. Experiences between patients are interactive resources, invoked, defined and gendered to support a particular definition of the problem and accompanying blamings and excusings. As such, patients are located in interrelationship with significant others; significant others and their experiences become resources for understanding patients and their experiences, and vice versa.

Thus the formulation of "he can be verbally abusive and physically intimidating...she doesn't feel confident enough" configures the trouble as relational and allocates the role of wrongdoer to Laurence and role of victim to Natasha (Emerson & Messinger 1977). And discourses of "his violence" and "<u>him</u> as the patient not <u>her</u> as the patient" invokes a relational understanding in order to dissolve the relational core of the problem and position Ian as deviant, Harriette as victim. In this latter definition, patient status is explicitly deployed to assign the role of deviant in the way Emerson & Messinger (1977) suggest. However, the doctor's response infers that the distinction between patient and non-patient (carer) statuses may not be so clear-cut. It is suggestive that the assignment of categories of patient and carer, which might be thought to be clearly understood and differentiated, can take on a fluidity as the distinction between the two is accomplished and then blurred within the interaction.

In this section, I have discussed the way in which professionals formulate patients' and significant others' experiences to accomplish initial configurations of trouble and accompanying allocations of blame. In the next section, I continue with these two meetings in order to track the way that experiences are reconfigured in gendered relational terms to support redefinitions of trouble and alternative allocations or mitigations of blame.

2.2 Reconfiguring Experiences to Redefine Troubles: "maybe he'll grow up" and "they have a difficult relationship"

In this section, I continue with Natasha's and Ian's meetings to trace the fluidity and complexity that experiences and relational understandings can take on when definitions of relational problems are contested, and I discuss how differing versions implicate particular allocations of victim and wrongdoer (Emerson & Messinger 1977). I also consider how gender identities and categories may be "transportable identities" (Zimmerman 1998: 90) which, once invoked and made relevant, are transported across a number of turns of talk.

Firstly, I return to Natasha's meeting. As the meeting proceeds Natasha contests Celia's version of her experiences with Laurence, reformulating the nature of the problem and undermining the intimation of blame. The extract below begins with Natasha orienting back to Celia's report and attempting to counter it through her recirculation of "physically intimidating" (previous extract, lines 303-4, this extract, line 340). Natasha directly repudiates Celia's claim that Laurence is physically intimidating but reinforces the notion of verbal abuse. However, she is treading carefully here, moving from "hes hes" to "its" and back to "hes" which suggests some reluctance to attribute even verbal abusiveness to Laurence.

Meeting 12 (main meeting): Natasha

340 Natasha:	hes not exactly (.) physically intimidating hes hes but its more verbally
341	hes very verbally abusive
342 Dr. S.:	yes=
343 Natasha:	=y'know its the sort of thing that gives you a headache
344 Dr. S.:	yes yes=

345 Natasha: =you just wanna say go away Laurence you do=
346 Dr. S.: =yes uha
347 Natasha: y'know its:: not the sort of thing you want going on all the time=
348 Dr. S.: =°no no I know° have your parents met him
349 Natasha: yeah
350 Dr. S.: well maybe he'll GROW UP (0.6) maybe (1.7)
351 Natasha: °yeah° (1.6)

From this initial partial repudiation Natasha goes on to downgrade Laurence's behaviour even further. The notion that it "gives you a headache" (line 343) infers that the effect is minor in comparison, say, with physical intimidation and that Laurence is a bit of a nuisance rather than an abuser. In addition she deploys "you" four times in this sequence (lines 343, 345 & 347) which conveys the impression of an appeal to any general reasonable person. In this way Natasha reformulates and downgrades her experience with Laurence from abusive and intimidating to being with someone who is a constant nuisance, and would be viewed as such by anyone. The effect of Natasha's downgrading is to take much of the sting out of Celia's problematisation and blaming; Laurence is not much of a problem, just a nuisance who gives you a headache. And if Laurence is not such a problem then no one is really to blame; her response is what anyone's would be and there is little that is blameworthy.

After a series of agreements and encouragements for Natasha to continue, the doctor brings in "parents" (line 348). This could be an attempt by the doctor to press the link between Natasha's problems with Laurence and her parents as an alternative (and preferred) source of support. However, reintroducing the category of "parents" raises the potential relevance of the category child (Sacks 1972). Dr. South uses this to move to her formulation of the problem with Laurence. Now Natasha's reframing of Laurence as a nuisance is summarised by the doctor as immaturity, Laurence is positioned as a child who has not yet grown up "maybe he'll GROW UP" (line 350). The two pauses and use of "maybe" (twice) clearly convey the idea that it is not very likely that he will do so. The reframing of the problem in terms of Laurence as immature founds the inference that whatever Laurence is doing it is child*ish*, a thorough downgrading from Celia's initial formulation, and that the only change that can be expected of Laurence is maturational, not something the professionals can do much, if anything, about. It is no longer clear at this point in the meeting, who, if anyone, is to blame if the problem is a maturational one; Laurence may be a nuisance but the notion of a child who has not grown up mitigates blame.

Natasha's downgrading of Celia's initial framing of the problem, and the doctor's subsequent reformulation work to redefine the nature of the problem and allocation of blame. Celia's version allocates Natasha as victim, Laurence as wrongdoer, even though Natasha is partially to blame because she is not confident enough. And, while Natasha might be expected to press her claim as victim, she does not do so. Instead, her redefinition retains the semblance of the same allocation of victim and wrongdoer but downgrades the behaviour of the wrongdoer to a degree where it barely counts as wrongdoing at all. In turn, the doctor draws on Natasha's definition of her experience with Laurence to reformulate the trouble from wrongdoer/victim to one of conflict and non-alignment as one party is defined as a child and blame is mitigated.

In Ian's meeting the meaning of experience is also reconfigured, this time to redefine the trouble as mutual and reciprocal. However, in this case the effect is not simply to mitigate blame for Ian but to shift blame onto Harriette. The extract below follows on directly from the extract in the previous section. The final exchange between the doctor and Erica in the previous extract appears to mark a turn in the talk. Firstly, the doctor takes control of the interaction for several turns (Erica, "yeah yeah", lines 35, 38 & 40). Secondly, understandings of Ian and Harriette are now configured in relational terms as Harriette's experiences are framed in relation to Ian's and vice versa. As such, Erica's relational and gendered formulation of "<u>him</u> as the patient not <u>her</u> as the patient" has made relevant a relational understanding which is taken up in the subsequent talk. The extract continues with the doctor formulating an alternative assessment of Ian which counters Erica's version that Ian is untrustworthy. She draws on Erica's invocation of Ian's violence and shapes it to support a positive framing of Ian as aware and honest, "he is sort of a<u>ware</u> that they have a difficult relationship" and "he admits to feeling quite violent towards he::r" (lines 33-4 & 36-7). The doctor re-establishes the trouble as conflict with an overt sense of equivalence: it is the relationship that is the problem and both parties contribute, "they have a difficult relationship..they have a lot of <u>ro::ws</u>" (lines 34 & 36).

Meeting 16 (pre-meeting): Ian

32 Dr. N.: :no well is there any possibility of that because I think it is a real
33 problem because we've talked to Ian about it and he sort of is awa::re
34 that they have a difficult relationship=
35 Erica (ASW): =yeah yeah=
36 Dr. N.: =they have a lot of ro::ws he admits to feeling quite violent towards
37 he::r=
38 Erica (ASW): =yeah yeah
39 Dr. N.: and he hes even said things like one day I'm going to kill her
40 Erica (ASW): yeah yeah=
41 Dr. N.: =um=
42 Erica (ASW): =and she understands the ( ) as well she [wants to]
43 Dr. N.: [WELL BUT] then
44 what is she doing still living with him because hes being up front
45 about it=
46 Erica (ASW): =yeah
47 Dr. N.: um and he says its his flat and shes sort of living there because she
48 can't afford [to live anywhere else]
49 Erica (ASW): [well that's the tension be]cause he feels he can't kick her
50 out because (.) she she y'know she would then be rendered homeless
51 Dr. N.: yes and then she can't [y'know afford to to rent a place or what]ever
52 Erica (ASW): [so that puts a lot of pressure on him yes]
53 Dr. N.: and hes (1.9) got her living there because she sort of (0.7) well almost
54 insisted o::n it I don't think he he doesn't seem willing to have her there
55 but hes sort of got her there against his will

However, this overt formulation of equivalence and conflict is accompanied by a positive assessment of Ian which covertly implies that, perhaps, Harriette is not so honest and aware. Moreover, Ian's violence is subtly reframed from being "there anyway" (previous extract, line 25) to something that is directed "towards he::r" (Dr.N., lines 36-7) and as a result of the rows to which she is a party. The verbatim report of what Ian says, despite being an extreme statement, works to support the level of his awareness and honesty "he's even said things like one day I'm going to kill her" (line 39). In this way Ian is reformulated from generally violent and untrustworthy to aware and honest about his feelings of violence towards Harriette. The nature of the trouble, therefore, is subtly reframed as mutual, and there is an intimation that one party might be more aware and honest than the other, and that this other party may contribute to the violent feelings. The effect is to mitigate blame for Ian and, at the same time, tacitly infer that some blame should be allocated to Harriette.

Erica does not attempt to undermine the doctor's assertion of Ian's awareness but seeks to accord it to Harriette too, "she understands...as well" (line 42). However, the doctor immediately responds with evidence to the contrary which she interrupts Erica to propose; if Harriette understands the situation then why is she living with him, founding the 'Catch-22' inference that either Harriette is not aware (as the doctor has intimated) or she is aware (as Erica has claimed) but extremely foolhardy. This is followed up by a three-part list that begins with a reiteration of Ian's honesty, moves to a verbatim report that establishes Ian's rights of residence, and ends with a depiction of Harriette's behaviour as economic expedience, "hes being upfront about it...and he says its his flat and shes... living there because she can't afford to live anywhere else" (lines 44-8). The list items enable the doctor to reaffirm her assessment of Ian as honest whilst at the same time moving the topic away from Ian's violence and towards an alternative framing of the problem in which Ian has certain rights in relation to Harriette and Harriette's motives for living with Ian are cast in a dubious light. This relational reconfiguring of Ian's and Harriette's experiences strengthens the mitigation of blame for Ian and the reassignment of blame to Harriette.

In response to the doctor's invocation of Ian's rights of residence, Erica brings in his responsibilities in relation to Harriette. Ian is repositioned as caring and responsible, "he feels he can't kick her out", and Harriette as economically dependent and powerless, "she...would then be rendered homeless" (lines 49-50). Notice how "can't afford" is reconfigured in such a way that economic expediency is reframed as economic dependence. But in the process Erica also subtly redefines the sense of blame. The notion that this is the cause of "tension" and "pressure" (lines 49 & 52), implies that the *source* of pressure/tension is Harriette although neither party to the trouble is to blame. But the doctor immediately reproblematises Harriette and re-attributes blame to her; Harriette is demanding and forceful and it is actually Ian who is powerless, "she...insisted o::n it" and "hes...got her there against his will" (lines 53-5).

Therefore, several reconfigurations of the problem and accompanying blamings and mitigations are advanced and countered between the two professionals. By turns, he is aware and honest in relation to her being unaware of the difficulties, he is honest and has rights of residency in relation to her economic expedience, he is caring and responsible in relation to her being economically dependent and powerless and she is demanding and forceful in relation to him being powerless. The doctor's formulation of "they have a difficult relationship" reconfigures the trouble as relational and mutual. However, while both parties are to blame initially ("they have a lot of rows"), Ian's honesty and awareness appears to mitigate blame. In the final exchange between Erica and the doctor (lines 47-55), relational understandings, experiences and accompanying blamings and excusings are configured and reconfigured as firstly Harriette is blamed (his rights of residency versus her economic expediency), no one is to blame (his caring and responsibility versus her economic dependence and powerlessness), and finally Harriette is blamed again (her insistence versus his powerlessness).

The doctor's redefinition of the problem deploys discourses and accomplishes blamings and excusings that have been found to occur in other settings. Men who are violent have been found to define, excuse or justify their violence in such a way that they neutralise or minimise the act and its consequences (Scully & Marolla 1984; Adams et al 1995; Hearn 1996a) and staff in agencies that deal with abusive/violent men may recirculate the same excusing or justificatory discourses (Hearn 1996b). The discourse of "they have a difficult relationship...they have a lot of rows" portrays what is occurring as mutual and reciprocal, and works to minimise the violence and blame Harriette equally (Hearn 1996a), a blaming that is subsequently further mitigated for Ian and enhanced for Harriette.

It is clear that problems in this setting become public phenomena as professionals scrutinise, evaluate and define problems (Buttny 1996), and patients and other professionals reformulate definitions of the nature of troubles. The experiences of patients and significant others, therefore, become complex and fluid resources as they are invoked and shaped, formulated and reformulated to support or undermine definitions of the problem. As such, it is not only the case that the nature of the trouble has no intrinsic meaning (Emerson & Messinger 1977) but neither do the experiences of the parties to the trouble. Each configuration of the problem accomplishes a particular blaming and excusing (Buttny 1990) and different permutations of conflict and deviance, wrongdoer and victim.

But it is not immediately apparent whether the gendered relational pairings of boyfriend/girlfriend and him/her, invoked and made relevant to the initial definitions of the problems have continued across the interaction as unrestated relevances. As such, relevancies can be "manifested without being explicitly named or mentioned" (Schegloff 1997: 182; West & Zimmerman 1987; Ochs 1992), particularly in the case of gender which is an omnirelevant category (Garfinkel 1967) or a "transportable identity" (Zimmerman 1998: 90-91). That is, gender identities "travel with individuals across situations" and are therefore "potentially relevant in and for any situation and in and for any spate of interaction" (Zimmerman 1998: 90).[5] Invocations of boyfriend/girlfriend and him/her simultaneously orient to a relational and gender understanding. As such it may not be safe simply to assume that gender ceases to be relevant while the relational understandings (now decoupled from gender) continue to operate. Rather, it is feasible that the relational understandings continue as gendered relations without the necessity of reinvoking the gender identities of the parties at every turn of talk.

On this basis, as Natasha's and Laurence's experiences are reconfigured femininity is associated with reasonableness (rather than lack of confidence) and masculinity with being a nuisance and immaturity (rather than abusiveness and intimidation). In Ian's meeting, understandings of femininity and masculinity take on a number of contradictory meanings. Femininity is associated with lack of awareness, economic expedience, dependence, powerlessness and being demanding, and masculinity with violence, awareness, honesty, rights, responsibilities and powerlessness. The final exchange between the doctor and Erica becomes particularly interesting as they dispute who is powerless: masculine rights/feminine expediency is reconfigured as masculine responsibilities/feminine dependence and then reconfigured again as feminine

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[5] However, Zimmerman adheres to the CA convention that participants may be aware of gender identities without orienting to them. And he distinguishes between this sort of transportable identity and what he calls "discourse" and "situational" identities which are accomplished in moment-by-moment interactions.

demands/masculine subordination. It is not that any of these understandings are inherently feminine or masculine but rather that they are accomplished within the interaction as troubles are configured and contested in relational terms which, I have argued, are founded on gendered categories and gender relational pairings. In the final section I track the fate of the competing discourses formulated to define and redefine the problems in Natasha's and Ian's meetings. I trace the way that discourses are reconfigured or reaffirmed to accomplish (for the time being) a resolution to the nature of the trouble, an understanding of who is to blame, and who should be the subject of professional intervention.

2.3 Gendering, Blame and (Un)changeability: "she needs to stick up for herself...unless he suddenly matures" and "you rub each other up the wrong way.../she just wants to make use of the flat"

From the analysis in the previous sections it appears that patient status can be invoked to allocate blame for a relational trouble but patient and carer statuses can also be blurred as professionals accomplish definitions of trouble. And whilst an understanding of schizophrenia could be deployed to configure the problem and ascribe wrongdoing (Warren 1987) it has not been made relevant by any of the participants. Rather, formulations of patients' and significant others' experiences which, I have argued, are gendered are accomplished and reaccomplished to define the trouble and assign blame. As such, patient status does not pre-determine who is "sided against" (Emerson & Messinger 1977: 131).

In this section, I continue with Natasha's and Ian's meetings to explore the trajectory of competing discourses deployed to define their troubles. I track these definitions from Natasha's main meeting (where she downgraded a professional definition) to the post-meeting when she is no longer present, and from Ian's pre-meeting (where one professional reformulated the definition of another professional) to the main meeting where Ian and his mother participate in the discussion. I draw out what configurations of relational experiences and gender understandings are deployed to accomplish a (temporary) resolution to the nature of the trouble. I discuss how definitions of trouble and ascriptions of blame include formulations of changeability and intractability which inform who should be the subject of professional intervention. I also consider what relevance schizophrenia, patient status and notions of 'illness' have for discussions about relational troubles and allocations of wrongdoing.

I begin with an extract from Natasha's post-meeting where earlier themes of insufficient confidence and immaturity re-emerge together with other relational and gender understandings. The first point to note in the extract below is that a professional disagreement is occurring between Dr. South and Julia, the CPN, which started during the main meeting and has continued into the post-meeting. The disagreement can be glossed as whether Natasha should be referred to a social worker immediately or not. The extract below begins with the doctor providing evidence to justify her opinion that she should be. The doctor frames Laurence as an aggressive, noisy, disruptive child. The first depiction of Laurence as "very aggressive" is initially framed as something he *is*, and then corrected to something he *does* ("he he is he does", line 813), an important distinction between something that is internal to and part of the person and an external behaviour. The second depiction of Laurence is constructed as a three-part list in which the list items enable the doctor to move from behaviours associated with being very aggressive, which in an adult person could be frightening and harmful, and behaviour associated with a child, "screaming and shouting and having tantrums" (lines 814-5). The effect is to accomplish an understanding of Laurence's behaviour as aggressive but to downgrade the implications of that ascription.

Meeting 12 (post-meeting) : Natasha
813 Dr. S.: he is he does get very aggressive and I mean I can imagine as a
814 mother (.) she doesn't want (1.2) Laurence screaming and shouting and
815 having tantrums when shes got a child to look after=
816 Julia (CPN): =yeah (0.9) I I don't see it going that far
817 Dr. S.: you don't see her having the baby?=
818 Julia (CPN): =no I do::: I do see her having it cos shes happy and she seems to be
819 getting healthier and really better physically
820 Dr. S.: yes yes
821 Julia (CPN): °and OK° but I don't see their relationship °going (.) through the
822 normal y'know the normal sort of things°
823 Dr. S.: °o::h I don't kno::w° I think actually Laurence could think this is quite

824 a novelty:: I mean hes latched onto Natasha hasn't he?=
825 Julia (CPN): =mm

Sandwiched between these two depictions of Laurence, Natasha is emphasised as a "mother" (line 814). The category of "mother" enhances the notion of Laurence as a child, producing the relational pairing of mother and child and conveying the impression that Natasha will have two children to look after. It makes gender overtly relevant to the problematisation; Laurence becomes problematised in relation to Natasha *as* a mother, "as a mother (.) she doesn't want..." (lines 813-4). The category of mother suggests associated understandings in which Laurence's troublesome toddler-like behaviour becomes potentially disruptive to the true mother/child relationship and thus to Natasha's ability to be a good mother. What this relational pairing also accomplishes is a disappearing of any notion of Laurence as a father.

However Julia responds with a counter assessment that undermines the problematisation by dissolving the relationship; neither of the parties to the relationship are a problem if there is no relationship and she suggests that the relationship simply will not last. This is followed by a reiteration which infers that the relationship, or the parties to it, are not "normal" in some unspecified way, "I don't see their relationship °going (.) through the normal...sort of things°" (lines 821-2). Doctor South immediately counters this assessment by building on her previous relational formulation of Laurence and Natasha. The effectiveness of the counter relies on the paired relation of child/mother. Now Laurence's attitude to the pregnancy/baby is as a child to a toy ("novelty") and his relationship to Natasha is that of a child to its mother ("latched on"). Reworking it in this way conveys the notion that it may not be a "normal" adult relationship but that does not mean it will not last; it will be a mother-like and child-like relationship.

In the next extract the doctor moves to close the post-meeting with a final problematisation and attribution of blame which also includes ascriptions of who can and cannot change. The CPN has introduced the information that Laurence is going away and Natasha is "looking forward to him going" (text not included here). This provides Dr. South with the opportunity to close the argument. The extract begins with the doctor claiming that this is further proof of the problem and support for the need for a social worker, "thats why she needs some HELP" (line 831). Now Celia's report and original relational formulation is re-invoked, reformulated and combined with the doctor's own. Dr. South contrasts what Natasha should do with what she has been doing. Juxtaposing "stick up for herself" with "put up with" (lines 833 & 835) makes it clear that Natasha should "stick up" not "put up". The assessment appears to be drawing on Celia's earlier discourse of "she doesn't feel confident enough"; if Natasha is insufficiently confident then she needs help to be more assertive.

831 Dr. S.: I think thats why she needs some HELP
832 Julia (CPN): mm
833 Dr. S.: some quite skilled help in actually (.) being able to stick up for herself=
834 Julia (CPN): =mm
835 Dr. S.: because she has put up with all sorts of abuse from him=
836 Julia (CPN): =mm
837 Dr. S.: I think she must be quite frightened of him (1.1) but I mean what was
838 coming over from her is that she (1.3) she feels that um something
839 inside her tells her that this isn't right and I think shes (.) °shes right°
840 Julia (CPN): yeah
841 Dr. S.: unless he suddenly matures which I (2.8) I can't see happening

Celia's initial framing of Natasha mitigated blame with the idea that she had tried to do something but Laurence was frightening, but now the need for her to change and be assertive is due to how *she* behaves towards and feels about Laurence rather than Laurence himself. In a subtle move, "verbally abusive" and "physically intimidating", terms which were contested and downgraded by Natasha, are incorporated under the all encompassing umbrella of "all sorts of abuse" and the fact that Natasha has "put up with" this places the onus on her rather than Laurence. The notion that she "puts up with" suggests that she submits to the abuse, or at the very least lack of appropriate action on her part. And, where Laurence was "intimidating", now she is frightened of him, a subtle difference that resituates the problem in Natasha, "she must be quite frightened of him" (line 837).

Laurence has been problematised throughout the meeting, even if the problem has been downgraded and mitigated by his immaturity, but Natasha is finally the one who is problematised, she has "put up with...abuse" and she is "frightened of him". Now it is not so much Laurence's abusiveness/aggression or even immaturity that is the problem, it is Natasha's inadequacy in dealing with it. This problematisation is sandwiched between two blamings/excusings and notions of who should change. If Natasha is the problem and she should "stick up for herself", then responsibility is attributed to her to do something about the situation, she is to blame and she is the one who should change. In contrast, the final reiteration of Laurence's immaturity not only reasserts his child-like status, suggesting that he cannot be held responsible, but also reinforces the idea that he is not likely to change. The problematisation and blaming works through reformulations of relational understandings: she is submissive, frightened and needs to be assertive in relation to Laurence who is abusive, immature and unchangeable. The formulations of "put up with all sorts of abuse", and "she needs to stick up for herself" suggest that she has "brought-it-on-herself" (Caplan 1995: 91).[6] In effect, the professionals have excused Laurence by invoking immaturity and intractability and excused whatever abuse is occurring through blaming Natasha (Scully & Marolla 1984; Hearn 1996a; 1996b).

Therefore the definition of trouble is reconfigured in the intra-professional post-meeting in such a way that allocations of and distinctions between wrongdoing and victimhood are collapsed. Natasha appears to be allocated both roles as Laurence's child-like status and immaturity mitigate blame and preclude change. The formulation that she should "stick up" not "put up" retains the role of victim whilst also allocating blame and positioning Natasha as the one who can and should change (Buttny 1990). Thus Emerson & Messinger's (1977) distinctions are less clear-cut here. An alternative understanding might be that if he is abusive, then he is to blame and he should be the subject of professional intervention. However, through reconfigurations of relational understandings, responsibility is shifted away from Laurence and onto Natasha. Further, the initial gendered relational pairing of boyfriend and girlfriend is reconfigured: boyfriend becomes boy-child, girlfriend becomes mother. Natasha becomes framed as a frightened mother[7] who needs to be more assertive in relation to an abusive boy-child. In effect, his

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[6] For example, Caplan (1995) argues that the psychiatric diagnostic category of Self-Defeating Personality Disorder (SDPD) in the appendix of DSM-IIIR, represents a "victim-blaming, she-brought-it-on-herself attitude" (Caplan 1995: 91).

[7] It is noteworthy that Diane was also framed as a "frightened lady" (see chapter four, section 3.1). Although this depiction was invoked for very different interactional purposes, it does appear to be a co-term that is associated with femininity in professionals' formulations.

immaturity and child-like status makes her submission and fear more reprehensible and less understandable. Thus femininity is associated with being frightened, lack of assertiveness and changeability and masculinity with aggression, childishness, abusiveness and intractability.

In Ian's main meeting understandings of femininity are also associated with an attribution of blame and changeability as the professionals, Ian and Ian's mother reaffirm and build on the definition accomplished by the doctor in the pre-meeting. In the next extract, Mrs. Peach (Ian's mother), Ian and the doctor elaborate on, configure and reconfigure the problem and the doctor moves towards a resolution. The extract below begins with Mrs. Peach orienting to the relational trouble between Ian and Harriette. She makes a claim about Harriette presented as a verbatim report of what Ian has said, "Ian says (.) she knows where to press the buttons to upset him" (line 549). This verbatim report enables Mrs. Peach to found a blaming of Harriette while at the same time not 'owning' what might be construed as a highly contentious statement: it is what Ian says, not what she says. It suggests that Harriette provokes Ian (Scully & Marolla 1984; Hearn 1996a), placing the blame squarely on Harriette. Mrs. Peach presents this situation in terms of an extreme formulation which both suggests that it is irremediable and carries connotations of a war zone, "its a no go situation" (line 550).

Meeting 16 (main meeting): Ian

549 Mrs. Peach: Ian says (.) that she knows where to press the buttons to upset him (0.9)
550 its a its a no go situation shes a nice enough girl (.) but I think she has
551 a lot of problems herself (1.2) and it just isn't good at this point in time
552 with his illness as he is at the moment for them to be together it would
553 be nice if they could meet a couple of nights a week (1.4) and if it
554 doesn't work out Ian says well I'm going home...

564 Dr. N.: ...wha'd'you think of what your Mum said Ian do you agree with her?
565 or do you=
566 Ian: =its er totally true theres a bit of friction there because (.) I do love
567 Harriette and I think she loves me deep down >its just that< we can't
568 live together

569 Dr. N.: well that does seem to be the problem that you you you're not very
570 good at living together that you rub each other up the wrong wa::y?=
571 Ian: =°mm°
572 Dr. N.: so um has that been (0.8) agree::d to be a problem by everybody like (.)
573 by you and Harriette >well I mean< thats [the main people]
574 Ian: [Harriette isn't] thinking like
575 I am she still y'know she still wants to stay with me (.) I don't know
576 whether she wants to stay with me or whether she just wants to make
577 use of the flat I don't know
578 Dr. N.: well I think this is so I mean Erica do you feel you can have some
579 useful discussions there because I think this has gotta be clear because
580 I mean nobody can tell you who you should live wi::th

The statement that "shes a nice enough girl (.) but I think she has a lot of problems herself" (lines 550-1) works as a disclaimer which wards off in advance the suggestion that Mrs. Peach's assessment of Harriette may be based on personal feelings. It has the flavour of damning with faint praise, she is "nice enough", and the category and gender identity "girl" signals a possible downgrading of Harriette's status and the status of her relationship with Ian (Edwards 1998). As such it supports the notion of faint praise, and at the same time infers the gendered relational categories of girl and boy. The claim that "she has a lot of problems herself" implies what the doctor has inferred in the pre-meeting, that Harriette should or could be a patient. As such Mrs. Peach redresses a potential imbalance between the two parties, which could be a resource for allocating wrongdoing to Ian, without establishing equivalence. This subtle distinction becomes clear as she deploys the notion of Harriette as someone with problems to frame her as detrimental for Ian's wellbeing as someone with an "illness", "it just isn't good at this point in time with his illness as he is at the moment for them to be together" (lines 551-2). The qualifiers "this point in time", "at the moment" soften the force of her claim by suggesting it is only a temporary situation while at the same time founding the notion that Harriette is not good for Ian. She goes on to present an alternative and preferable arrangement. The potential relevance of "girl" and associated category of boy as a downgrading is put to work to frame their relationship in boy/girl terms, "it would be nice if they could meet a couple of nights a week" (lines 552-3).

Mrs. Peach's definition of the trouble is formulated in relational terms which make relevant the gender identities of the parties; Harriette is a girl with a lot of problems in relation to a boy with an illness. The not-quite-equivalence of Harriette's problems versus Ian's illness founds the irremediable nature of the problem and at the same time is suggestive that Harriette is to blame. However, Mrs. Peach's downgrading of Ian and Harriette's relationship occasions a response from Ian which reformulates the problem back to one of mutual reciprocity, for a time at least.[8] The doctor provides an explicit opening for Ian to respond to his mother's account. He opens with a claim that creates the impression of complete agreement, "its er totally true", whilst at the same time downplaying the extent of the problem, "a bit of friction" (line 566). The notion of "friction" suggests it is conflict, a mutual problem, reaffirming the doctor's discourse in the pre-meeting of "they have a difficult relationship". The relationship is depicted in terms of I can't live with her, can't live without her, a formulation of an adult loving relationship that counters Mrs. Peach's version.

However, there is a sense of non-equivalence encapsulated within this formulation; while Ian straightforwardly and openly declares his love for Harriette, "I do love Harriette", Harriette's love for him is hidden and more questionable, "I think she loves me deep down". In this way, he founds the can't live with/can't live without inference whilst presenting himself in a more favourable light than Harriette. In response the doctor affirms Ian's definition of the trouble. She draws on the notion of "friction" to summarise the problem in terms of conflict and mutuality, "you rub each other up the wrong wa::y" (line 570), a summary that she elicits Ian's agreement to. The implication is that they are each as bad as the other and they are both to blame. The doctor follows this with a question which initially seems to be soliciting "everybody"'s agreement to her definition but also introduces the notion that Harriette's agreement is required and covertly infers that this could be a problem. As such she provides a potential opening for Ian to reproblematise Harriette.

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[8] The ten lines that have been omitted from this extract involve Mrs. Peach claiming that Ian is using the hospital to get away from Harriette but that he came into hospital because he was "heading for a breakdown" which is perhaps an attempt to reorient the conversation back to Ian's medication. And the doctor's response has dismissed this attempt to redirect the conversation, "it doesn't matter what the reasons are for you being here".

Now Ian builds upon his non-equivalence with Harriette, interrupting the doctor to do so. She is framed as wrong-headed ("Harriette isn't thinking like I am"), unable to move on ("still" twice) and somewhat demanding and selfish ("wants", three times), (lines 574-6). He includes a stark contrast between loving and using which makes it even more doubtful whether she loves him and reaffirms the doctor's earlier formulation of Harriette in terms of economic expedience, "whether she wants to stay with me or whether she just wants to make use of the flat" (lines 576-7). Sandwiching this contrast between two proclamations of "I don't know" either enhances the notion of doubt thus working up the dubiousness of Harriette's feelings and motives and/or it is a "stake inoculation" (Potter 1997: 155) warding off what could be read as a motivated account. The effect is to undercut the definition of reciprocity and reformulate Harriette as the problem; a definition that the doctor affirms.

The doctor's final ascription in this extract supports this reading as she accords a similar sort of autonomy to Ian to that identified in chapter five in relation to purpose: he is accorded self-regulation over whom he lives with. Moreover, the extreme formulation "nobody" covers absolutely anybody who might say or act otherwise; Harriette, Mrs. Peach and the professionals, "nobody can tell you who you should live wi::th" (line 580). And Erica's discussions with Harriette are predicated on this autonomy, ("because" twice, line 579). Thus the doctor founds a notion of self-determination over living arrangements for Ian and a concomitant abrogation for Harriette: the professionals and/or Ian *can* tell Harriette whom she should live with. Moreover, this ascription establishes who can and should be the subject of professional intervention. Therefore, the problem is configured as mutual and reciprocal but Harriette is framed as the obstacle in the way of resolving the situation and thus she is the problem and she is to blame. The problematisation of Harriette is reformulated in relational terms; Harriette is reticent, not so loving, wrong-headed, unable to move on, selfish and using in relation to Ian who is open, loving and right-thinking and this understanding is endorsed by the doctor. In this formulation, any notion of Ian's "violence" is disappeared. Further, Ian's autonomy establishes who can be told who they live with (Harriette not Ian) and thus who should be the subject of professional intervention. At no time during this meeting has there been any discussion around the possibility that something could be done about Ian and "his violence".

In the final extract Mrs. Peach provides an explicit formulation of Ian's blamelessness which founds an accompanying understanding of intractability, and the doctor uses this to provide a final resolution of the problem. The extract begins with Ian attributing the idea of making Harriette homeless to his mother, suggesting that she does not understand his feelings or the nature of his relationship with Harriette. His use of "wife" (line 597) invests the relationship with depth of emotion and adulthood while simultaneously invoking a gendered relation in which he positions himself as husband in relation to "wife". Two paired relations are set up here: mother/son and husband/wife. The first pair sets up associated expectations of caring mother but reverses the association; mother is hard-hearted and she does not understand. The second pair of husband/wife sets up a number of associated obligations so that Ian's claim takes on the flavour of an appeal to any reasonable person, "you wouldn't see your wife on the streets" (lines 596-7). And the appeal is further heightened by the use of verbatim speech. The effect is to position himself as a caring and responsible husband in relation to a dependent wife.

595 Ian: I wouldn't I mean as as my Mother said to me if it were me Ian she
596 said I would've thrown her out a long time ago and I said yeah but you
597 wouldn't see your wife on the streets and you wouldn't
598 Mrs. Peach: it it the point is that at the moment its one good day and six bad its not
599 a way to live is it (.) it it normal people probably could cope with it but
600 Ians got an illness he's a:::lways gonna have that illness=
601 Dr. N.: =°alright°
602 Mrs. Peach: I can't make him into a perfect pi person you can't and Harriette won't
603 be able to (.) hes got an illness you've gotta abide by that and you've
604 got to (.) help him when you can how you can=
605 Dr. N.: =°mm°
606 Mrs. Peach: not antagonise it (.) and thats how I feel
607 Dr. N.: alright well I think I think y'know we're all sort of agreeing about (1.0)
608 tha::t and if Harriette were here maybe >she would agree too< but she
609 shes not here so its a >bit of a shame< she isn't but we'll have to leave
610 it with Erica that you discuss with Harriette? that so we've agreed that
611 it would be better for Ian if Harriette had her own place and then you
612 can choose how much time you spend together it would be a choice

Mrs. Peach responds with a contrast between "normal people" and Ian's "illness" (lines 599-600). Ian's depiction of a "normal" husband-wife relation is countered by an inference that neither the relationship nor Ian is "normal". The doubt surrounding whether normal people could cope with it ("probably") suggests that the relationship and or Harriette might be too difficult *even* for normal people. She goes on to formulate Ian's illness in terms which convey the notion that the illness is never going to change, "hes a:::lways gonna have that illness" (line 600). The effect is not only to undermine Ian's account of a normal husband/wife relationship but also to infer that Ian's illness mitigates responsibility for anything he does, including his violence (Scully & Marolla 1984). The notion that it will never change founds intractability; although it is the illness *not* Ian. The implication is that something/someone has to change and if it cannot be Ian then it will have to be Harriette.

Mrs. Peach goes on to provide a three-part list of the consequences of an unchangeable illness. In moving from "I can't make him into a...perfect person" to "you can't" and finally to "Harriette won't be able to" (lines 602-3), she founds the inference that if his mother and the professionals, who have his best interests at heart, cannot change it, then Harriette certainly will not. The order of items in this list, and the emphases, work to position Mrs. Peach herself as an emphasised first item, the professionals as the emphasised second item and Harriette as third. As such the inference is that she is the person with the greatest care and concern for Ian. This is reinforced by a contrast between accepting that Ian is ill and providing flexible "help", and "antagonise". The contrast suggests that Harriette is unrealistic and antagonises his illness. In effect, Mrs. Peach has unravelled Ian's relational understanding of husband/wife and formulated an alternative understanding in which Ian has an unchangeable illness and Harriette is unrealistic and makes the illness worse. In this reformulation, Harriette is clearly to blame and Ian is excused.

Ian and Mrs. Peach are doing all the discursive work for the doctor, recirculating and elaborating the problematisation and blaming formulated in the pre-meeting. In this respect, all the doctor has to do is to provide the right sorts of openings and then agree with the claims that have been formulated. And while Ian and his mother are disagreeing, it is only in respect of the *nature* of the relationship, not the fact that Harriette is to blame. Sandwiched between two affirmations of agreement (lines 607 & 610) the doctor provides a contrast with Harriette; it is unfortunate that she is not at the meeting, she might agree although some doubt is attached to this, and Erica will have to "discuss...that" with her (lines 608-10). The overall effect, and positioning within the sequence, suggests that regardless of whether Harriette agrees or not, she is completely outnumbered; *they* have all agreed. The solution is framed in terms of Ian's best interests and choice. Ian's well-being is prioritised and made contingent upon Harriette moving out, "if Harriette had her own place...it would be better for Ian" (line 611). And the notion of choice, "you can choose...it would be a choice" (lines 611-2) is ambiguous; it could be Ian's choice or both their choices although given the preceding discussion it is suggestive of it being Ian's choice.

Therefore the problematisations, blamings and excusings in the main meeting, formulated by Ian, Mrs. Peach and the doctor, largely recirculate, reaffirm and build on the doctor's discourse in the pre-meeting. In turn, Erica's definition of "his violence" and associated blaming of Ian is absent. It is either that Harriette provokes Ian's violence and makes his illness worse, "she knows where to press the buttons to upset him" and she "antagonises it"; Harriette is clearly to blame and Ian is completely excused (Scully & Marolla 1984; Hearn 1996a). Or it is a question of mutual reciprocity encapsulated in the formulation, "you rub each other up the wrong way"; both parties contribute to the problem although not in equal measure. Finally Mrs. Peach provides a third alternative which enhances the allocation of blame to Harriette; whatever Ian does is excused by his illness (Scully & Marolla 1984). In effect, Mrs. Peach deploys Ian's illness to excuse him of any wrongdoing and to allocate Harriette as wrongdoer, Ian as victim. Ian on the other hand is attempting to manage the dual problems of accomplishing the same allocations whilst also presenting his relationship with Harriette, and thus himself, as loving and adult. And the doctor is attempting to provide a formulation that can be agreed on by all the participants; the discourse of "you rub each other up the wrong way" accomplishes a definition of mutuality but one in which Harriette can be framed as the wrongdoer (she is wrong-headed, selfish, using and antagonises Ian's illness) and Ian as the victim (he is right-thinking, loving, caring, responsible and has got an illness).

Definitions of trouble, blamings and excusings are accomplished through (re)formulations of the parties' experiences which are framed in terms of relational understandings and paired relational categories (Sacks 1972; 1974) which are gendered. Harriette is a girl with a lot of problems in relation to a boy with an illness; Mrs. Peach is a hardhearted mother in relation to a caring son; and Ian is a responsible husband in relation to a dependent wife. As such, these gender identities and associated understandings are made explicitly relevant and deployed to accomplish particular activities within the talk.

However, and further to the notion of gender as a transportable identity, this does not necessarily mean that gender ceases to be relevant in the subsequent turns of talk. Rather, the understanding of a boyfriend/girlfriend relation is relevant throughout these exchanges and pertinent to the relational formulations accomplished. As such, the gender identities and gendered relation of the parties to the trouble may *only* be made explicitly relevant when a participant is attempting to reconfigure what the relation *means*. Thus boyfriend-girlfriend is reconfigured to girl-boy, then to husband-wife. On this understanding the girlfriend-boyfriend relation is a background relevance throughout and acts as a flexible resource whose meaning can be downgraded or upgraded according to the activity at hand. On this basis femininity and masculinity are associated with a range of understandings. Femininity is allied with reticence, being wrong-headed and selfish, using and dependence, and masculinity with being loving, right-thinking, caring and responsible. Finally, through these gendered relational pairings, it is Harriette who is identified as the subject of intervention/change and Ian who is positioned as unchangeable; either he *cannot* be changed because he has got an unchangeable illness, or he *should not* be changed because he is an autonomous being who cannot be told whom he lives with. A summary of this section will be included in the conclusion below.

Conclusion

In the era of community care patients lead interrelated lives. Significant others are a resource for professionals' understandings of patients in relational terms, and vice versa. Professionals' discourses of care, definitions of trouble and negotiations of blame are accomplished through the deployment of membership categories and standardized relational pairs (Sacks 1972; 1974; Watson 1978), which are gendered, and a whole range of gendered relational understandings. In these negotiations, experiences between patients and significant others are complex and fluid resources configured and reconfigured in gendered relational terms to support definitions, blamings, excusings and implications of change.

The formulations of "the mother could help more" and "her husband's become overprotective" configure these carers as not doing what carers should and accomplishes an understanding of the role of community carers as helping and not inhibiting the professionals to help patients. Care is framed in terms of doing whatever the professionals deem necessary to enable patients to follow the course of action the professionals prescribe, rather than taking the burden off of professionals (Gorman 1992). Professionals draw on membership categories (Sacks 1972; 1974) and associated understandings to gender carers within interactions; mother is not doing enough as a mother, and the husband is overdoing it but it is understandable for a husband. These discourses appear to draw on understandings of caring as a traditional feminine activity to inform definitions of an unsatisfactory state of affairs. The effect is to frame masculine care in more positive terms than feminine care (Gorman 1992; Fisher 1997) but contrary to the literature on the gendering of care (Banton et al 1985; Showalter 1987; Ussher 1991; Gorman 1992), care is not reinscribed as a feminine activity per se.

Professionals deploy "standardized" relational pairs (Sacks 1972), mother/father, husband/wife, and associated gender understandings to enhance problematisations, and accomplish blamings and excusings (Watson 1978). Mother lacks sense in relation to father being sensible, and the husband is caring and self-sacrificing in relation to a chronically sick wife. When these gender understandings come into play, patient and carer statuses do not necessarily determine allocations of wrongdoer and victim (Emerson & Messinger 1977). Patients are therefore located in interrelationship with carers and significant others and these interrelationships are played out discursively within interactions. Gender relational understandings about mothers and fathers, husbands and wives are produced to accomplish problematisations, blamings and excusings. Carers' experiences of care are interactional resources formulated, shaped, interrelated and gendered by professionals to support the activity at hand.

When significant others are girlfriends or boyfriends, and professionals' (re)configurations are traced through the course of meetings, the interrelated and negotiated nature of experience is even more evident. Once again paired relational categories and associated understandings (Sacks 1972; 1974), boyfriend/girlfriend, him/her, patient/non-patient, mother/child, girl/boy, wife/husband, most of which are also gender identities, are deployed to accomplish definitions of relational troubles. Natasha is an insufficiently confident girlfriend in relation to an abusive and intimidating boyfriend, or a nurturing mother in relation to an aggressive, disruptive child. And Ian is a violent, masculine patient in relation to a feminine non-patient, or a boy with an illness in relation to a girl with problems, or a responsible and caring husband in relation to a dependent wife. Parties to the trouble are gendered in particular ways, drawing on features that might be expected of such pairings, to give sense to the definitions and to accomplish blamings and excusings. The formulation of "he can be verbally abusive and physically intimidating...she doesn't feel confident enough" configures masculine abuse and intimidation as a problem in relation to feminine lack of confidence and suggests that both contribute to the problem but he is mainly to blame. Whereas, the notion of "his violence" and "him as the patient not her as the patient" frames a violent masculine patient as clearly to blame in relation to a feminine non-patient.

Drawing on the notion of gender as an "omnirelevance" (Garfinkel 1967) and "transportable identity" (Zimmerman 1998), I have argued that the relational gender identities of the parties, once invoked and made relevant by participants, are transported across subsequent stretches of talk as an unrestated relevance. The relational formulations produced by professionals, patients and others are also accomplishing gender. Complex and contradictory relational understandings of femininity and masculinity are produced within the talk as troubles, blamings and excusings are configured and reconfigured. In Natasha's meeting feminine lack of confidence in relation to masculine abusiveness and intimidation is reconfigured as: feminine reasonableness/masculine nuisance and immaturity; then as mother/masculine aggression and childishness; and finally as feminine fear, lack of assertiveness and changeability in relation to masculine abusiveness, immaturity and unchangeability. And in Ian's meeting an initial configuration of masculine violence and patient status in relation to a feminine non-patient runs through a long series of reconfigurations: masculine awareness and honesty/feminine lack of awareness; masculine rights/feminine economic expedience; masculine responsibilities/feminine dependence and powerlessness; masculine powerlessness/feminine demands; masculine lovingness and right-thinking/feminine wrong-headedness, selfishness and usage; masculine care and responsibility/feminine dependence; and finally, masculine autonomy and unchangeability/feminine changeability.

The meanings of femininity and masculinity are fluid and may even be reversed (as in who is powerless), but there is a preponderance of socially undesirable or derogatory characteristics associated with femininity (e.g. frightened, dependent, selfish, using) and positive attributes associated with masculinity (e.g. aware, honest, right-thinking, caring, responsible).[9] Further, negative framings of masculinity are reformulated into positives or extenuated by notions of immaturity. Associations between femininity, dependence and being frightened, and between masculinity and self-regulation were also identified in chapters four and five, suggesting that these gender understandings are regularly deployed in this context although for a variety of different purposes. In this chapter, understandings of femininity are deployed to attribute blame for an unsatisfactory state of affairs or relational trouble (a mother not doing enough, a sick wife, a frightened and submissive mother, a wrong-headed, selfish, using girlfriend), and understandings of masculinity to mitigate or excuse (a caring and self-sacrificing husband, an immature boyfriend, a loving, right-thinking, and responsible boyfriend). Notions of femininity position certain patients and carers as the subjects of professional intervention/change and thus change*able* (she should help more, be more assertive, move out). Concomitantly and relationally, notions of masculinity position other patients as unchangeable (he is unlikely to grow up, he cannot be told whom he lives with).

Therefore interrelated lives are discursively constituted and played out within clinical encounters. The experiences of patients and significant others are (re)configured, interrelated and gendered to accomplish particular definitions of trouble, blamings and mitigations. Rather than having intrinsic meanings, experiences of care, understandings of mothers or wives, relationships between girlfriends and boyfriends are resources within interactions invoked, given meaning and deployed according to the activity at hand, suggesting a more complex picture of women's (and men's) experiences than in the

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[9] While some of these positive notions of masculinity are produced by the patient, they are affirmed by the doctor and used to support the resolution of the nature of the trouble and what should be done.

traditional feminist literature (Al-Issa 1980; Warren 1987; Barnes & Maple 1992). As such, the very notion of who is and is not/should not be significant is constituted and negotiated within psychiatric interactions.

Just as the experiences of patients and significant others have no intrinsic, pre-defined meaning, neither does the nature of trouble (Emerson & Messinger 1977). Allocations of wrongdoer and victim are (re)configured as the nature of trouble is (re)defined. In Natasha's meeting, an initial definition of trouble in which Laurence is the wrongdoer, Natasha the victim, is reconfigured via the discourse of "maybe he'll grow up" to one in which blame is mitigated. However the formulation of "she needs to stick up for herself...unless he suddenly matures" maintains the relational nature of the trouble but assigns the roles of both victim and wrongdoer to Natasha and excuses Laurence. In Ian's meeting the initial configuration dissolves the relational core of the trouble, assigning Ian as deviant and Harriette as victim. However, the notion that "they have a difficult relationship" re-establishes the relational nature of the trouble, redefines it as mutual, and shifts wrongdoing away from Ian. Finally, the formulations of "you rub each other up the wrong way" and "she just wants to make use of the flat" reverses the allocation of wrongdoer and victim.

Thus definitions of trouble which initially draw on understandings of masculinity in terms of violence and abusiveness are reconfigured, via gendered relational understandings, to reverse the assignments of wrongdoer and victim. Notions that she brought-it-on-herself (e.g. "doesn't have the confidence", "put up with all sorts of abuse", "frightened of him", and "needs to stick up for herself) or that it is mutual (e.g. "they have a difficult relationship" and "you rub each other up the wrong way") attenuate or conceal earlier attributions of violence and abusiveness[10] and appear to circulate discourses identified in other contexts (Scully & Marolla 1984; Adams et al 1995; Caplan 1995; Hearn 1996a; 1996b). Once again, professional pre- and post-meetings are a powerful institutional practice that enable professionals to assert their authority to decide what experiences

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[10] However, while Ian's "violence" in relation to Harriette is disappeared and excused, it is reinvoked, reassigned and reproblematised in relation to the professionals in the post-meeting. For example, Dr.N: "its predictable once hes on the booze then hes going to start hitting people and and that includes me"/ Martin (CPN): "its not even he knows me when you walk in you you you can't you can't take that chance"/ Dr.N.: "no I I I know I've seen him very psychotic and and I mean I wouldn't even be y'know". Thus it is not the case that Ian either is or is not "violent" but how he is understood in relation to others.

mean. However, professionals may also contest definitions amongst themselves and patients may exercise power over significant others by refusing to allow them to attend meetings[11] and thus facilitate the founding of their version. In addition, as we saw in Ian's meeting, professionals may also collude with patients' definitions.[12]

Furthermore, professionals' understandings of schizophrenia are not made relevant to definitions of trouble or allocations of deviance and wrongdoing. Schizophrenia is not applied as a label at all within these discussions in the way labelling theory would predict (Rosenhan 1973). Nor does this diagnostic category produce an individualisation of trouble (Chesler 1974; Davis 1986; Warren 1987) or necessarily relieve those close to the patient of blame (Emerson & Messinger 1977). Rather, troubles are defined through relational understandings, distinctions between patient and carer statuses can have a certain fluidity and generalised notions of "mental illness" are an experience and resource much like any other. Such notions can be deployed to attribute blame and assign wrongdoing *or* to excuse and allocate the role of victim.

In this chapter, I have argued that patients are located in interrelationship with significant others in psychiatric interactions. Experiences are complex and fluid resources, interrelated and gendered to accomplish definitions of trouble, blamings, excusings and decisions regarding change. In particular, negative discourses of femininity are deployed to accomplish an association between femininity, blame and changeability in relation to notions of masculinity which work to excuse and found unchangeability. However, understandings of schizophrenia do not intersect with definitions of trouble or assignments of wrongdoing. Rather, broader notions of "patient" and "illness" are resources that can be deployed either for blaming or excusing. As such, it is understandings of femininity and masculinity, not schizophrenia, that inform definitions of trouble, blame and change. In the next chapter, I draw together the conclusions of the thesis.

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[11] It is the patient's decision who is invited to meetings in a non-professional capacity.

[12] For example, in Ian's main meeting the doctor provided openings for Ian and Mrs. Peach and then agreed with their definitions of the nature of the trouble, and blaming of Harriette.

Conclusion

This thesis has used a discursive approach to examine contemporary psychiatric/patient interactions in CPA meetings for patients with a diagnosis of schizophrenia. I have identified co-existing relations of benevolent psychiatry/responsible patient and supervisory psychiatry/untrustworthy patient which produce considerable professional persuasion and negotiation, patient resistance and professional concessions to dispreferred options. But professional power is reasserted through discourses of pathology, the institutional practice of pre- and post-meetings and occasional understandings of femininity. Within these relations, professionals are more concerned with restoring lives than enforcing gender conformity, however understandings of femininity and (masculine) personhood inform and differentiate restoration to purposes and autonomies, as discourses of (in)dependence, emotions and activity take on a plurality of meanings. Within these negotiations, the experiences of patients and significant others become fluid and complex resources configured and reconfigured in gendered and relational terms to inform the restoration of lives, and to accomplish definitions of trouble in which understandings of femininity are associated with blame and change, those of masculinity with excusing and unchangeability. Finally, within CPA meetings, schizophrenia is not applied as a label and is rarely named at all, although it does operate as a background understanding.

This suggests a more complex and differentiated picture of the relationship between gender, schizophrenia and contemporary psychiatric power than in the feminist and sociological literatures. My central argument is that the interplay between locally accomplished power and the broader mandate of community care produces co-existing practices of professional benevolence and control at the local level which have a number of implications for the relationship between gender and schizophrenia. Professional assumptions about schizophrenia, rather than gender, intersect with discourses of responsibility, supervision and choice producing a simultaneous encouragement and limitation of self-regulation for patients. In turn, professionals' discourses of femininity and (masculine) personhood intersect with understandings of schizophrenia to differentiate and delimit restoration to purpose and autonomy. However, professionals' understandings of femininity and masculinity, rather than schizophrenia, are major resources for negotiating and defining trouble, blame and change.

I began with an initial exploration of how contemporary psychiatric power unfolds within local encounters and the professional/patient relations that are constituted. I suggested that psychiatric practices are formulated in terms of "help", "advice" and "persuade" producing a relation of benevolent, persuasive psychiatry and responsible, voluntary, co-participatory patient, which was reinforced by discourses framing compulsion as a last resort. I identified the theme of "forget" as a particularly important means for assigning patient responsibility for taking medication and keeping appointments. However, professional orientations to "see"ing and "monitor"ing constitute an alternative, co-existent relation of supervisory psychiatry and untrustworthy patient and, together with consumer themes which restrict meaningful choice, indicate the limits of responsibility and participation for this set of patients.

I explored these issues further through considering where points of patient resistance and professional reassertions of power occur within interactions. Patients appropriate and reformulate professional discourses of choice and responsibility to resist professionals' plans and assessments, temporarily disrupting psychiatric authority. Through formulations such as "I need a couple more weeks to make up my mind", "I worry about the long term effect" and "sorting what I'm thinking", choice is reconfigured as something that requires time and thought, responsibility becomes responsibility for long-term health or for self-healing and self-understanding, and self-help is prioritised over professional help. These localised everyday forms of resistance ultimately reaffirm professional discourses of choice and responsibility but are not insignificant in terms of the practical effects for patients' lives and securing professionally dispreferred outcomes.

I identified intra-professional post-meetings as an important context and institutional practice for reasserting professional power in response to patient resistance. Post-meetings are a site for a professional "hidden transcript" enabling explicit ascriptions to be forwarded in an "off-stage" context where patients do not have an opportunity to contest them (Scott 1990: 14). In particular, (re)ascriptions of pathology are deployed which draw on professionals' understandings of schizophrenia, for example, "she doesn't believe theres an illness" and "still psychotic", to undermine patient discourses and re-establish professional authority. However, while patient resistance is small-scale and temporary, and professional ascriptions of pathology bear a resemblance to Goffman's (1968) analysis of psychiatric responses in the asylum, dispreferred professional concessions elicited by patients during main meetings are not overturned. I also suggested that professional understandings of femininity, such as "frightened lady" and "single Mum", are an occasional resource for reasserting professional authority, deployed when useful, overridden when not. I argued that this occasional deployment of feminine gendering did not concur with traditional feminist accounts of psychiatry pathologising female patients (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992). Instead, patients are pathologised without recourse to gender understandings, and feminine genderings are only an occasional response to resistance.

Psychiatric power and patient resistance are accomplished within interactions and I traced some of the turn-by-turn interactional moves deployed by participants, such as interruptions, direct questioning, partial repeats and defending claims (Scheff 1968; West 1984; Mehan 1990; Mellinger 1995). But I also argued that broader legislative concerns are incorporated into interactions. Professional discourses of compulsion as a last resort, patient voluntarism and participation and, in particular, patient responsibility for medication and appointments suggest that the uncertain limits of professional compulsion and patient rights (Gostin 1983; Mental Health Act 1983; Jones 1993) are played out within local encounters. Professional concessions to dispreferred actions and reluctance to engage with topics that undermine the benefits of medication are further indications of professionals incorporating wider legislative and rights discourses into interactions, and an awareness of broader concerns regarding community patients. Moreover, broader discourses which specify the institutional practice of intra-professional post-meetings are a powerful determinant of who has the last word.

I argued that while schizophrenia is not explicitly articulated in association with core psychiatric practices and professional/patient relations it nevertheless operates as an important background understanding for professionals, intersecting with discourses of responsibility, supervision and choice to frame patient self-regulation as necessary yet limited. Further, understandings of schizophrenia are an explicit resource for (re)ascriptions of pathology and thus reassertions of professional authority. As such, it is professional assumptions about and understandings of schizophrenia, rather than gender, that underpin these discourses; notions of patient responsibility, choice and supervision are not differentiated by gender.

From the analysis of psychiatric practices and professional/patient relations I suggested that there is considerable professional persuasion and negotiation at the local level indicating that professional understandings of gender and patients' experiences will not be simply imposed on patients; opportunities are likely to open up for negotiating and contesting meanings. But professionals may be less benevolent and more controlling when patients' versions do not concur with their own, and intra-professional pre- and post-meetings are likely to be contexts where professionals (re)assert their definitions of gender and experiences.

These psychiatric practices and professional/patient relations suggest that contemporary psychiatry is more concerned with encouraging self-regulation within local encounters (Miller 1986; Rose 1986b; 1989; Lunbeck 1994) than straightforward repression and social control (Laing 1967; Szasz 1973; 1974; 1976; Chesler 1974). Relations are not simply those of powerful psychiatrists and subjugated patients; patients resist professional plans and assessments and professionals concede to dispreferred options. Moreover, professionals seek to "invest" patients' subjectivity through the encouragement of responsibility and choice (Miller 1986: 32). However, at the same time they retain elements of social control through supervision of patients and restriction of meaningful choice. As such, contemporary psychiatry at the local level is a both controlling and persuasive discipline in relation to these particular patients. And while professionals largely retain their dominance, there are indications that psychiatric power is constrained in some measure by wider 'rights' discourses.

Having established what kind of relations are constituted between professionals and patients in local encounters, and where points of resistance and reassertion of professional authority occur, I turned to an explicit focus on professionals' gender understandings and intersections between gender and schizophrenia. I began by considering discussions about restoring patients' lives. I traced the way professionals position women as "women" and draw on related understandings of femininity to interweave purpose and independence. Themes of "shes stuck in the house", "she doesn't have any friends" and "she does get dependent" problematise home, loneliness and emotional dependence for "women" and feed into the proposed solution: doing something independent from home and family in a professionally organised activity/environment that is "just all women". In contrast, other patients are positioned as (masculine) "people", and their emotions are assigned external causes and/or dependence is framed as practical. Through the theme of "he'll do what he wants to do", these patients are ascribed an independence construed as self-regulation over how they spend their time, which is disconnected from purposefulness. Such ascriptions of autonomy may be invoked in response to patient resistance, working to affirm that resistance, although they are not dependent on it.

Professionals' understandings of femininity and (masculine) personhood cannot be viewed as assessment of performance on gendered tasks (Busfield 1989; 1996), or enforcing gender conformity in a straightforward or traditional sense (Chesler 1974; Al-Issa 1980; Barnes & Maple 1992), nor as a feminisation of all patients (Szasz 1976). Rather, these understandings subtly inform and differentiate notions of purpose and autonomy. In the process, traditional associations between women and home are overturned as home is framed as psychologically unhealthy for "women" and somewhere to be got away from, although home remains problematised for "women" in a way it is not for (masculine) "people". Further, viewing these discourses in terms of women being more emotional and less independent than men or adults (Broverman et al 1970) underplays the plurality of professionals' understandings: emotions, (in)dependence and activity have a diversity of meanings in discussions about restoring patients' lives. However, while professionals are more concerned with restoring lives than gender conformity (Allen 1986), the psychiatric project of re-making individuals back into purposeful, autonomous subjects (Rose 1989) is finely differentiated by understandings of femininity and (masculine) personhood within clinical interactions.

Professionals' understandings about schizophrenia are also relevant to discussions about restoring lives. Formulations such as "its unlikely but perhaps in the future" and "this gentleman can't have paid employment because he has schizophrenia" suggest that assumptions about schizophrenia, in particular notions that complete recovery is unlikely

(APA 1994), inform and delimit purpose and autonomy. Daytime activities become partial restoration and have a filling-in-for-the-real-thing quality. In this way, professional understandings of femininity and (masculine) personhood intersect with assumptions about schizophrenia to differentiate and delimit the psychiatric project of restoring these patients to purpose and autonomy.

In effect, patients are "gendered subjects" within local professional/patient interactions (Busfield 1996: 114), supporting Busfield's contention that gender understandings remain salient to contemporary psychiatry in the era of community care. Moreover gender differentiations within clinical encounters are hidden beneath, and run counter to schizophrenia's gloss of gender neutrality at the level of statistical associations (Holstein 1987). As such these differentiations are qualitative rather than quantitative (Smith 1975a). These findings suggest that, contrary to some feminist writers' claims (Busfield 1988; Pugliesi 1992: Russell 1995), schizophrenia is relevant for a feminist analysis, and perhaps more broadly, that there are gender issues to address in psychiatric categories other than those where women predominate.

Patients' past and present experiences are an important resource in discussions about restoring lives; different experiences can be shaped towards the same problem and solution, or similar biographical details can be made relevant to very different problems and solutions as they are associated with femininity and (masculine) personhood. However, the meanings of patients' experiences are not necessarily imposed by the professionals (Barrett 1988; Mehan 1990; Soyland 1994; Ravotas & Berkenkotter 1998); meanings are negotiated and may be contested by patients within meetings, but professionals do assert their own understandings in intra-professional pre- and post-meetings. Experiences take on even more complexity and fluidity when patients are located in interrelationship with significant others in psychiatric interactions: significant others are a resource for understanding patients in relational terms, and vice versa. In particular, professional discourses of care, definitions of trouble and negotiations of blame and change are accomplished through the deployment of membership categories and standardized relational pairs (Sacks 1972; 1974; Watson 1978) and a range of relational understandings which are gendered.

Notions of "the mother could help more" and "her husbands become overprotective" frame care in terms of helping and not hindering the professionals and doing whatever the professionals deem necessary to enable patients to follow the course they prescribe. These discourses draw on understandings of care as a feminine activity (mother is not doing enough as a mother, the husband is overdoing it but it is understandable for a husband), but contrary to the literature on the gendering of care (Banton et al 1985; Showalter 1987; Ussher 1991; Gorman 1992), care is not reinscribed as a feminine activity per se. Professionals deploy standardized relational pairs (Sacks 1972) such as mother/father and husband/wife, and associated gender understandings to accomplish problematisations, blamings and excusings (Watson 1978). When associated gender understandings come into play, patient and carer statuses do not necessarily determine allocations of wrongdoer and victim (Emerson & Messinger 1977). Carers experiences of care, therefore, are interactional resources, shaped and gendered within interactions.

The negotiated and fluid nature of experience is even more evident when significant others are girlfriends or boyfriends and professionals' configurations are traced through the course of meetings. Definitions of relational troubles are configured and reconfigured through the deployment of paired relational categories and associated understandings (Sacks 1972), many of which are also gender categories such as boyfriend/girlfriend, girl/boy, and wife/husband. The formulation of "he can be verbally abusive and physically intimidating...she doesn't feel confident enough" draws on the boyfriend/girlfriend relation to configure masculine abuse and intimidation as a problem in relation to feminine lack of confidence, suggesting that both contribute to the problem but he is mainly to blame. And the framing of "his violence" and "him as the patient not her as the patient" presents a violent masculine patient as clearly to blame in relation to a feminine non-patient.

I argued that complex and contradictory relational understandings of femininity and masculinity are accomplished within interactions. However, there is a preponderance of negative or socially undesirable (Broverman et al 1970) characteristics associated with femininity (such as frightened, dependent, selfish, using), and positive characteristics associated with masculinity (such as aware, honest, caring, responsible). In turn, negative associations with femininity are deployed to attribute blame for an unsatisfactory state of affairs or a relational trouble (a mother not doing enough; a sick wife; a frightened mother/girlfriend; a wrong-headed, selfish, using girlfriend). And understandings of masculinity are deployed to excuse or mitigate blame (a caring and self-sacrificing husband; an immature boyfriend; a loving and responsible boyfriend). Further, notions of femininity position certain patients and carers as the subjects of professional intervention and thus changeable (she should help more, be more assertive, move out) in relation to notions of masculinity which position other patients as unchangeable (he is unlikely to grow up, he cannot be told whom he lives with).

Therefore, rather than having intrinsic meanings, experiences of care, understandings of mothers and wives, relationships between girlfriends and boyfriends are resources, given meaning within interactions and deployed to accomplish activities of defining troubles, blaming and excusing. This suggests a more complex picture of women's (and men's) experiences than in the traditional feminist literature (Al-Issa 1980; Warren 1987; Barnes & Maple 1992), where women's experiences are assumed to have relatively straightforward singular meanings which are reflected in language. In contrast, experiences become complex and fluid resources as interrelated lives are discursively constituted, gendered and played out within clinical interactions, including who is and is not or should not be significant.

By the same token, the nature of trouble also does not have any intrinsic, pre-defined meaning (Emerson & Messinger 1977). As trouble is (re)defined, allocations of victim and wrongdoer are assigned and re-assigned; definitions of trouble which initially drew on notions of violent and abusive masculinity were reconfigured via formulations of "she needs to stick up for herself...unless he suddenly matures" and "you rub each other up the wrong way...she just wants to make use of the flat", to reverse assignments of victim and wrongdoer. Moreover, formulations such as these, which suggest that she brought-it-on-herself or that the problem is mutual, attenuate earlier attributions of violence and abusiveness, circulating discourses and attributions identified in other contexts (Scully & Marolla 1984; Adams et al 1995; Caplan 1995; Hearn 1996a; 1996b). I suggested that the absence of the problematised person facilitated accomplishments of blame and, once again, intra-professional pre- and post-meetings were a site for professionals to assert their authority to decide what experiences mean. However, I also traced the way that professionals may contest definitions amongst themselves or may collude with patients' definitions.

Throughout these meetings, schizophrenia is not applied as a label within discussions in the way labelling theory would predict (Rosenhan 1973); the past and present experiences and behaviour of patients are not interpreted in the light of schizophrenia in any straightforward way. It is rarely named at all. Rather, (background) understandings of schizophrenia inform discussions about patient responsibility and choice, and restoring patients' lives. However this does not appear to be the case when it comes to definitions of trouble and assignments of wrongdoing. As such, a diagnosis of schizophrenia does not produce an individualisation of trouble (Chesler 1974; Davis 1986; Warren 1987), nor necessarily relieve those close to the patient of blame. (Emerson & Messinger 1977). Instead, patient and carer statuses can take on a certain fluidity as troubles are defined through relational understandings and general notions of "mental illness" can be deployed as an experiential resource to attribute blame and wrongdoing or to excuse and assign the role of victim. Therefore, it is understandings of femininity and masculinity, not schizophrenia, that are major resources in local interactions for accomplishing definitions of trouble, blamings, excusings and decisions regarding change.

In this respect, there is little evidence from these findings to support the contention that women with schizophrenia are perceived by psychiatry as over-active and assertive, men with schizophrenia as dependent and passive (Cheek 1964; McClelland & Watt 1968; Chesler 1974). However the findings do provide some support for the broader thesis that psychiatry holds a negative conception of femininity (Broverman et al 1970; Chesler 1974). But in contemporary local encounters negative characteristics associated with femininity are not deployed to pathologise patients but rather are produced, negotiated and sometimes contested within interactions to accomplish blamings for relational troubles.

From a feminist perspective, how should we place a value on these findings? Professionals' differentiated understandings of emotion, dependence, independence and activity do not connote greater or lesser value in and of themselves but rather according to what they are deployed to do and their practical effects. Arguably, and overall, discourses associated with femininity are more often framed as problematic than those associated with masculinity or (masculine) people; notions of emotional dependence, loneliness, home, lacking confidence and economic expedience are all identified as feminine problems. In turn, feminine problems include the notion that something should be done in a twin movement of professional intervention coupled with feminine change. In contrast (masculine) people are also problematised in terms of practical dependence and needing emotional support but solutions are framed differently; professionals provide solutions in the form of "support" which enables these patients to cope in the community. While it could be argued that professionals are merely taking the shortest route to keeping patients out of trouble, it is clear from the analysis that this shortest route is informed by gender understandings about who can and should change and who cannot, and where professionals can intervene to facilitate change, and where they cannot.

As such, the practical effect of these discourses is a greater professional intervention in the lives of women patients and carers than men/(masculine) people. In terms of, say, getting women out of the house, ameliorating loneliness, helping them make friends with other women, or to be more assertive, or move out of a violent home, it could be said that such aims are well-meaning if not laudable. If women are capable of change, making friends, being more assertive and purposeful, is this simply greater malleability or positive and life-enhancing attributes? On the other hand, if (masculine) people and men are simply provided with basic support to enable them to cope in the community, are excused from problematic situations and do what they want to do with their time are they being given greater control over their lives or being framed as intractable and unlikely to improve? There are no easy answers to these questions but if we take account of the finding that understandings of schizophrenia delimit restoration, then it is not clear that greater professional intervention, no matter how well-meaning, is preferable to being 'left alone'.

Furthermore, there are areas of clear concern. Firstly, discourses of femininity, but not masculinity, are an occasional resource for reasserting professional authority whereas ascriptions of autonomy to (masculine) people are conferred in response to resistance and work to affirm it. In this way, understandings of femininity and (masculine) personhood impact upon the extent to which patients can resist professionals' plans for restoring their lives. Secondly, and most importantly, negative discourses of femininity are deployed to assign blame for problematic states of affairs and relational troubles; that women (mothers, wives, girlfriends) are blamed and given the onus to change, should be a distinct cause for concern, particularly when professionals' definitions attenuate masculine violence and abusiveness. The idea that nothing can or should be done to intervene in male patients' lives (beyond basic support and ensuring they take their medication and keep appointments) places an unacceptable weight on female patients and carers.

These findings and their implications from a feminist perspective present a rather different understanding of the intersections between gender and schizophrenia than in the traditional feminist literature, and of how schizophrenia and contemporary psychiatric power are played out within local professional/patient interactions. As such, a DA approach which focused on psychiatric/patient interactions within a psychiatric institution has been productive for investigating these issues. In broad terms, conceiving and analysing language as constitutive of social reality enabled a focus on what knowledges of gender and schizophrenia were created in CPA meetings in this particular psychiatric unit, avoiding the conceptual confusions and contradictions between schizophrenia as social construct and/or social product. Approaching professionals' understandings as interactional achievements deployed to accomplish social actions in this context, allowed consideration of the practical social effects for patients in terms of blamings and excusings and, more generally, their future treatment and care. Further, a focus on 'naturally' occurring clinical interactions between professionals and patients provided detailed insights into the "logic-in-use" (Coulter 1991: 167) of gender and schizophrenia in this context, insights which are unlikely to have been gained from interviews or textual materials. Professionals were there to accomplish the everyday business of CPA meetings rather than attend to the questions and concerns of a researcher.

This approach allowed me to investigate psychiatric power as a more open question than when the direction of power is assumed in advance (Gill 1996) and facilitated an exploration of the way power unfolds within clinical encounters (Banton et al 1985). It enabled a focus on the way psychiatric practices and professional/patient relations were accomplished within interactions but at the same time to take account of points where participants incorporated broader discourses and concerns about community care into interactions, such as psychiatric compulsion and patients' rights. From this approach I have attempted to draw out the way that psychiatric power at the local level is not solely an interactional accomplishment, but neither is it simply determined by broader discourses.

Taking a DA approach to professionals' understandings also elucidated the plurality of meanings of emotion, activity and (in)dependence which previously had been conceived and measured as relatively simple and singular characteristics (Broverman et al 1970). From a discursive perspective these characteristics take on a diversity of meanings as they are associated with understandings of femininity and (masculine) personhood, and deployed to frame problematisations and solutions; for example, dependence can be emotional or practical, emotions can be internalised or externalised, and independence can mean independence from home and significant others or self-regulation over how patients spend their time. Further, analysing experience as an interactive accomplishment has highlighted the fluidity and complexity of patients' and significant others' experiences. Rather than having pre-defined meanings, experiences are configured and reconfigured to support particular formulations of problems and proposed solutions, definitions of trouble, and accomplishments of blame and change. Moreover, a DA approach which has focused on a clinical context has been particularly useful for understanding that schizophrenia is rarely invoked and named as a category within interactions, in the way labelling theories would predict (Rosenhan 1973; Chesler 1974). Rather schizophrenia largely operates as a background understanding in this clinical context, and one that does not inform all aspects of professional/patient discussions.

Finally, conceiving and analysing gender as created within language and interaction and according to the activity at hand, rather than having an essential or stable meaning, has accentuated the way that women and (masculine) people and understandings of femininity and masculinity are produced within the talk, and the consequences of these assignments and meanings within the concrete practices of contemporary psychiatry (Flax 1987). Furthermore, a focus on gender (women and men, femininity and masculinity) rather than solely on women has enabled a better understanding of the intersections between femininity, masculinity and schizophrenia and a more dynamic picture of the interrelationships between them and the fluidity of meanings associated with these categories. The interrelated nature of professionals' gender understandings was particularly evident when defining troubles, assigning blame and excusing.

I have attempted to remain within the bounds of participants' own understandings, particularly in relation to gender, rather than bringing in my own cultural knowledge. This has further highlighted the contingent and situated nature of gender meanings within psychiatric talk and, I hope, provided an effective critique of psychiatric understandings. However, this approach has also posed problems for demonstrating the relevance of gender when it is operating as a background understanding rather than being explicitly indexed within the talk (Frith 1998; Stokoe 1998; 2000; Kitzinger 2000; Stokoe & Smithson 2001). I drew on Garfinkel's (1967) notion of gender as an omnirelevance and Zimmerman's (1998) discussion of "transportable identities" to argue that the notion of a generalised person in professionals' talk did not automatically mean that masculinity was not relevant and that this understanding was best characterised as (masculine) personhood. I also suggested that gender identities, such as girlfriend/boyfriend, once invoked and made relevant by participants, could continue to have relevance for a stretch of interaction without being restated turn-by-turn. However, the question of the status of background knowledge within CA/DA remains and has been particularly apparent in the present research which has drawn data from a 'naturally' occurring interactive context, where gender is only one amongst a number of professional concerns. As such, what is to count as relevant to participants is more complex and less certain in this sort of context than when gender is "relevant to the...talk as a matter of recipient design" (Schegloff 1998; 415), for example in interviews and focus groups.

Nevertheless a DA approach has provided detailed insights into professional/patient interactions within contemporary clinical encounters: an understanding of how psychiatric power unfolds at this local level, how professionals accomplish gender understandings and to what effects, and a different understanding of the intersections between gender and schizophrenia. However the research was limited in a number of senses, each of which were related to the difficulties of access and ethics encountered when researching a psychiatric context. The research context was confined to one psychiatric unit in the South East of England serving a particular community. Other units serving different communities, in particular institutions with a greater number of patients from ethnic minorities, might have introduced professional discourses of ethnicity which may have interacted with understandings of gender and schizophrenia. Given that African/African-Caribbean people in Britain are over-represented in the diagnostic category of schizophrenia (Mercer 1986; Littlewood & Lipsedge 1997), and gender is "conspicuous by its absence" in transcultural psychiatric research (Mercer 1986: 292), this is a regrettable absence in the present research directly attributable to the difficulties and lengthy process involved in gaining access to psychiatric contexts. There were indications in the data that professional understandings of ethnicity could interact with those of gender (for example Diane was described as an "Irish lady") but there were insufficient instances to form any firm findings.

Further, CPA meetings were only one of a range of contexts within the psychiatric institution. The insights gained from the research could have been deepened with wider access to, for example, outpatient meetings between patients and the consultants and some of the professionally organised activities such as women's group. Again, this might have introduced additional or alternative discourses and provided a better understanding of the discourses and practices of the institution. In particular it would have enabled me to trace, say, how discourses of responsibility are played out in one-to-one discussions between the consultants and the patients in outpatients, and/or to pursue further discourses of femininity deployed at women's group. Furthermore, confinement to one context within the broader context of the psychiatric institution as a whole also confronts notions of the meaning of context itself (Tracy 1998) and thus what is to count as participants' relevance and the boundaries between intrinsic and extrinsic, micro and macro.

In addition, although in principle I was given access to patients who were newly admitted under the Mental Health Act, in practice I was unable to gain consent from any of these patients. Therefore I was unable to consider how professionals' understandings of schizophrenia might be brought into play at this early stage in patients' 'careers'. Again there are indications from conversations I had with psychiatric nurses on the in-patients' ward that staff were both aware of problems associated with labelling people with diagnostic categories and that they engaged in some contestation over whether schizophrenia was a suitable diagnosis for a particular patient. It is possible then, that the first CPA after a patient's admission to hospital could have produced more explicit discourses of schizophrenia than was the case in the meetings to which I had access.

These limitations and the findings of the research suggest a number of future directions in which the research could be taken. However, such suggestions should be tempered by an awareness of the difficulties of gaining access to psychiatric settings. The intimation that professional discourses of ethnicity might interact with understandings of gender and schizophrenia, and the lack of research in this area, particularly in interactive psychiatric contexts, suggests that similar research in a psychiatric unit with a higher number of ethnic minority patients could contribute to filling this gap. On a more general level, the research could be extended by widening the focus from schizophrenia to other diagnostic categories, for example a category such as depression. I have argued that professionals' understandings of schizophrenia underpin the simultaneous encouragement and limitation of self-regulation for patients, and delimit their restoration to purpose and autonomy. In the latter case, these assumptions intersect with discourses of femininity and (masculine) personhood. A similar research approach and context would provide an interesting exploration of the continuities and disjunctures produced when the focus is professionals' understandings of the relationship between gender and depression within clinical encounters.

A different direction that could be pursued, which was beyond the scope of the present study, would be a greater focus on patients' discourses. Although a great deal of patients' talk has been included here, and I have detailed the way that patients appropriate and reformulate psychiatric discourses of responsibility and choice to resist professionals' plans and assessments, the major focus has been on professionals' understandings. One aspect that I highlighted was the professional "hidden transcript" (Scott 1990: xii) whereby professionals make more open avowals in the context of pre- and post-meetings where patients are unable to contest their definitions. However, patients will also have "off-stage" (Scott 1990: 4) sites for producing a "hidden transcript":

> Every subordinate group creates, out of its ordeal, a "hidden transcript" that represents a critique of power spoken behind the back of the dominant.
> (Scott 1990: xii).

It is likely to be in contexts such as patient groups and organisations, or patient drop-in centres where patients produce their own "hidden transcript", discourses that resist and counter professional understandings of gender and schizophrenia/mental distress, and this would be an important and interesting future research direction. However, given that patients are not always told their diagnosis, this research would have to be widened out to a more general notion of mental distress.

Appendix I

Patient and Staff Information Leaflets and Consent Forms

Patients' Information Leaflet

CAN YOU HELP WITH THIS RESEARCH PROJECT ?

WHO I AM AND WHAT THE RESEARCH IS ABOUT

My name is Lin Williams and I am a research student from Brunel University. I am looking at the relationship between gender and mental distress. I want to consider questions such as:

- does your gender affect the way you and your behaviour are understood by mental health professionals (e.g. psychiatrists, psychologists, psychiatric nurses and social workers)?
- what influence, if any, does it have on your care?
- does gender have any bearing at all?

One way to explore these questions is to look at mental health professionals' talk when they are discussing your care.

WHAT WILL IT INVOLVE?

Can you help with the study by letting me sit in on your care-plan meeting? I will not take part in any of the discussions but I would like to tape-record what people say in the meeting. If you are worried about the idea of tape-recording, then you can say so on the form provided at the end of this leaflet, and I will take notes instead. If you wish, you are welcome to a copy of the audio tape after the meeting. Please remember that my focus is on the mental health professionals and what they say in the meeting, not on you.

HOW WILL THE RESEARCH BE USED?

The results of the research will be written up for the university. Parts of the research may be published in the future in academic journals. A summary of the results, made completely anonymous, will be given to the Trust. Your help with this research cannot benefit you directly or immediately. But it will increase awareness and understanding of the way gender affects mental distress and will be useful to users of mental health services, mental health professionals and organisations in the future.

CONFIDENTIALITY

Your right to confidentiality will be protected in the following ways:

- I will change your name and take out all details which could identify you.
- I will make these changes as I transcribe (make a copy in writing) the tapes or notes and destroy the original tapes/notes.
- I will destroy all the original tapes/notes within a maximum of two years.
- before this, I will keep all the tapes/notes locked away at my home.

YOUR RIGHTS

You have the right to decide to take part, or not to take part in this research project based on the information I have given you - this is your right to informed consent.

- please make sure that you understand what the research is about and how you will be involved, before you agree to take part.
- if you would like to know more before you decide, speak to .... who will contact me and I will be happy to come and answer any questions you may have.
- your decision, either way, will not affect your treatment or dealings with staff.

CHANGING YOUR MIND

You have the right to change your mind about taking part in this project at any time. If you change your mind, speak to .... who will contact me. I will immediately cancel any plans to be at your care-plan meeting or destroy any tape-recording, transcription, or notes that I have made. Changing your mind about taking part in the project will not affect your treatment or your dealings with staff in any way.

Patients' Consent Form

Please make sure that you understand what the research is about and how you will be involved before you sign this form.

I agree to take part in the research project investigating the relationship between gender and mental distress.

I do not object to a tape recording being made .... ☐

I do object to a tape-recording being made................ ☐
(Please tick which statement applies to you)

Signed .... **Date** ....

Please keep this leaflet for your information and return the signed consent form to

....

Staff Information Leaflet

YOUR SUPPORT IS NEEDED FOR A NEW RESEARCH PROJECT

WHO I AM

My name is Lin Williams and I am a postgraduate research student from Brunel University. I have previous experience working in a child guidance clinic, and conducting research in a healthcare setting.

THE RESEARCH : WOMEN, MEN, AND SCHIZOPHRENIA

I am looking at the relationship between gender and schizophrenia. Women and men seem to be at equal risk of developing schizophrenia but recent medical research suggests that gender differences (such as in symptoms, response to treatments, age of onset) could be important for understanding the disorder.

Gender is one of our most basic and important social categories, which we all use to make sense of our world, the people in it, and their behaviour. I want to explore how you, as a mental health professional, understand gender and its relationship to schizophrenia. It is important that research of this kind takes into account the everyday practicalities of a busy mental health unit, and the professionals who work there. I will be considering questions such as:

- does gender influence the way you understand patients with schizophrenia and their behaviour?
- what effect, if any, does it have on decisions regarding patients' care?
- does gender have any bearing on schizophrenia at all in this context?

I will be using a method called discourse analysis. This is a qualitative methodology which focuses on language itself, how it is organised and to what effects. This approach has provided exciting new understandings of a wide range of topics within psychology, sociology and anthropology.

The research will be:

- a positive exercise seeking to elucidate mental health professionals' understandings and meanings.
- taking account of the practicalities of the clinical context.
- looking at the complexity of gender which may have many different dimensions and take many different directions.

The research will not be:

- judgmental - in the vein of simplistic ideas about sexism and gender bias .
- finding fault - this is not an investigation into something that is going wrong.

HOW WILL STAFF BE INVOLVED?

I would like to sit in on care-plan meetings for patients who have been diagnosed with schizophrenia. I will not participate in the meeting but I would like to observe and tape-record the discussions. I understand that people can feel uncomfortable with audiotaping, but it is important for the rigour and accuracy of the research that there is an exact record of what is said. Notes can only capture an impression and can lead to misunderstandings and misinterpretation. Previous research suggests that people quickly overcome their initial discomfort and become used to audiotaping. If you, or the patient, are unhappy about tape-recording, then I can take notes instead.

HOW WILL CONFIDENTIALITY BE PROTECTED?

Your confidentiality will be protected in the following ways:

- I will change all names of staff participating in the research, and delete all identifying details, to ensure anonymity.
- I will make these changes and deletions as I transcribe the tapes or notes, and destroy the original tapes/notes.
- I will destroy all the original tapes/notes within a maximum of two years.
- Prior to this, I will keep the tapes/notes locked away at my home.

WHAT WILL HAPPEN TO THE RESEARCH AFTERWARDS?

My findings will be written up for the university and will form the basis of my doctoral qualification. A summary, in anonymised form, will be made available to the Trust. Parts of the research may be published in academic journals in the future.

I hope that the findings will increase awareness and understanding of the ways gender impacts upon mental distress, and will be useful to mental health professionals, organisations and users of services.

IF YOU WOULD LIKE MORE INFORMATION

- I will be happy to arrange a group meeting where any questions or worries can be raised and discussed.
- if you would prefer, we can meet on an individual basis.
- if you would like a copy of the full research proposal, and the 'information leaflet for patients' I will be happy to send them to you.

YOUR INVOLVEMENT IS CRUCIAL TO THE SUCCESS OF THIS PROJECT

This is an opportunity to be part of a research study which takes account of professionals working in the front-line of mental health care.

PLEASE GIVE THIS PROJECT YOUR SUPPORT

Staff Consent Form

I agree to take part in the research project: "Women, Men and Schizophrenia" which will be investigating the relationship between gender and schizophrenia.

Signed .... **Date** ....

Please return the signed consent form to Lin Williams or ....

If you have any concerns about tape recording, please contact Lin Williams on ***** ******

Appendix II
Ethical Guidelines and Practice

I based my ethical guidelines and practice on Mind's Policy (1993) and Principles of Confidentiality (Mind 1994) and the British Sociological Association's Statement of Ethical Practice (1991).

Patients' confidentiality was respected by changing all the names of participants and deleting identifying details to ensure anonymity. I made these changes and deletions as the tapes were transcribed. In terms of patients' rights, I undertook to give adequate and understandable information about the research, in writing, to all potential participants, avoiding jargon. I made it clear that agreement or refusal would be respected and would not affect their dealings with staff in any way. I made clear to patients how their confidentiality would be protected, but advised them that parts of the research might be published in the future. I took care to ensure that participants were sufficiently aware and understood the research before giving their consent. I also advised them, in writing, that they were free to change their minds and withdraw consent at any time. If patients were worried about the idea of audiotape recording they were given the option of note-taking instead. Following the advice of the medical ethics committee, I offered patients a copy of the audiotape if they wanted one. The same guidelines for confidentiality and consent were followed for professional staff.

On the advice of Dr. North, the word "schizophrenia" was replaced by "mental distress" on the patients' information leaflet, in recognition that not all patients are made aware of their diagnosis. While this seemed to contravene the spirit of "informed consent" somewhat, Dr. North suggested that sometimes it is not "therapeutic" for patients to know their diagnosis and only those with "sufficient ego strength" to accept the diagnosis and not be frightened by it are told. In this sense she had given me an ethical reason for not disclosing diagnosis to the patient and I felt I should abide by her policy.

Appendix III

Data Sources, Participants and Background Information to the CPA and the Psychiatric Unit

Data Sources

My primary data source was audiotape recordings of Care Programme Approach (CPA) meetings for people diagnosed with schizophrenia in the borough of Worthington. The meetings lasted between 20 minutes and one hour, the average was 35-40 minutes. I tape-recorded eleven CPA meetings in total across the four sites that composed the psychiatric unit: seven at the community mental health centre, one at the residential rehabilitation hostel, one at the day unit and two at the acute in-patient ward. I used a Sanyo M-1140 Compact Cassette Recorder and a miniature microphone. I made the decision to trade a good level of sound quality for unobtrusiveness given the setting and participants. When patients did not want to be tape-recorded, I took notes at five meetings, three at the community centre and two at the day unit. In these cases I attempted to take down segments of verbatim talk in written form, rather than writing for gist. In this way, notes formed a data source for analysis, albeit a less perfect source.

In addition to audiotape recording and taking notes in CPAs, I also conducted semi-structured interviews with five professionals; one from each of the four research sites and one with the manager of the community centre. The consultant psychiatrist and the ethics committee had only given approval for me to attend CPA meetings and so I was unable to spend time freely in the psychiatric unit and associated sites observing their day-to-day workings. Because of this I had little idea how the CPA, as a certain kind of psychiatric event, fitted into all the other activities in the unit. The interviews were primarily for the purpose of obtaining background information about the sites and the activities that went on there from the professionals' perspective. Four interviews were recorded and in one I took notes. The interviews were conducted at the end of the research period at each site. The semi-structured interview schedules varied slightly according to the site, but a copy of one of the schedules is attached to the end of this appendix.

I also gathered a variety of secondary sources such as leaflets designed for patients about the CPA, the role of community psychiatric nurses and schizophrenia, as well as internal documentation and guidelines for staff on confidentiality, CPAs, and consent forms. These sources were also used to provide background information.

Finally, I kept a fieldwork diary from the time I made initial contact with Dr. North until the end of the research. In this diary I noted and dated all phone calls (from mundane to long conversations), face-to-face conversations I had with professionals and patients, observational details from the meetings I attended and my thoughts and feelings about them. I took notes while I was engaged in phone conversations, and wrote down other notes as soon after the event as possible. Again, when noting conversations, I attempted to take down, or remember, verbatim segments of talk which seemed important. The fieldwork diary provided a valuable source of observational material, some verbatim talk, and a chronological account of the research process and my experiences.

Participants and Programme of Research

In effect, there were two main groups of participants in the research, the professionals and the patients (without whose consent the research could not go ahead), as well as their relatives and friends. Thirty-seven psychiatric professionals took part in the research, of which twenty-three were women and fourteen were men. Their ages ranged from early twenties to fifties. In terms of ethnicity, eighteen professionals were white, thirteen were African/African-Caribbean or Asian, six were Irish. In order to preserve anonymity I have given all participants English pseudonyms. In terms of professional affiliation and status, there were three consultant psychiatrists, one registrar, three psychiatrists and one junior doctor. From the team at the community health centre, nine community psychiatric nurses, five approved social workers, and two community support workers took part. Within the day unit and the ward, there were four psychiatric nurses. Other professionals involved were five housing officers, two managers, an occupational therapist and a social work student.

The extent to which professionals participated varied greatly; one of the two female consultants, Dr. North and Dr. South, took part in all the meetings except one (ten meetings and five meetings respectively), whilst the registrar attended four meetings and the male consultant, who was based at another unit, only attended one meeting. One community psychiatric nurse attended four meetings, another attended three, and one approved social worker and one community support worker attended three each. The other professionals mostly took part in only one meeting. Not all the professional staff at the psychiatric unit and associated sites participated although none of them explicitly refused. However, over the period of time I was at the unit, the vast majority of staff did become participants at some stage in the research. The five professionals who were interviewed were an approved social worker and four managers.

Sixteen patients participated in the research, eight women and eight men. Their ages ranged from late teens to early fifties. Thirteen of the patients who participated were white, three were African/African-Caribbean, Asian or Irish. Once again I have given them all English pseudonyms for confidentiality purposes. Eight of the patients were accompanied by relatives/friends including mothers, fathers, husbands, brothers, sons, and girlfriends. Three women and five men attended alone. All patients participated in only one meeting each. I wanted as wide a range of participants as possible and also it did not seem fair to ask for their help more than once. Of the patients that participated, seven women and four men agreed to be audiotape recorded, one woman and four men opted for notes only.

I provide brief descriptions of patients' background circumstances as they are introduced in the analysis but I did not have access to their medical biographies and so my knowledge about them was limited to a visual impression and the talk within the meetings. While I did include descriptions of all the participants in my fieldwork diary, I decided that this level of information could contravene my ethical obligations in terms of ensuring anonymity. But, at the same time, a more ethnographic sense of who these people are has been lost.

Dr. North proposed a rolling programme of research which would begin at the community health centre and then move on to the residential hostel and day unit, and finally to the ward. Her rationale was that CPAs are "calmer" in the community centre than on the ward which would give me an opportunity to get used to the meetings. I started my research at the community centre in October 1997 (eleven months after my initial contact with Dr. North) and finished there in early July 1998. Research at the day unit ran from November 1997 to April 1998; at the residential hostel from February until July 1998; and on the ward from July 1988 until December 1998. In total I spent fifteen months conducting research at the psychiatric unit and associated sites.

Background Information to the Care Programme Approach (CPA)

The CPA was introduced by the government in 1991 as an adjunct to the Mental Health Act of 1983 (DoH&WO 1993) after some high profile cases of violent community patients. Although CPAs are part of the code of practice of the Mental Health Act, they have not been implemented in all areas of the country and where they have been introduced they are not uniform. CPAs were introduced into Treetops psychiatric unit in December 1995. Some CPAs may have taken place before this time, but at this point they were formalised across the Trust. As part of the CPA process the Government also introduced a Supervision Register in 1994, which was introduced into the psychiatric unit the same year, and is completed by the consultant towards the end of the meeting. The primary aim of the Supervision Register is "to reduce the risk of serious violence, suicide or self neglect" (quoted from Worthington Community & Mental Health Trust internal document of guidelines). A Health of the Nation Survey (HONOS) Score Sheet is also included in the CPA which lists twelve "problems" (e.g. behavioural, physical, mental) which are scored on a scale from zero to four. This is usually completed by the consultant or the keyworker, also towards the end of the meeting.

The aim of the CPA is to co-ordinate care between different professionals involved in a case; to produce a care plan negotiated between the multi-professional team, the patient, and any significant others involved in the patient's care; and more broadly to prevent patients "slipping through the net". CPA meetings are attended by all the professionals involved in the care of the patient, the patient, and any friend/relative the patient wishes to invite. At the end of the meeting a plan is agreed which is written up on an official form, signed by the patient and her/his keyworker, and circulated to attendees. There are two tiers of CPA; the full CPA is convened for patients who have "complex needs", who need multi-professional care, who are or have been formally detained under the Mental Health Act, or who are deemed "vulnerable" (taken from internal guidelines and "screening document"). Patients on minimal CPA have less complex needs and usually only need care from one professional. Meetings are only convened for patients on full CPAs. All new patients coming into contact with Worthington mental health services are "screened" to determine which level of CPA they require.

Sample copies of the CPA Screening Document, the CPA form that is completed at the end of each meeting, and the Risk Assessment form are attached to the end of this appendix.

Background Information to the Psychiatric Unit and Associated Sites

I attended CPA meetings at four sites which make up the mental healthcare provision for the borough of Worthington, and over which the consultants, Dr. North and Dr. South, have responsibility. The borough of Worthington includes five towns and is a mixed area in terms of socio-economic status; it is predominately middle-class but there are also areas of poverty.

There are several large council estates, housing association housing, and a large travellers community. I was told that the Asian community was increasing and that approximately one quarter of one of the social worker's caseload consisted of people from ethnic minorities including African-Caribbean. Each psychiatric site had a different staff complement and remit.

The Acute In-Patient Ward

The acute ward was opened in 1981, partially replacing an old mental institution. It is housed in prefabricated buildings built during the war, which are attached to Treetops General Hospital. This was viewed initially as a temporary measure until more permanent accommodation was found. There are nineteen beds, eighteen for mental health cases, one for alcohol detoxification. All the rooms are situated off of one long main corridor. They are all single occupancy and patients can lock their doors from the inside (although staff have keys for access). There are also various larger rooms such as a dining area, lounge, smoking room and activity rooms, and the acute ward links via corridors with the day unit and the outpatient unit where the consultants have their offices. The ward usually has full bed occupancy requiring careful bed management. It is an acute ward and the aim is that patients should be short stay. Length of stay can vary from two or three days to a year, the average is forty-eight days. If patients remain too unwell to go home, they may be sent to the residential rehabilitation hostel (Applegate), if they are too violent/dangerous then they are sent to a secure unit.

In this respect it is an open ward; I was informed that the locked door and keypad entry is to keep people out, not in. I was also told that patients generally do not try to leave. Those who are compulsorily detained are informed that if they leave, staff will implement a missing persons order. If patients are assessed as at risk (to selves or others) and likely to abscond, then they may be continually observed by a nurse. The general proportion of admissions is 30% compulsory and 70% informal. Patients do appeal against their compulsory admission, to the Trust Managers or the Mental Health Review Tribunal, quite often and, I was told, are sometimes successful.

There are nine to ten nursing staff on the ward split between three shifts, a manager, and an occupational therapist. On a day-to-day basis there is a clinical associate specialist (registrar) and a senior house officer on the ward. Patients also see one of the two consultants at the weekly ward round and can be referred to a psychologist or psychotherapist. A variety of occupational therapy activities take place during the day, e.g. healthy living group, anxiety management group, cooking, run by the occupational therapist (OT). There is also a "women's group" run by the OT and one of the nurses which, I was told, deals with "women's issues" such as "relationship problems, hormone replacement therapy". There is no such group for men. In addition there are drug treatments, electroconvulsive therapy, and psychological assessments. According to the ward manager, interaction between nurses and patients is "encouraged" and it is policy that nurses do not wear uniforms in an attempt to "break down the nurse/patient barrier".

Frequency of CPAs on the ward varies according to "level of need" but usually a patient will have one CPA shortly after admission and another prior to discharge. While the weekly ward round is concerned with "managing the care" of the patient on the ward and looking at what needs to be done to work towards discharge, CPAs involve the community care team and are concerned with care after discharge.

The Day Unit

The Day Unit was opened in 1985 and is housed in the same prefabricated buildings as the ward. It is open from 8.30 a.m. until 4.30 p.m., Monday to Friday. The day unit has a very similar layout to the acute ward, and appears to be a 'mirror-image'. There is a long corridor with several small rooms off of it, including a room where team meetings and the CPAs are usually held, a small kitchen, a waiting room for patients, a medical treatment room and the manager's office. At the end of the corridor there is a large activities room. The numbers of patients attending the day unit varies but the average is thirty. The number of days or hours that patients attend also varies, depending on their needs, their treatment plan, and "what suits them". If they are very unwell, they are "encouraged" to attend for all five days. If they are close to discharge, it could be only one session a week. Length of stay again varies with an average of two months.

The main aim of the day unit is to provide intensive support and assessment as an alternative to admission. It is, like the ward, an acute service. Referrals to the unit come from a variety of sources such as Accident and Emergency, the ward, outpatients and the community mental health (CMH) crisis team. Patients may move in either direction from the day unit; if they deteriorate, are a harm to themselves, or cannot cope at home alone out of hours, they may be admitted to the acute ward. Or they become community patients. The day unit often works closely with the CMH crisis team to provide patients with the support they need. Attending the day unit is an informal arrangement but if a patient does not attend, and staff are "worried about them", the keyworker or a community psychiatric nurse will visit them at home.

There are two junior doctors, a senior clinical nurse, two nurses, two OTs, and a manager at the day unit, as well as additional sessional staff. There is an "intensive group programme" on Mondays, Wednesdays and Fridays which consists of various activity groups focused towards treatment, e.g. support groups, relapse prevention, assertiveness, anxiety management. On the remaining days, keyworkers work with individual patients using different approaches such as cognitive behavioural therapy or problem solving approaches. Patients can also be referred to a psychotherapist or psychologist. It is a hospital environment and the day unit offers the same treatments as on the ward. They have a meeting every morning to discuss all the patients and a weekly review with one of the consultants when the consultant usually sees the patient. The unit also liaises with the community mental health team (CMHT) and the ward.

CPAs are usually scheduled at the day unit every two to three months, either when the patient is shortly to be discharged, or when a patient is "difficult to manage", or the patient is unsure of their treatment plan or not happy about it.

Hillcrest Community Mental Health Centre

The Community centre was opened in 1995. Before this, social services staff were based in the local council offices, and community psychiatric nurses were in General Practitioner practices. The Centre is based in a large converted house in a residential area several miles from the hospital. On the ground floor there is a reception area and room for administrative staff, a quite small room in which the CPA meetings are held, and a much larger room with kitchen off, for team meetings, activity groups etc.. There is also a large conservatory in which artwork is laid out. On the two floors above are the offices of the community psychiatric nurses (CPNs) and social workers (ASW & SW). The total case load for Hillcrest is 370-380 cases. The average case load for CPNs is 50-60 cases, and for social workers is 20-30 cases. The CPNs have more cases because a proportion of them are "just depo injections", that is injections of medication. Actual case loads are determined by weighting on a points system according to the amount of work involved. Weighting is based on the degree of complexity, level of risk, frequency of contact and intensity of contact where high intensity is over one hour per contact, and high frequency is more than once a week.

When I began the research at Hillcrest the staff consisted of six CPNs, one OT, one psychologist, one senior social worker, five ASWs, one SW, four community support workers, one social work student, and five administrative staff. ASW refers to 'approved' social workers, that is social workers who have undertaken extra training and are qualified to approve a compulsory admission to hospital. However there were a number of staff changes while I was there and the numbers of particular types of staff fluctuated. Apart from visiting clients in their own homes, CMHT staff also organise group activities at the centre, such as a living with your beliefs group for people with delusions and hallucinations, relaxation, sports group, social group etc. There is also a women's group run at Hillcrest by two community support workers but, while I was there, no men's group. However, I was told that one of the consultants had approached an ASW about starting a men's group, which may now be running. It may well be an effect of my presence there, and the gender focus of my research, that led the consultant to raise this issue.

I was told that group activities are a "key area" where staff can "get information" about clients and may pass it on to other professionals. Group activities also "reduce the stress on key-workers, they have to make less visits, it helps spread responsibility and weight". I was also informed that if "difficult" clients attend even one group activity, this is a sign of "improvement, they have engaged". In addition there is a charity run day centre nearby, the Castle, offering activities such as cookery and woodwork, and a charity drop-in centre, as well as a local adult education college, Down's College, which runs the usual range of adult education courses but has a programme for people with learning disabilities and mental health problems. While I was conducting research at Hillcrest, the adjoining house was being renovated and the intention was that the Castle would move into this building and, together with the CMHT, they would be able to offer more choice of activities.

CPAs are scheduled at intervals between three to twelve months. There is a minimum requirement of at least one CPA per year and community patients are seen by one of the consultants in outpatients between CPAs, as well as having regular contact with other CMHT professionals. If the patient is on the supervision register, they will have a CPA at least every six months and will be seen at least monthly by their keyworker or consultant. From the meetings I attended, CPAs were scheduled every three to six months for community patients with a diagnosis of schizophrenia.

Appendix III

Applegate Rehabilitation Hostel

Applegate opened in 1994 as a temporary measure when a long-stay ward in one of the large metropolitan hospitals, which took patients from Worthington who were "treatment resistant", closed. It is situated in part of a modern, purpose-built, single-storey residential unit for people with learning disabilities near Hillcrest. There are five bedrooms for residents, a staff room, and several communal rooms including two lounges (one smoking and one non-smoking) and two kitchens. It is surrounded by a private garden. At the time of the research there were six residents; two of the residents were sharing a bedroom. The hostel is "just about always full". Applegate caters for patients who have been on the acute ward for some time but cannot be discharged into the community because it is thought they are unable to cope. They are patients who "have a residue of symptoms and disastrous relationships with carers". Their length of stay can vary between one month and two years, the average is ten months. From Applegate, they usually move on to supported accommodation, either somewhere that has a resident staff member or a housing association house with a visiting housing support worker. Some may return to their family home but this is rare because of previous marital or family conflict.

Staffing at Applegate consists of two managers, two nurses, two psychiatric nurses and one support nurse, providing twenty-four hour cover. Social workers from Hillcrest are also involved in residential patients' care, particularly in facilitating the move on to supported accommodation. The aims of the hostel are "closely identified with social psychiatry". Treatment comes partly from the "milieu"; patients have to get along with each other and do their own cooking and shopping. At the same time staff "encourage" patients to "self-medicate" and teach them the skills they need to recover and live in the community, such as cooking. Patients can "come and go as they please" from the hostel but they are "strongly encouraged to announce their movements" through an in/out book and daily morning "activity" meetings. Most patients referred to the hostel are on full CPA, and there is a requirement of one CPA every six months.

The residential hostel was due for closure soon after I completed the research. I was told that this was due to fiscal pressures. A housing association supported accommodation facility was being built by the borough, although this would not provide the same level of support as Applegate, leaving "a service deficit for a while".

Appendix III

Interview Schedule - In-Patient Ward

Section 1 - Ward

1. When was the ward opened?
   Was it a replacement for other facilities?

2. How many staff are there on the ward?
   What is their professional background?

3. How many beds are provided here?
   Are they all single rooms?
   Are they usually all occupied?
   Who has final responsibility for the use of beds?
   What is the general proportion of formal and informal patients?

4. How variable are patients' lengths of stay?
   How are they referred to you?
   What happens if a patient has been on the ward some time and they are not recovering? Are they moved to a longer stay unit?

5. What kinds of treatment and activities are offered here?

Section 2 - CPAs

1. How often do ward rounds occur?
   Do the consultants/Drs. see everyone every time?
   Do patients see a consultant or doctor at other times?

2. What does the CPA achieve that cannot be done on the ward round?

3. How often is a patient likely to have a CPA while they are on the ward?

Section 3 - General questions

1. What kind of rules or guidelines are there for visitors?

2. Given that many patients here are formal admissions:
   How are they prevented from leaving - the locked door seems more to keep people out than in? Containment? Monitoring?
   Are patients able to lock their bedroom doors from the inside?
   How do you cope with patients who are or may be violent?
   Do patients ever get moved from here to more secure units?
   Do many patients appeal against their formal admission? How successful are they?
   Do you ever get problems with male patients pestering female patients?

Appendix III

Care Programme Approach Screening Document

A client's Care Programme Approach may be either **FULL** or **MINIMAL**. This form should be used to identify the appropriate CPA Level a client requires.

PATIENT NAME: ______________________ **PSYMON No./ HOSPITAL No:** ______________

ADDRESS: __________________________ **DIAGNOSIS** ______________

______________ **POST CODE** ________ **DATE OF BIRTH** ______________

Indicate as appropriate if the client meets any of the following criteria:	
Clients who are admitted or who are resident in the community and may be vulnerable without a full health and social needs care plan ***Place a tick in the appropriate box if you have answered "YES" above*** ◆ Clients who have had more than one admission to hospital within the past year ☐ ◆ Clients requiring in excess of two professional visits per week ☐ ◆ Clients with a chronic mental illness requiring continuing specialist community support and who may live alone with no identified carer ☐ ◆ Clients with mental health needs requiring multi-professional input ☐ ◆ Clients who meet the criteria for the supervision register ☐	**YES/NO**
Client is subject to Section 117 of the Mental Health Act 1983.	**Yes / No**
Client is being discharged following an admission of at least 6 months.	**Yes / No**
Clients whom a Multi-professional team member deems potentially appropriate for the Full CPA, but does not meet any of the above criteria. **Please specify the reason** ______________________	**Yes / No**

IF ANY OF THE ABOVE CRITERIA HAVE BEEN CIRCLED YES, THE CLIENT REQUIRES A FULL CPA. IF ALL OF THE ABOVE HAVE BEEN CIRCLED NO, A MINIMAL CPA IS REQUIRED. Occasions may arise when a client does meet the full CPA criteria, but only a minimal CPA is required. If this is the case please indicate a minimal CPA below with an explanation in the box underneath.

Please tick the box for the CPA level required:

FULL CPA ☐ **MINIMAL CPA** ☐

Assessor's Signature ________________ **Date** ______________
Assessor's Name ________________

Service Area: Outpatients ☐ Inpatient ☐ Day Hospital ☐ Social Services ☐
Community ☐ Psychology ☐ Psychotherapy ☐ CDU ☐ Rehab ☐

FULL CARE PROGRAMME APPROACH/SECTION 117
OF THE
MENTAL HEALTH ACT 1983

CLIENT NAME: **DATE OF CPA MEETING:**

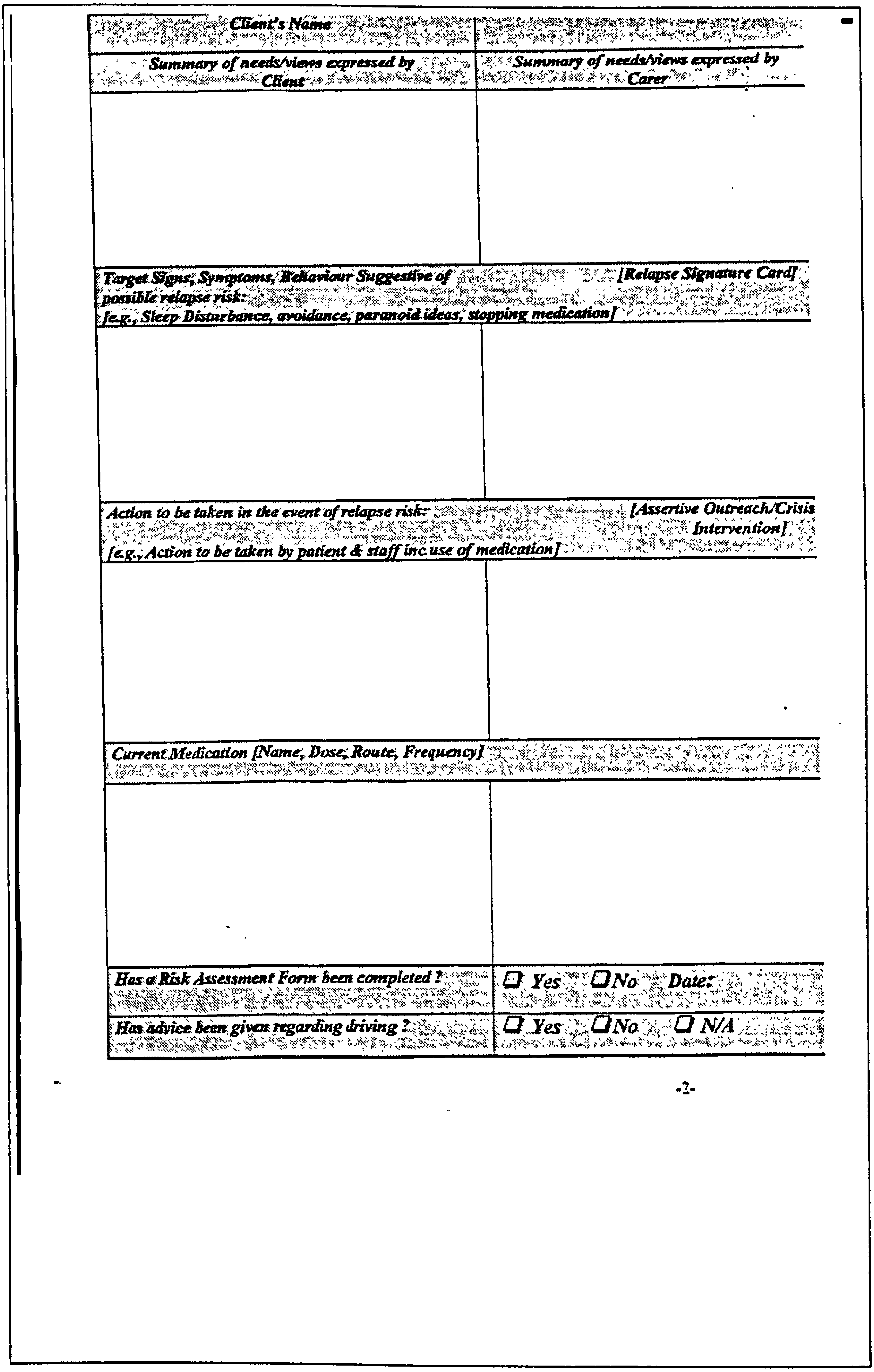
	Name	**Tick if attended meeting**	**Tick if copy of CPA is required**	**Tick if to be invited to next meeting**
Client				
Client's Relative				
Consultant Psychiatrist				
General Practitioner				
Community Psychiatric Nurse				
Psychiatric Nurse-Ward/Day Hosp				
Occupational Therapist				
Psychologist/Psychotherapist				
Social Worker				
Community Support Worker				
Case Manager				
Voluntary Services				
Other [please state]				

Keyworker **Tel:**

Next Review	
Date:	
Time:	
Venue:	
Rescreened for minimal CPA : **YES** ☐ **NO** ☐	

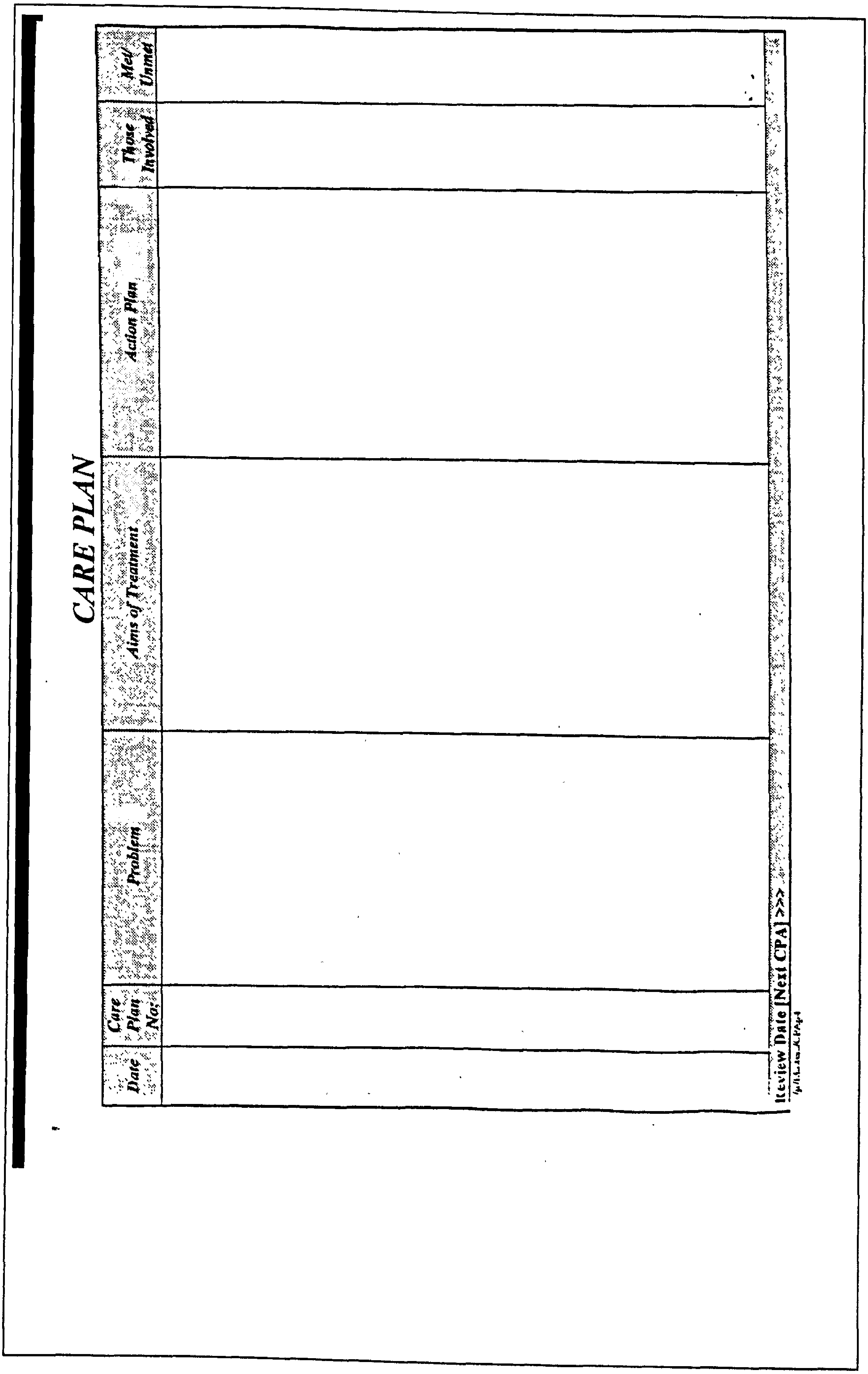
IS THIS PATIENT SUBJECT TO SECTION 117 of MHA 1983 : YES/NO

IS THIS PATIENT ON THE SUPERVISION REGISTER : YES/NO



Client's Name	
Summary of needs/views expressed by Client	***Summary of needs/views expressed by Carer***
Target Signs, Symptoms, Behaviour Suggestive of possible relapse risk: ***[Relapse Signature Card]*** ***[e.g., Sleep Disturbance, avoidance, paranoid ideas, stopping medication]***	
Action to be taken in the event of relapse risk: ***[Assertive Outreach/Crisis Intervention]*** ***[e.g., Action to be taken by patient & staff inc use of medication]***	
Current Medication [Name, Dose, Route, Frequency]	
Has a Risk Assessment Form been completed ?	☐ *Yes* ☐ *No* *Date:*
Has advice been given regarding driving ?	☐ *Yes* ☐ *No* ☐ *N/A*

-2-



CARE PLAN

Date	Care Plan No:	Problem	Aims of Treatment	Action Plan	Those Involved	Met/ Unmet

Review Date	Next CPA	>>>

Appendix III

OVERALL PROGRESS SINCE LAST CPA

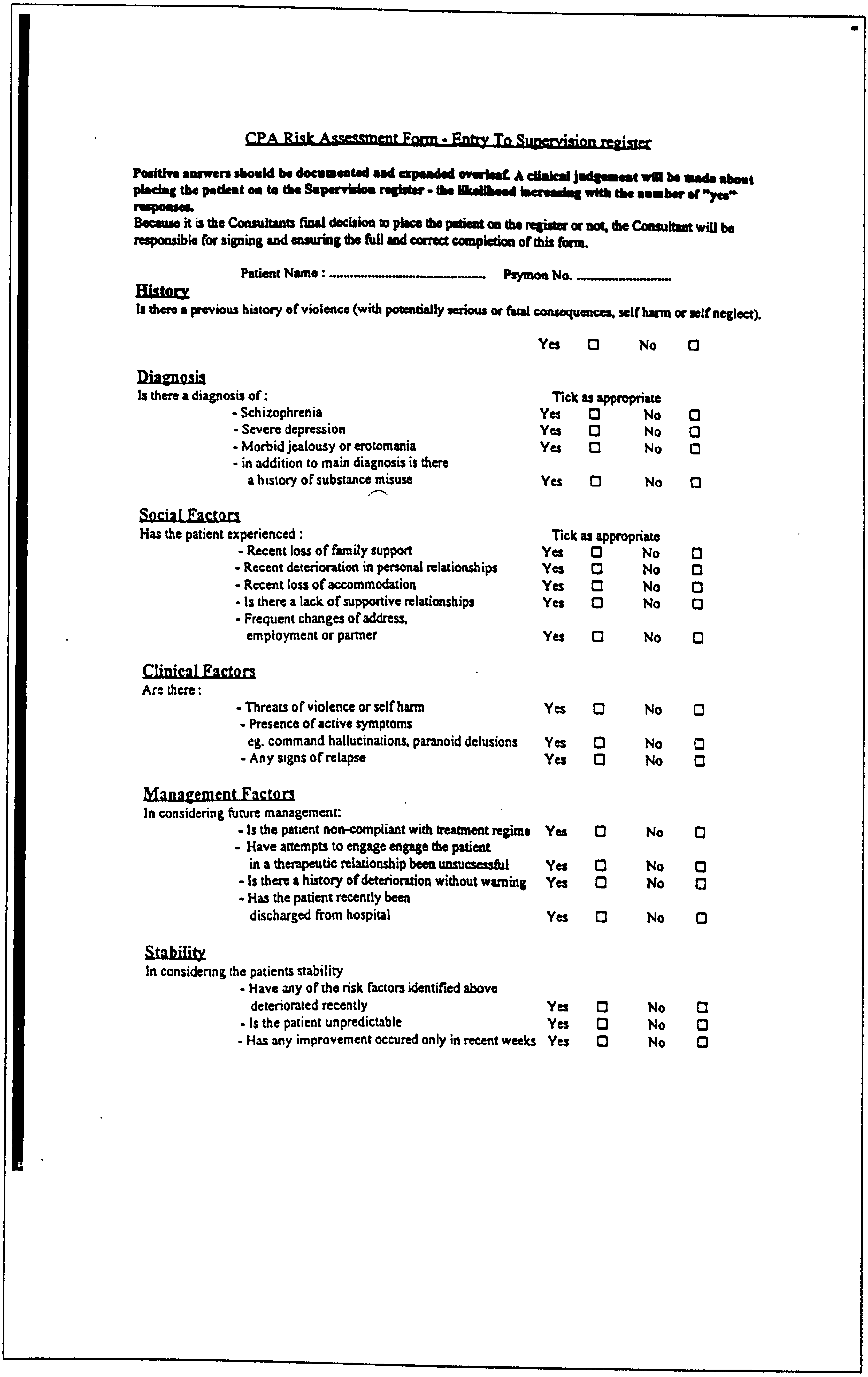
HoNOS Score Sheet		***Comments***
Rate [9] if not known or not applicable	MDT C	
[1] Overactive, agresssive, disruptive behaviour	0 1 2 3 4 - [ ] [ ]	
[2] Non-accidental self injury	0 1 2 3 4 - [ ] [ ]	
[3] Problem-drinking or drug taking	0 1 2 3 4 - [ ] [ ]	
[4] Cognitive problems	0 1 2 3 4 - [ ] [ ]	
[5] Physical illness or disability problems	0 1 2 3 4 - [ ] [ ]	
[6] Problems with hallucinations or delusions	0 1 2 3 4 - [ ] [ ]	
[7] Problems with depressed mood	0 1 2 3 4 - [ ] [ ]	
[8] Outer Mental & Behavioural Problems *[specify disorder, A,B,C,D,E,F,G,H,I,J]*	0 1 2 3 4 - [ ] [ ]	
[9] Problems with Relationships	0 1 2 3 4 - [ ] [ ]	
[10] Problems with activities of daily living	0 1 2 3 4 - [ ] [ ]	
[11] Problems with living conditions	0 1 2 3 4 - [ ] [ ]	
[12] Problems with occupation & activities	0 1 2 3 4 - [ ] [ ]	
TOTAL SCORE >>>		***Any item score of 3 or more should be addressed by thorough assessment & using appropriate tools and interventions***

Crisis contact: Out of Hours

Keyworker Name:	***Telephone Number***	***Bleep***
GP Tel.No:		
Emergency Duty Social Worker Tel.No		
Duty Psychiatrist Tel.No:		

Keyworker Signature:		***Date:***	
Client Signature:		***Date:***	

Appendix III



CPA Risk Assessment Form - Entry To Supervision register

Positive answers should be documented and expanded overleaf. A clinical judgement will be made about placing the patient on to the Supervision register - the likelihood increasing with the number of "yes" responses.
Because it is the Consultants final decision to place the patient on the register or not, the Consultant will be responsible for signing and ensuring the full and correct completion of this form.

Patient Name : .... Psymon No. ....

History

Is there a previous history of violence (with potentially serious or fatal consequences, self harm or self neglect).

Yes ☐ No ☐

Diagnosis

Is there a diagnosis of :

	Tick as appropriate			
- Schizophrenia	Yes	☐	No	☐
- Severe depression	Yes	☐	No	☐
- Morbid jealousy or erotomania	Yes	☐	No	☐
- in addition to main diagnosis is there a history of substance misuse	Yes	☐	No	☐

Social Factors

Has the patient experienced :

	Tick as appropriate			
- Recent loss of family support	Yes	☐	No	☐
- Recent deterioration in personal relationships	Yes	☐	No	☐
- Recent loss of accommodation	Yes	☐	No	☐
- Is there a lack of supportive relationships	Yes	☐	No	☐
- Frequent changes of address, employment or partner	Yes	☐	No	☐

Clinical Factors

Are there :

- Threats of violence or self harm	Yes	☐	No	☐
- Presence of active symptoms eg. command hallucinations, paranoid delusions	Yes	☐	No	☐
- Any signs of relapse	Yes	☐	No	☐

Management Factors

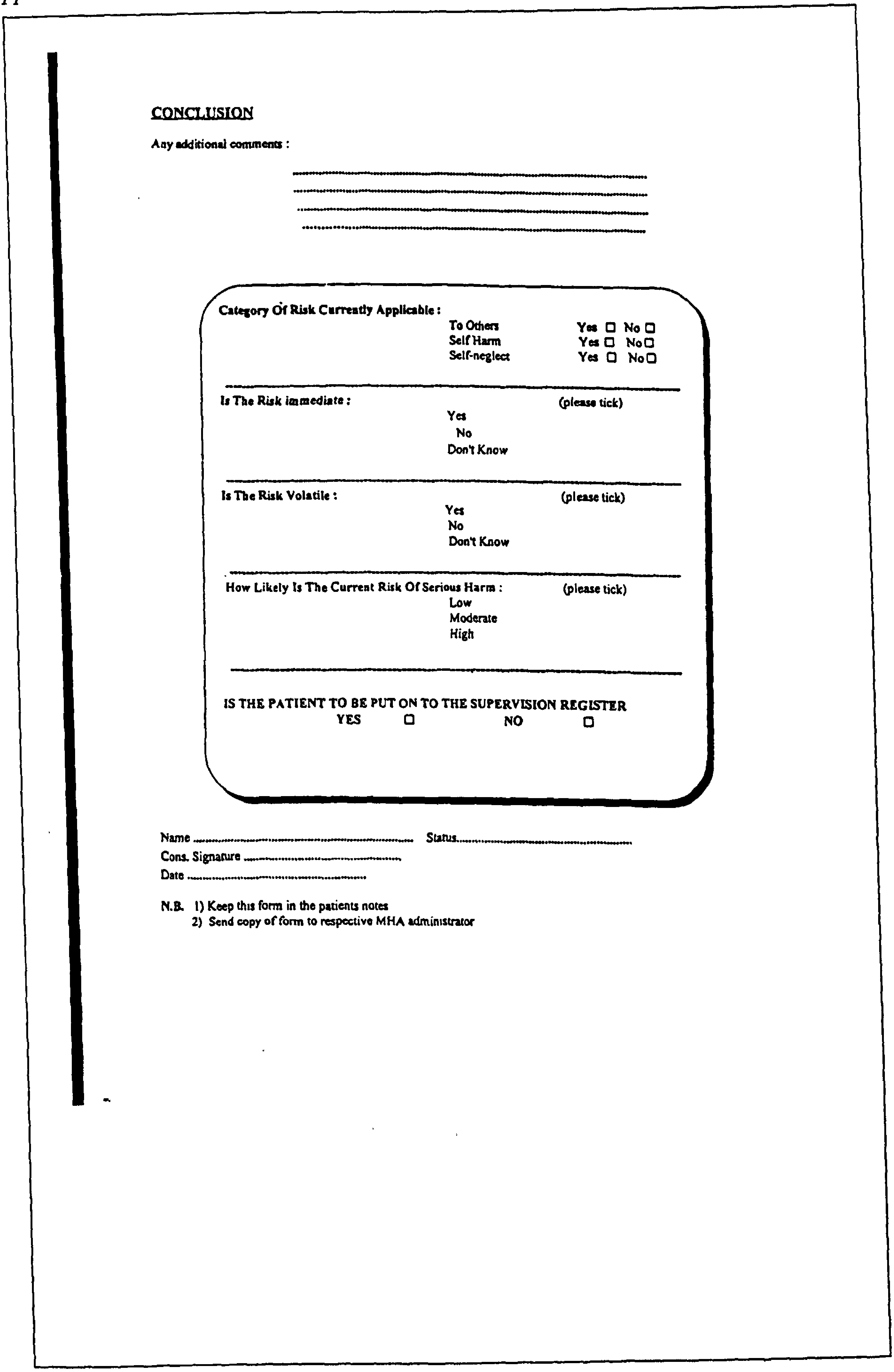
In considering future management:

- Is the patient non-compliant with treatment regime	Yes	☐	No	☐
- Have attempts to engage engage the patient in a therapeutic relationship been unsucsessful	Yes	☐	No	☐
- Is there a history of deterioration without warning	Yes	☐	No	☐
- Has the patient recently been discharged from hospital	Yes	☐	No	☐

Stability

In considering the patients stability

- Have any of the risk factors identified above deteriorated recently	Yes	☐	No	☐
- Is the patient unpredictable	Yes	☐	No	☐
- Has any improvement occured only in recent weeks	Yes	☐	No	☐



CONCLUSION

Any additional comments :

....
....
....
....

Category Of Risk Currently Applicable :

To Others Yes ☐ No ☐
Self Harm Yes ☐ No ☐
Self-neglect Yes ☐ No ☐

Is The Risk immediate : (please tick)

Yes
No
Don't Know

Is The Risk Volatile : (please tick)

Yes
No
Don't Know

How Likely Is The Current Risk Of Serious Harm : (please tick)

Low
Moderate
High

IS THE PATIENT TO BE PUT ON TO THE SUPERVISION REGISTER

YES ☐ NO ☐

Name .... Status ....
Cons. Signature ....
Date ....

N.B. 1) Keep this form in the patients notes
2) Send copy of form to respective MHA administrator

Appendix IV

Transcription Conventions

Advi:::ce	One or more colons indicate extension of prior sound; the more colons, the greater the extension.
H h h	Marks laughter; proportionately as for colons.
Did you?	Question marks signal an upward questioning intonation, but not necessarily a grammatical question mark.
Underline	Indicates words or parts of words emphasised by speakers.
[Overlap]	Square brackets show the beginning and end of overlapping speech.
((to Natalie))	Double parentheses contain comments from the transcriber.
(1.5)	Length of pause in tenths of a second.
(.)	Micropause which is noticeable but less than one tenth of a second.
[.]	Untimed pause in "notes only" transcriptions.
=	Marks no discernible gap between the end of one speaker's turn and the beginning of the next turn.
°Quieter°	Degree signs enclose speech that is quieter than the surrounding talk.
LOUDER	Words or parts of words which are capitalised show speech that is louder than the surrounding talk.
>Faster<	Enclose speeded up talk.
(Doubtful)	Single parentheses contain words and phrases that the transcriber is unsure about. Empty brackets indicate talk that is inaudible.
house...help	Three full stops indicate material that has been omitted either for reasons of brevity or because talk was missed during note-taking in 'notes only' meetings.
****	Four stars denote the name of medication.

The original line numbering of transcripts is reproduced in the extracts to give the reader a sense of where the extract occurred in the meeting as a whole.

Appendix V

Background Analysis of Intra-Professional Relations: Articulating and Managing Professional Domains

The number of professionals attending CPA meetings can vary from as many as eight professionals to as few as two, and areas of expertise range from consultant psychiatrists, psychiatrists, registrars and junior doctors, through psychiatric nurses, approved social workers, community support workers and housing support workers, to occupational therapists and managers. Professionals arrive at meetings with pre-designated roles and areas of expertise accorded to them, enshrined in their professional titles, but in coming together and negotiating decisions about patients' futures, different domains of expertise are also accomplished, managed and ranked within these interactions. The following analysis provides a background understanding of CPA meetings in terms of how professionals constitute and manage intra-professional relations interactionally within meetings.

Differentiating Domains: The "mental" and the "social"

The most basic differentiation between professional domains occurs at the level of the "mental" and the "social". Given the seeming "obviousness" of the distinction between the social and mental domains of expertise, it is perhaps surprising that professionals articulate this differentiation at all. In the first extract Sarah, a community psychiatric nurse (CPN), establishes her professional identity and differentiates her domain from that of Betty, a community support worker (CSW).

Meeting 2 (main meeting) : Diane

377 Sarah (CPN): so the care plan that we have at the moment is:: that your depo will be
378 reduced to every three weeks so I'll come round every three weeks to
379 do that and also to monitor your mental state [make sure] you're alright
380 Diane: [yes right]
381 Sarah (CPN): and also I can check out see how you're getting on with your
382 medication
383 Diane: the new medication yeah

384 Sarah (CPN): um (.) activities in the community Bettys gonna try (.) to get you to the
385 womens group

Sarah provides a three-part list of her responsibilities, she will "come round every three weeks" to do the depo, "and also to monitor your mental state", "and also I can check out ...your medication" (lines 378-382). In the process she establishes her professional identity as a community psychiatric nurse (CPN) which is reinforced by her use of medico-psychiatric language ("depo", "monitor", "mental state" and "medication"), although she amends "monitor your mental state" to "make sure you're alright", and "check out" to "see how you're getting on". In making these amendments Sarah succeeds in founding her professional domain whilst at the same time diminishing the force of supervisory discourses of monitoring and checking out, a theme I have discussed in chapter three. She goes on to differentiate her domain from Betty's, the community support worker (CSW), in a contrast between her medical mental domain and a social one, "activities in the community". And whilst Sarah's responsibilities are couched in terms of medical administrations and surveillance, Betty's are framed more in terms of encouragement and persuasion ("try (.) to get you to", line 384) providing further differentiation.

However, in the next extract it becomes clear that what constitutes a site of mental or social intervention is not always so clear-cut and is open to negotiation and reformulation. Nicola, the patient, has an on-going problem with noisy neighbours and Alan, the CPN, has been attempting to help her resolve the matter with her housing association. Alan's opening statement is related to the fact that he is leaving and another professional will be taking over from him. In this sense the "we" is not referring to himself but formulating the necessity for his successor and Dr. North to take the problem seriously. In a contrast between "support" and "helping", and "forgotten" (lines 371-2), Alan is countering a previous implication by Dr. North that the noisy neighbours may not be as serious or intentional as Nicola and Alan have claimed. At this point the doctor raises the possibility that this is more the domain of a social worker, rather than a CPN.

Meeting 5 (main meeting) : Nicola

371 Alan (CPN): I'll be quite clear that I think its impo::rtant that we (.) um support you
372 in helping to pursue the issue around the noise and its not (.) °forgotten
373 about er°
374 Dr. N.: so is there a social worker angle to it at all?
375 Alan (CPN): well ((sighs))=
376 Dr. N.: =is Rose Turquoise still involved?=
377 Alan (CPN): =no no um and >I I think that that thats< what we've actually been
378 trying to do is to to highline the (.) potential health risks (.) er to to
379 Nicola in the event that the matter is is not resolved
380 Dr. N.: ya=
381 Alan (CPN): =and it seems as though we've got a little bit further by using that
382 rather than just er using it as [a social issue]
383 Dr. N.: [oh I think that yes] yes well I think thats
384 right the health risk is there (.) °yes yes° they ought to be more
385 sympathetic

The doctor's introduction of a social worker elicits a noncommittal response from Alan and his sigh at line 375 could be read either as a weary response to an argument he has heard before, or that perhaps a social worker could do it but has not. Dr. North continues to press the "social" by citing a named person together with the implication that a social worker has been "involved" in the past (line 376). But Alan responds with an argument that it is a "potential health risk" to Nicola (line 378), resituating the problem from the social realm back into the mental domain. This is followed up with a small and careful claim ("we've got a little bit further", line 381) in a contrast between what has been achieved from a health risk perspective rather than a "social issue" one. Although this claim is formulated carefully, in that the problem has not yet been resolved, Alan is founding the notion not only that the ostensibly social (as in a housing issue) can in fact be medical/mental, but also suggesting an order of gravity in which the medical/mental outweighs, or adds weight to, social factors ("just...a social issue", line 382) - an argument which receives the doctor's wholehearted support.

This preliminary analysis suggests that discursive differentiations between the "mental" and the "social" are routinely formulated by professionals and can be deployed to establish and differentiate professional identities and responsibilities, to (re)situate problems and thus interventions in one area of professional expertise rather than another, and to prioritise one professional domain over another. However, professional domains are also articulated and differentiated in terms of levels of expertise that cut across simple distinctions between the "mental" and the "social" and provide more explicit gradations.

Ranking Expertise: "someone who knows what they're doing" and "ultra-therapeutic"

In the following extracts professional domains are differentiated in ways that are not straightforwardly "mental" or "social". Rather, domains are constituted in terms of levels of expertise in which some professionals "know" more than others and provide better therapeutic value for the patient. In the first extract, Natasha is in a relationship with another patient, Laurence, and she is pregnant. During the main meeting she has raised issues about needing different accommodation and the dilemma of whether she should move in with Laurence or not. Also during the main meeting the consultant has raised the possibility of whether a social worker should be involved, framed as her preference, which has been blocked by Julia the CPN, and the consultant raises the issue again in the post-meeting. In the sequence preceding this one, the CPN has again attempted to block the consultant by claiming that it is "a child and families problem... and the child and families social workers don't come in until the childs...actually born". The extract begins with the doctor framing her disagreement to the CPN's claim.

Meeting 12 (post-meeting) : Natasha

Dr. S.: yes but I think I mean we don't actually I >don't think we have to<
automatically bring them in
Julia (CPN): right yeah
Dr. S.: cos I mean if shes coping fi::ne then there won't be a problem but I
suspect we need probably a social worker (0.9) checking that out=
Julia (CPN): =yeah
Dr. S.: so its a matter of what point (.) whether we ask Celia Beige (.) to think
about the accommodation but you see I don't think its fair for Celia cos
Celias only a housing worker=

775 Julia (CPN): =mm
776 Dr. S.: a support worker I don't think shes gonna be ab it doesn't sound as if
777 Natasha confides in her (1.4) in terms of the nuances of this
778 relationship I mean obviously from the report she doesn't know (.) but I
779 think its going to be quite subtle as to (0.8) y'know I think shes gonna
780 need quite a bit of counselling
781 Julia (CPN): yeah
782 Dr. S.: in terms of whether she does want to move in shes very uncertain
783 Julia (CPN): yeah
784 Dr. S.: um and I'm not sure who should be doing that I I I think it >probably
785 should be one of the social workers< (0.8) unless you feel you want to
786 do it (5.0) but I think it we can't just say to Celia (1.0) go for getting a
787 different cou::nselling I mean I think >theres gonna be< there needs to
788 be someone who knows what they're doing

The doctor frames her disagreement carefully. She begins by making the problem contingent, "if shes coping...there won't be a problem", rather than "automatic", however this works as a disclaimer as the doctor goes on to found the likelihood that it will be a problem. This is also formulated carefully in terms of "suspect" and "probably" (line 770) but nonetheless founds the claim that a social worker will be necessary, with the social worker's role articulated in terms of supervision and assessment, "checking that out" (line 770). Up to this point the talk has concerned assessing Natasha's ability to mother but now the consultant brings in Celia Beige, a professional already assigned to Natasha, and begins to reformulate the problem. In another disclaimer Celia is brought in as someone who could "think about the accommodation" (lines 772-3) but is raised in order to be dismissed. Dr. South frames Celia as unsuitable for the job. Firstly it is not "fair" because she is "only a housing worker...a support worker" (lines 773-6) suggesting that it is too much to expect of Celia, given her (low) level of professional expertise, followed by an unfinished claim that such a level of expertise is insufficient, "I don't think shes gonna be ab" (line 776). The doctor then goes on to undermine the relationship between Celia and Natasha; Natasha does not "confide" in Celia, evidenced by the fact that Celia "doesn't know" Natasha is pregnant (lines 777-8).

The doctor finishes by reformulating what is required; it is no longer a question of checking out Natasha's ability to mother but rather "subtle...counselling" (lines 779-80), to decide whether she should move in with Laurence, and Dr. South brings in Natasha to support this reformulation, "shes very uncertain" (line 782). The doctor's reformulation of the problem is probably a pre-emptive move to prevent Julia blocking her again. Finally, the consultant moves back to her original claim but it is framed extremely carefully, "I'm not sure", "I think it probably" (line 784). Now Julia is presented with a fixed choice; either we get a social worker or you do it. The pause (five seconds) at line 786 is significant; Dr. South waits for Julia's response but when she does not respond the doctor is left to work further at her argument, reiterating her claim that Celia is not suitable for the job, and finishing with the assertion that it has to be done by a professional with sufficient level of expertise, "someone who knows what they're doing" (line 788). The doctor has worked up the problem to the point where the only real option is a social worker, and "we can't just say to Celia" (line 786) positions Julia with the doctor on a level of professional expertise that positions Celia on the other side of a professional 'us and them' divide.

In the above extract professional domains are differentiated by levels of expertise that are not straightforwardly "mental" or "social". In this case "counselling" could be undertaken by a social worker or a CPN but what is made distinctive is that it should be by "someone who knows what they're doing", that is someone with a sufficient level of expertise. It is also apparent that the consultant does not consider that she should provide this counselling, suggesting further differentiations and gradations.

Differentiating domains through levels of expertise can also be articulated in terms of therapeutic value for the patient. In the following extract the professionals are discussing the previous care plan for Christine, the patient, where it had been "agreed" that Christine would attend the beliefs group at the community centre. Claire, the CPN, has been explaining to Dr. North that Christine had attended for a while but "had trouble with her car", "then she went on holiday" and subsequently "just lapsed from it" (text not included here). At the start of this extract, Dr. North is attempting to obtain the professionals' agreement ("shouldn't we just say" line 162) in a rhetoric of argument construction that "if shes going to go anywhere" then "this is what she should go to" (lines 162-3), suggesting that it does not matter what the reasons were, it is important that Christine should go to this group (out of "anywhere" this is the one thing she should attend) and they should all agree.

Meeting 1 (pre-meeting) : Christine
162 Dr. N.: well shouldn't we just say well if shes going to go anywhere this is
163 what she should go (.) to I mean could you maybe fit it in with your
164 visits and sort of bring her >here or something because otherwise<
165 shes having things that are ni::ce but (0.6) er maybe SEMI-therapeutic
166 but the sort of ultra-therapeutic thing of the (0.5) grou::p shes not
167 actually getting to
168 Jane (CSW): what day is it on now Claire?
169 Claire (CPN): its still on a Thursday but you'll have to check with Sarah ( )
170 because I know ( )
171 Dr. N.: so maybe you could combine that with bringing her here and then
172 maybe (.) having a cup of coffee afterwards and then a chat or a stroll
173 or whatever
174 Jane (CSW): yeah possibly depending on whether I've already got something I
175 regularly do on [tha::t]
176 Claire (CPN): [yeah]

Having established that this is the most important activity for Christine, the doctor moves to enlist the help of Jane, the CSW, to "bring her" followed by a damning contrast between what is of real value, "ultra-therapeutic", and a much less valuable alternative, "SEMI-therapeutic" (lines 165-6). The emphasis on each differentiation adds force to the contrast between something pleasurable ("nice") and something really important. And the pause and "maybe" between "nice" and "semi-therapeutic" implies it barely counts as therapy at all. The contrast is set up in such a way that it is clear which is the preferred alternative and in the process the beliefs group, and by implication the professionals involved in it, is framed as highly professional and expert in delivering ultra-therapy whereas Jane's domain ("your visits", lines 153-4) is formulated as barely reaching the level of professional expertise.

Jane does not engage with the consultant but instead puts a practical question to Claire which suggests that she is considering the doctor's suggestion. Although some of the talk is inaudible here, it would seem that Claire is raising possible organisational constraints, signalled by the "but", and then bringing in someone who is not present but needs to be consulted. However, Dr. North ignores Claire and reiterates her argument reinforcing the insubstantiality of what Jane does in a three-part list of "a chat or a stroll or whatever" (lines 172-3). The first two list items suggest the sort of activities one might engage in with a friend (rather than a professional) and convey little sense of expertise or therapy, while the third item, as a generalised list completer, implies both that there are many more equally insubstantial activities and that these are something of a mystery to the doctor. In this way the doctor constitutes Jane's domain as a low level of expertise in order to further her plan for Christine; Jane could "combine" something useful and therapeutic with "whatever" it is she does.

Jane attempts to refurnish her professional role by implying that it is contingent upon her other obligations and commitments, "possibly depending on whether I've already got something I regularly do" (lines 174-5). In turn, Claire's response at line 176 supports Jane's status as someone who does do valuable work which cannot be changed at the drop of a hat. It indicates that professional alliances may be formed which constitute domains that cut across both the mental and the social, and levels of expertise: in this case a differentiation, based on geographical location, between the hospital-based consultant and the community-based community mental health team.

Therefore, the discourses of the "mental" and the "social", "someone who knows what they're doing" and "ultra-therapeutic" articulate, differentiate, prioritise and, in the case of the latter two, rank professional domains within interactions. Through these discourses, professional identities and responsibilities are established, and problems and interventions situated. But what constitutes a domain can be open to negotiation and professional alliances can cut across mental/social differentiations and levels of expertise. The differentiation of professional domains is further accomplished through articulations of a chain of mediation.

Articulations of Chains of Mediation, Authority and Status: "tell Sarah and you can let me know" and "I usually say ring Claire"

Chains of mediation between patients and professionals are articulated within meetings in such a way that professional responsibilities are accomplished and differentiated. In turn, differentiated responsibilities implicate a chain of authority; professionals do not have equal access to activities of supervising, informing, knowing etc.. The distribution of "status" and "competence" amongst professionals (Rose 1986b: 209), and thus who has authority over whom, is formulated at a broader level of discourse outside these meetings and this institution, and is reproduced and represented in designations such as 'doctor', 'nurse' and 'support worker'. However, responsibilities, authority and status are also accomplished and managed interactively within meetings. In order to establish that this is the case, I have removed identifying designations in the extracts that follow. In the first extract, participants are discussing the problem of side effects from the patient's medication. The extract begins with "A" formulating the problem as a source of concern ("what concerns me") which both works to frame it as a matter for professional concern and presents the speaker as a concerned professional.

Meeting 2 (main meeting) : Diane (**** denotes name of medication)

A: what concerns me is the side effects because I can see you've got it (.)
and that is a problem (.) um and we can't ignore it
B: yeah=
A: =so y'know C really you need to keep an eye on that to make sure it
doesn't get worse but it gets bette::r u::m (.) so I mean hopefully with
the injection cut down to three weekly you'll be doing just as we::ll but
the side effect will be less but I I'll wait to hear about that from C
[but I]
C: [yes we] had a discussion already about the **** when I noticed the
shaking=
A: =yeah
B: yeah I mean sometimes even after my tablet C sometimes it's rea::lly
A: well I think if it's ba::d I mean tell C and=
B: =yes=

430 A: =and you can let me kno::w

"A" goes on to embed the "problem" in a three-part list of "I can see you've got it (.) and that is a problem (.) um and we can't ignore it" (lines 416-7). The positioning of items in the list enables "A" to shift the topic from her personal concern and naming as a problem, to a more collective responsibility. Her move from "I" to "we" ("can't ignore it") becomes clearer at line 419 when (some of) the responsibility is placed on "C". In framing it as "C" who "really you need to keep an eye on that", the implication is that C either did not see it, did not think it was a problem or ignored it. This reading is supported by "C"'s response in the form of a counter-claim, which she interrupts "A" to make, that she did see it ("when I noticed"), she knew it was a problem and she did not ignore it, "we had a discussion. already" (lines 424-5). At the same time, "A" lays out "C"'s professional responsibility as supervision in two contrasts between "get worse" and "gets bette::r", and between "doing just as we::ll" and "the side effect will be less". "A" finishes this sequence with a caveat "but I'll wait to hear about that from "C" (line 422) which establishes a chain of supervision and mediation which flows from "C" to "A"; "C" "needs" to supervise the effects of the medication and "make sure" there is improvement and "A" will "wait" to be informed about the patient's progress from "C".

At this point B re-enters the conversation implying that "C" did have a discussion with her about taking the medication but also, perhaps, that that was not sufficient, "even" (line 428). "A" uses "B"'s intervention to reinforce the chain of responsibility and mediation, "tell C and... you can let me kno::w" (lines 428-30), in which "B" tells "C" and "C" tells "A". In this way a chain of mediation is established with "B" at one end, "A" at the other and "C" as the mediator between the two. In turn, different responsibilities are also established: "B" is responsible for informing "C" "if its ba::d"; "C" is responsible for supervising the effects of the medication, making sure it gets better rather than worse and informing "A" of any progress or deterioration; "A" is responsible for "know"-ing, but not for actively pursuing that knowledge ("I'll wait to hear about that"), with the implication that she is also responsible for making adjustments to the medication.

From this we can see that who tells, who keeps an eye on and makes sure and who waits to hear and needs to know is accomplished and differentiated within the interaction. As such, the participants do not have equal access to the activities and responsibilities of informing, supervising and knowing. "B" only informs, "C" supervises and informs, but "A" needs to know. Thus the chain of mediation also implicates a chain of authority from "B" to "C" to "A". Moreover, the accomplishment of this chain of authority is reinforced by who ascribes and delegates responsibilities within the interaction; throughout this sequence it is "A" who establishes this 'right'. In addition, what is not apparent from the extract itself is that there is another professional, "D", present in the meeting who has regular contact with the patient. But "D" is excluded, by absence, from the chain of mediation and authority altogether.

The chain of mediation constituted within interactions can also implicate differentiations of status. In the next extract I continue with the same identifiers of "A", "B", "C" and "D" which designate the same kinds of roles, although the actual participants may differ. In this extract the professionals have been having a discussion about the need to get the patient out of the house to take part in activities at the community centre. In the sequence immediately preceding this, "A" has suggested that the patient is "dependent" on the professionals evidenced by the fact that "she rings me" (text not included here). However, the emphasis on "me" suggests that it may be inappropriate for a patient to telephone "A" and signals a turn in the conversation.

Meeting 1 (pre-meeting) : Christine

A: she sort of rings me up (0.6) often (.) well >most of the time< she
doesn't get through to me but she gets through to Sandra and says oh
y'know I've got to (0.5) speak its very important and its usually
something y'know quite psychotic that she has to convey (1.1) but
y'know she seems not to have (.) anyone else to turn to (4.0)
C: well she does that (.) to all of us I think I get
D: you get the phone calls [too]
A: [you] get them as well well I usually say ring C
h h h
C: that's probably what it is h h h h

339 A: well I mean I've learnt that its never I mean its sort of presented as
340 y'know a terribly <u>urgent</u> (.) problem and when I have spoken to her its
341 just been the usual thing of can I come into hospital please because I
342 think I need a rest (1.3)
343 C: h h

"A" begins by reiterating that Christine rings her, followed by the assertion that usually Christine speaks to someone else, not her, "she doesn't get <u>through</u> to me but she gets through to <u>Sandra</u>". The claim together with the emphases sets up the notion that "A" is important enough to have someone who screens her calls and too important to take calls from patients. The use of verbatim reporting gives her narrative an immediacy and veracity and the notion that it is "usually something...quite psychotic that she has to convey" (lines 331-2) appears to be founding the, perhaps surprising, inference that Christine only talks nonsense and it is a waste of time. The closing segment, "she seems not to have (.) anyone <u>else</u> to turn to" (line 333) is double-edged; on one hand it supports her previous argument that Christine's mother is not sufficiently supportive (text not included here) and Christine is dependent on the professionals. But it also implies that if Christine is phoning her, then the other professionals are not being sufficiently supportive and perhaps are not doing their jobs properly: "anyone else" covers Christine's Mum *and* the other professionals. The long pause at the end suggests she expects a response from the other professionals.

"C"'s response is in the form of a counter claim; her use of the extreme formulation "all of us" (line 334) counters the equally extreme "anyone else" and reformulates it as a problem for all the professionals, suggesting it is not a case of not doing their job. "D" enters the discussion here, supporting "C"'s formulation. However, "A" interrupts "D" to found a chain of mediation, "I usually say ring "C"" (line 336). "A"'s laughter and "C"'s response, "thats probably what it is" (line 338), followed by more laughter, lightens and defuses a potentially contentious exchange regarding who is, and is not, meeting their professional responsibilities. However, the shared laughter and exchange between "A" and "C" also excludes and discursively dismisses "D"'s claim that she gets calls as well. Finally "A" provides a further narrative with more verbatim reporting which reiterates her claim that speaking to Christine is a waste of time, but this time the narrative is used to make a joke at Christine's expense. In formulating that it is "never...a terribly urgent problem" it is "just" that she wants to come into "hospital" for "a rest" (lines 339-42), more nonsense on Christine's part it would seem, "A" restores the professional consensus. In this extract, a similar sort of chain of mediation and responsibility is established in which "A" should not be responsible for taking phone calls from patients, "C" is responsible for doing so and "D" is excluded. This time, the chain of mediation implicates and differentiates professional statuses; "A" is too high status to take patients' calls while, it is implied, "D" is not of sufficient professional status. And again, it is "A" who accomplishes and ascribes the chain of mediation and differentiations of status.

Therefore chains of mediation and responsibility are discursively accomplished in meetings in such a way that a chain of authority is implicated and professional status is differentiated. It is not entirely surprising that "A" signifies "doctor", "B" patient, "C" community psychiatric nurse (and in other meetings social worker) and "D" community support worker. In effect, a chain of mediation is established which positions the doctor at one end, CPNs and ASWs between the doctor and the patient and CSWs are excluded. Furthermore, a chain of authority and status is also established in which: doctors need to know but do not directly supervise patients or take their phone calls; CPNs and ASWs supervise patients, inform the doctor of progress and take calls from patients; and CSWs are discounted. While such a chain of authority and status might be expected, given that relations between professionals are formulated at a broader level of discourses, the analysis suggests that professional authority and status also has to be accomplished and managed discursively and interactively within the meetings. It may become particularly salient when professional responsibility is framed as an issue. Doctors seem to invoke and deploy the chain of mediation and authority, and differentiations of status to attribute blame for a problematic state of affairs to other professionals (e.g. side effects, inappropriate phone calls), while at the same time retaining ultimate authority and responsibility themselves.

That CSWs are excluded from the chain of mediation might be the most surprising outcome, given that they often have more contact with patients than the other professionals. For example it might be thought that they would be positioned as mediators between the CPNs/ASWs and the patient. However this is not to say that CSWs are excluded from making judgments and contributing knowledge about patients within meetings. In the final part of this section, I turn to the ways in which professionals warrant their accounts in meetings, perhaps the most subtle way in which professionals differentiate their domains and status.

Warranting Accounts : Opinion, Situational Knowledge and Reported Speech

Warranting is a discursive device which speakers employ to justify the authenticity and veracity of their claims. Edwards & Potter (1992: 68) describe warranting as "accomplishments in the rhetoric of truth-telling". They suggest, for example, that a plethora of 'facts' and details may warrant an account and conceal contentious aspects of the narrative. Or the 'truth' of a statement can be warranted by "category entitlement" (pg. 160), that is the category membership of the speaker who is presumed to possess certain areas of knowledge. In their analysis of Chancellor Lawson's memory they identify a range of warrants such as appeals to records, highly-coloured and detailed memories, independent sources and witnesses. In this section I use the notion of warranting to explore further the ways in which professionals differentiate their domains through strategies for warranting the truth and accuracy of their accounts.

The use of "I think" preceding an opinion or judgment is routine within meetings in that everyone (including patients) uses it, but doctors use it to a far greater extent than other participants and more often in some sequences than others. In the first extract the conversation has been preceded by a long sequence in which Mrs. Peach (the patient's mother) has been complaining about the volume of medication Ian, the patient, is on and the fact that it is not very effective. The extract begins with Mrs. Peach mounting a direct attack on Dr. North's professional expertise by bringing in another doctor.

Meeting 16 (main meeting) : Ian

Mrs. Peach: he was doing very well (.) Dr. Orange at the other place a ma:::rvellous
lady (.) and she took the time (.) and got it <u>just</u> right for him (1.1) I

500 know things can happen y'know er er er (0.7) his illness (.) but she sent
501 him out of there (.) as good as gold (1.3) it was just right the aftercare
502 brilliant everything (.) you know and it was sad that it we tried to
503 experiment if you like
504 Dr. N.: we::ll but >I don't think< I don't think its its been a total failure because
505 I think we've gotta listen to what Ian says and he says it does give him
506 a clearer mi:::nd and I think that thats thats something worth havi::ng
507 (.) um I think its hard for [someone]

The expertise of the other doctor, Dr. Orange, is formulated by Mrs. Peach in two three-part lists. The first list suggests a representative description of a caring and expert doctor as the list items move from the kind of person the doctor was, to her careful approach and the outcome for Ian, "ma:::rvellous lady (.) and she took the time (.) and got it just right for him" (lines 498-9). The second list is deployed to support her claim that Ian was "as good as gold" after treatment from this doctor. The first item reiterates the last item of the previous list, creating a link between the two lists, and is accompanied by a further extreme formulation and a generalized list completer which suggests that there were many more praiseworthy and positive results for Ian, "it was just right the aftercare brilliant everything" (lines 501-2). Sandwiched between these lists is a disclaimer, "I know things can happen...his illness (.) but.." (lines 499-500) which makes her claim sound more reasonable but nevertheless founds the accusation that Dr. North is not marvellous and has not done these things. Her closing salvo, "experiment" (line 503), not only suggests tinkering with something that should have been left alone, but also implies that Dr. North did not really know what she was doing. The "we" seems to be an attempt to soften what is a strong accusation, bolstered by extreme formulations such as "marvellous", "just right" and "brilliant".

Dr. North's response begins with a signal of disagreement ("we::ll but") but her spluttering (">I don't think< I don't think its its", line 504) suggests she has been taken somewhat by surprise and is having trouble framing her counter-claim. However she goes on to name (and shame?) what Mrs. Peach has implied but is loath to say outright, "total failure", countering with an equally extreme formulation. She then invokes Ian to challenge Mrs. Peach's definition of well, counterposing "good as gold" with "clearer mi:::nd" (line 506) together with the suggestion that she listens to Ian, implying perhaps that Mrs. Peach does not, "we've gotta listen to what Ian says". The start of overlapping speech at line 507 is Ian interrupting the doctor to support and collude with her against Mrs. Peach.

Therefore, the doctor's expertise is under attack, necessitating a strong defence, and her alternative judgment of the situation is warranted by a series of "I think's". The sheer volume, five "I think's" in three and a half lines, suggests that she is warranting her account with her opinion, supported by an independent witness, Ian. Throughout these meetings, the doctors' most frequent mode of warranting is their opinion which increases when they are under pressure from others (patients, carers, or other professionals). A further example is provided in the first extract of the section on ranking expertise where the consultant is discussing and working up the necessity for Natasha, the patient, to be referred to a social worker but the CPN is attempting to block the consultant's preference. In that extract, the doctor warrants her account that the housing support worker is unsuitable (lines 773, 776 & 786), and the need for a sufficient level of expertise (lines 778, 779, 784 & 787) with her opinion, "I think".

Opinion, as a means of warranting, is not only used as a defence when doctors are under pressure, but also when they are framing a course of action which they anticipate will be contentious. In the following extract, the doctor is under pressure from the patient *and* anticipates a negative response to her account. Early on in this meeting Matthew, the patient, has challenged the efficacy of his medication ("I don't feel the medications helping me at all", text not included here), and the matter has remained unresolved for much of the meeting. However, details of patients' medication and dosage are required on the CPA form and Sarah, the CPN, raises the issue again towards the end of the meeting. The extract begins with Sarah checking with the doctor that the medication will be unchanged. This occasions Dr. North to launch into quite a complicated sequence to justify the effectiveness of the medication and to elicit Matthew's agreement to remain on the medication, something she anticipates he will be reluctant to do. "Depo" is the term used for a regular injection of medication.

Meeting 3 (main meeting) : Matthew

294 Sarah (CPN): so the depo will be the same (.) is that right to continue with that?
295 Dr. N.: well yes I think (1.2) we'll continue with the medication um later on
296 but you see (.) I know you don't quite (.) agree with me Matthew but I
297 think that the medication has helped you and the fact that you're better
298 is is (1.2)to do with the medication later on (0.8) we could (0.7) be
299 cutting it do::wn but I think at the moment as y you're saying things are
300 getting better I think it would >be the wrong time< to cut it down (.)
301 because I think it is helping you
302 Matthew: you think it is=
303 Dr. N.: =I think it is it's helping you to think (.) more clearly and because you
304 can think you can think out your problems better
305 Matthew: °yeah°

The doctor begins with a statement of intent to "continue" the medication, reiterating Sarah's word which suggests continu*ity,* and prefaced with her opinion. She goes on to start framing what appears to be a promise of change in the future, picked up again at line 298, "later on" (line 295), but changes tack to acknowledge Matthew's disagreement. This is presented in the form of a disclaimer, "I know you don't quite (.) agree with me Matthew but..." (line 296), which works to suggest that she has listened to what he has said suggesting, in turn, that she anticipates that her definition of the situation is likely to be disrupted by Matthew. At the same time she founds her own, opposing judgment that "the medication has helped you", again warranted by her opinion, "I think" (lines 296-7). Her recirculation of Matthew's "help" and emphasis on "has" both strengthens the claim that she has listened and at the same time counterposes and promotes her opinion over his.

Having founded this judgment, the doctor picks up the earlier aborted promise of change, presented as another disclaimer, "later on (0.8) we could (0.7) be cutting it do::wn but..." (lines 298-9). The second disclaimer appears to be warding off the notion that she is inflexible and/or that medication is something permanent and unchangeable, while furthering her claim that it should continue unchanged. It also could be anticipating a potential counter-claim from Matthew that the medication should be reduced and places this as a possibility, but one in the indefinite future. Her judgment is warranted, again, by her opinion sandwiched either side of an invocation of Matthew's own account of his progress, "as y you're saying things are getting better" (lines 299-300). The doctor finishes with a reiteration of her previous claim although now it is changed from the past, "I think that the medication has helped you" (lines 296-7) to the present, "I think it is helping you" (line 301), reinforcing the sense of, and need for, continuity. Throughout this sequence the doctor warrants her claim with opinion, "I think" (lines 295, 296-7, 299, 300, 301, & 303). In particular, her opinion immediately follows the two disclaimers, suggesting that it is warranting a claim that she anticipates may receive a negative response.

In response, Matthew picks up on and recasts the doctor's warrant, "you think it is" (line 302). This has a certain ambiguity and could be read either as a request for more information or as suggesting it is *only* her opinion, and one that he does not agree with. Given the discussion on medication earlier in the meeting, and the doctor's anticipation of a negative response, I would suggest that the latter is more likely. Either way, the doctor has been attempting to elicit Matthew's agreement to remaining on the medication, and his response withholds such agreement and forces the doctor to work further at her claim. The doctor immediately reasserts her opinion, "you think it is=/="I think it is". She goes on to fold a previous claim of Matthew's ("sorting what I'm thinking"/ "thinking yourself into being better", text not included here but discussed in chapter four) into her own claim, and makes his contingent on hers, "its helping you to think (.) more clearly and because you can think you can think out your problems better" (lines 303-4). In making Matthew's claim of thinking himself better contingent upon the medication, and having pre-empted a request for a reduction in medication, the doctor solicits the agreement she has been seeking.

Therefore, the doctors' chief means of warranting their accounts is with their opinion, "I think", which appears to be put to use particularly when they are under attack, when a preferred course of action is being disputed and/or when they anticipate a negative response. It is noteworthy that opinion is used overwhelmingly by doctors as their main warrant (although occasionally it may be combined with an independent witness) and suggests, I would argue, that it is professional opinion that is being mobilised. This becomes clearer when compared with the ways other professionals warrant their accounts. In contrast to doctors, professionals such as CPNs and ASWs draw on their situational knowledge about patients in combination with opinion to warrant their judgments. In the next extract Alan, the CPN, has been directly asked for his assessment of Nicola, the patient, by Dr. North, "anything you want to say Alan" (text not included here), and he formulates a positive assessment of Nicola's health and progress.

Meeting 5 (main meeting) : Nicola
279 Alan (CPN): but at the same time I think that u::m (1.3) I think cetainly:: (1.2) this
280 year it's been quite noticeable that you are you are more assertive in
281 yourself and you're actually managing (.) your symptoms of like
282 hearing voices in a lot more (.) er constructive way than before because
283 I can remember in the past >you'd have taken to your< be::d and (.) you
284 become very isolated and I think you challenge and you fight back a bit
285 more now and your confidence has impro::ved (.) and °that's helped
286 you a lot° (4.7)
287 Dr. N.: °well thats good thats good yeah° so shall we go through the
288 medication

Alan's assessment is constructed in terms of what could be called an opinion "I think" sandwich (lines 279 & 284) of two lists of positive attributes which Nicola possesses now, "more assertive", "managing (.) your symptoms" and "constructive" (lines 280-2) followed by "you challenge", "you fight back" and "your confidence has impro::ved" (lines 284-5). The filling is composed of a contrast with a past warranted by the CPN's memory of situational knowledge, "taken to your< be::d" and "become very isolated". While the consultant used more opinion and the patient as an independent witness, here the CPN uses less opinion and combines it with an appeal to his memory of Nicola's behaviour at home to warrant his account. Although Alan is not under the kind of pressures faced by the doctors in the previous extracts, he has been asked directly for his judgment of Nicola, which could be surmised as putting him under some pressure. This reading is supported by the doctor's response to Alan's assessment; she does not engage with it at all and changes the topic.

In my final example in this section, situational knowledge combined with reported speech is the primary means of warranting. In the sequences preceding this, the three professionals have been making claims and counter-claims regarding why Sarah, the CPN, will be "good for" Diane, in which the doctor has formulated it in terms of personality and ethnicity, Sarah in terms of her professionalism and Betty in terms of gender, "a female CPN". Dr. North and Sarah have just reached consensus by agreeing that it is "changes" for the "better", but Betty is still attempting to press her claim, suggesting that Diane's previous, male, CPN led her to reject her treatment. At this point, to support her argument, Betty begins a highly vivid narrative of what happened just before Diane became ill and was admitted to hospital.

Meeting 2 (post-meeting) : Diane

865 Betty (CSW): mm mm seems quite sad because she said to me (.) the day before she
866 was admitted (.) um I know you're you Betty but she said you're an
867 alien really aren't you
868 Sarah (CPN): ooh
869 Betty (CSW): and I said I'm not Di she said oh you are she said and the television
870 was on and she turned the sound down and she said I'm really
871 frightened actually because you've you've got the message from there
872 haven't you she said and you are an alien
873 Sarah (CPN): gosh isn't that psychotic=
874 Betty (CSW): =yes
875 Dr. N.: oh dear oh dear h h h yes

What is striking about this piece (and many others produced by CSWs) is the sheer volume of reported speech, "she said" (lines 865, 866, 869 twice, 870 & 872) and "I said" (line 869). In all there are seven instances in this short segment. It is clear that in order to warrant her account of how ill Diane became, and thus further her argument, Betty is drawing on highly detailed situational knowledge which is heightened still further and made more effective by verbatim reporting which includes the bewailing "oh" (line 869). But it is Sarah who names it, "psychotic" (line 873), which Betty does not do, another common feature of meetings whereby CSWs do not employ medico-psychiatric terminology. The doctor's amused response at line 875 is also common and could be the kind of 'gallows humour' that is said to occur amongst people working in difficult, hazardous, or life-and-death situations. But it could also be the case that the very bizarreness of such tales of the psychotic are what makes them funny and what marks them off from the 'normal', as in 'everyone' knows that aliens do not send messages through the television.

Therefore there are distinctive differences between the ways professionals warrant their opinions, assessments and arguments. For the doctors, (professional) opinion in the form of "I think" is the chief means for warranting, although they may also combine this with other strategies. CPNs and ASWs regularly combine opinion with situational knowledge which is usually deployed to provide supporting evidence. In contrast, CSWs, who often have the most day-to-day contact with patients and are accorded the lowest levels of expertise (as we have already seen), warrant their accounts with situational narratives that are highly coloured by reported speech, increasing their immediacy and veracity. After all, who is going to say that, actually, the patient did not say that? In effect, CSWs' warrants in terms of narratives appear to be used to claim the right to "say something interesting, relevant, and appropriate to the immediate recipient(s)" (Lynch & Bogen 1996: 281). Therefore it would seem that these different ways of warranting professional accounts are both a reflection of the levels of expertise accorded to different professionals and, in turn, subtly and tacitly reinforce the differentiation and status of professional domains.

In summary, in this appendix I have explored a number of discursive themes whereby professionals articulate and accomplish domains, expertise, authority and status within CPA meetings. The discourses of the "mental" and the "social", "someone who knows what they're doing" and "ultra-therapeutic", along with articulations of chains of mediation, authority and status, and different strategies for warranting accounts, suggest that professional domains are negotiated, differentiated and ranked within interactions. Despite broader discourses which establish relations amongst professionals, the themes discussed here suggest that status and competencies are discursively managed at a localised level. This may occur explicitly when issues of blame are at stake, or when professionals' expertise is challenged or more routinely during multi-professional discussions about patients. The analysis suggests that relations between professionals are interactional accomplishments that are not just determined by external factors.

However, it is difficult to sustain the notion that the doctors' authority and status, and their means for warranting their accounts, are solely the product of moment-by-moment interactional accomplishments. For example, when the doctor invokes "Sandra" this is a resource within the interaction used to further her accomplishment of status, but having a secretary to screen your calls is also determined by broader discourses and institutional practices. Similarly, the sufficiency of opinion to warrant doctors' claims cannot be easily explained within the interactions themselves, and once again is suggestive of the way broader discourses are productive at the local level.

Nevertheless, a complex of relations between professionals is articulated along a number of dimensions in terms of mental, social, expertise, responsibility, authority, status and warranting distinctions; professional relations are accomplished and managed, constituted and reconstituted within interactions. In many instances, but not all, such differentiations produce asymmetries whereby some professionals have more expertise, authority and status than others, although alliances can also be created that cut across and realign relations.

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notion that it is undemanding. In the second list, Betty builds on the notion that it is undemanding by linking it with beauty activities, "you're not under pressure to do anything er and someone comes along from the college to talk about makeup (.) someone came last week to talk about nai::ls" (lines 285-289). The first item in the list, "you're not under pressure", forms a bridge between the previous list and depictions of the sort of activities involved. In the third list Betty presents the women's group as an environment specifically for *women*, "theres about (1.9) eight or nine women and you will <u>kno:::w</u> some of them from the ward...and its all its just <u>all</u> women" (lines 291-4). The small numbers, the fact that Diane will "know some of them", and the emphasis that it is only women works to suggest that it is safe and undemanding *because* it is "just all women".

The final list reiterates and expands the notion that the group is undemanding, "its very relaxing and I don't think you'd feel pressurised or or um...um (.) uncomfortable in any way" (lines 294-7). Therefore, women's group is undemanding because it takes up little time and little is required beyond drinking coffee, because it is about beautifying activities, because it is a safe, women-only environment. Women's group in this formulation is for the kind of 'woman' who cannot manage to do very much, if anything, and who feels happiest and safest with other women. Nothing is required, just for Diane to be there. It is a small step from home to women's group. Therefore each discursive 'sell' of the women's group is furnished with constituent parts that are aimed to appeal to the particular woman concerned. But what is most salient, and what traverses both depictions is that it is a group with women for women. And whilst these women may have different biographical details and predilections, they are women who need to do something outside the home, make friends and be more independent and the best place for that is a professionally organised activity that is "just all women".

The four themes explored so far, "shes stuck in the house", "she doesn't have any friends", "she does get dependent" and "its just all women" suggest that psychiatric professionals are drawing on understandings of femininity in their decision-making regarding patients' futures in terms of their purposefulness and autonomy. Being stuck at home, friendless and dependent is framed as insufficiently purposeful while doing something outside the home, independent of significant others and in the company of other women is framed as the solution. In this way, purposeful activity and a certain understanding of independence