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Doing Fence Sitting: A Discursive Analysis of Clinical Psychologists' Constructions of Mental Health

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Abstract

A growing body of research indicates that the way health care professionals conceptualize mental health might have important clinical implications. We adopted a discursive psychology approach to explore clinical psychologists' accounts of mental health and its effects. Semistructured interviews were conducted with 11 clinical psychologists in the East Midlands region of the United Kingdom. The participants constructed mental health through building up biological factors and psychosocial aspects as opposite ends of the same spectrum, and then positioned themselves as distant from these extremes to manage issues of stake and accountability. A discourse of moral concern for service users was used to negotiate the implications of having different views of mental health from service users, enabling clinicians to manage issues of accountability and demonstrate their ability to be helpful. This suggests that clinicians should be mindful of the effects of their use of language and make the contingent nature of their knowledge explicit.

Keywords

critical methods; discourse analysis; health and well-being; health care professionals; interviews, semistructured; knowledge construction; mental health and illness; psychology; qualitative analysis

In this study we adopted a discursive psychological approach to explore clinical psychologists' constructions of mental health and its perceived influence on their work with service users. This approach is concerned with how language is used within social interactions to manage and create reality, and as such represents a move away from the traditional cognitive psychology view of language as a tool to discover mental states.

Since its inception more than half a century ago, the notion of mental health has been used to designate a range of concepts, including a psychological state, a dimension of health, and wider disciplines such as psychology and psychiatry. Given the variety of purposes for which the term has been adopted, it is not surprising that a great deal of controversy surrounds the meaning of mental health, with views reflecting the interests and values of the groups attempting to define the term. Indeed, a widely accepted definition of mental health remains absent from the literature, and the concept is frequently dismissed as "too nebulous" to warrant serious exploration (Newton, 1988; Secker, 1998). Notably, the APA Dictionary of Psychology (VandenBos, 2007) does not have an entry on mental health, whereas *Campbell's Psychiatric Dictionary* (Campbell, 2010) defines it as a synonym of mental hygiene and a state of psychological well-being. The failure to provide a clear definition of mental health could be seen to imply that the concept has a self-evident validity. Moreover, it suggests a peculiar state of affairs, because psychological literature rarely includes discussions about the general nature of mental health, but at the same time asserts knowledge about the concept.

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

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literature (Malek, 2004; Pickering, 2006), the boundaries between health and illness are drawn differently in different cultural contexts (Fernando, 2003), and the term mental health has frequently been employed to denote the management of mental illness (Vassilev & Pilgrim, 2007).

Despite its elusive nature, there is a growing body of research indicating that the ways in which clinicians conceptualize mental health guide and inform their attitudes, reasoning, and approaches to assessment, formulation, intervention, and evaluation (Harland et al., 2009). Researchers have therefore suggested that clinical psychologists' conceptualizations of mental health have significant clinical implications for their work with service users (Hugo, 2001; Stevens & Harper, 2007).

Clinicians' Conceptualizations of Mental Health and its Effects

Research examining clinicians' conceptualizations of mental health and its implications comprise two main parts. The first is concerned with how conceptualizations influence attitudes and behaviors in relation to service users. Such empirical studies have focused on the consequences of endorsing biological and psychosocial conceptualizations that have been found to influence clinicians' attitudes (Bennett, Thirlaway & Murray, 2008), treatment decisions (Cape, Antebi, Standen, & Glazebrook, 1994), engagement with service users (Kent & Read, 1998), and the quality of treatment provided (Wallach, 2004).

The second part includes studies concerned with the status of clinicians' ontological beliefs about mental health and the effects of these on their work with service users. Such studies have found that psychiatrists and clinical psychologists are unwilling to accept mental disorders as real and natural categories (Ahn, Flanagan, Marsh, & Sanislow, 2006), that ontological views about mental health influence clinicians' beliefs about the effectiveness of interventions and choice of treatment options, and that service users' views about the etiology of their condition are shaped by their clinicians (Ahn, Proctor, & Flanagan, 2009). All of these studies provide support for the notion that clinicians' conceptualizations of mental health have important clinical implications.

The Problematization of Mental Health

Although previous studies have been usefully conducted, they appear conceptually and methodologically limited because they rest on the a priori assumption that mental health is a consensual object of thought about which only attributions might vary. Past studies have assumed that conceptualizations, beliefs, and attitudes reside internally within individuals, that these remain relatively stable across contexts, and that they can be elicited through appropriate research methods. The notion that people's language reflects their underlying thoughts and feelings has been disputed by discursive psychologists such as Potter and Wetherell (1987), who have argued that people construct accounts to serve different functions. In support of this, there is extensive research on health (Crossley, 2002) and beyond (Gilbert & Mulkay, 1984) suggesting that people are often inconsistent in their discussions of ideological dilemmas and that attitudes change even during the same interactions (Billig, 1999). This poses difficulties for quantitative methodologies, argued to be insensitive to the performative, variable, and contextual aspects of people's accounts (Parker, 2012).

As such, we propose that clinical psychologists' accounts of mental health and their effects can be productively explored by focusing on the ways in which these are discursively constructed through employing a social constructionist epistemology. Social constructionism holds a relativist position with regard to truth and thus views scientific inquiry not as an objective pursuit of truth but as a social institution which actively and systematically produces specific versions of reality and truth (Nightingale & Cromby, 1999). Taking this perspective, an examination of the various ways in which mental health is constructed, negotiated, and authenticated, and the implications of such accounts, is made possible.

Methodology: Discursive Psychology

In this study we adopted the theory and methods of Potter and Wetherell's (1987) discursive psychology, in which it is assumed that language is constitutive and that people's accounts are constructed to perform specific functions. The variability and inconsistency of people's accounts are considered to be the result of language being oriented toward different functions. For instance, researchers have described how accounts are constructed as factual in journal articles by minimizing the agency of the scientist, thereby implicitly locating agency in the objects of research (Gilbert & Mulkay, 1984). It has been noted that speakers tend to draw on a range of rhetorical strategies when they have a stake in the outcome and in discussing contested issues, such as mental health (Harper, 1995). Through analyzing the various discursive strategies that speakers use to construct their accounts, the functions or interests served by these can thus be made more visible.

We propose that the application of a discursive psychological approach to the examination of clinical psychologists' constructions of mental health and its influence on their work with service users enables an analysis of the processes through which mental health is

"talked into being." Through paying attention to the organization and functions of such talk, the different issues attended to and how this talk is situated by the social and historical context in which it takes place, the adoption of this approach accommodates the variability and fluidity of clinical psychologists' accounts neglected by previous research.

Discursive psychology has been used in previous studies to explore how professional accounts of psychiatric medication can be employed to serve rhetorical and persuasive functions in managing questions about its efficacy (Harper, 1999), to examine the ways in which psychiatric diagnoses are produced in professional discourse (Wooffitt & Allistone, 2005), and to study how the professional use of psychological terms can be the site of discursive struggle (McHoul & Rapley, 2005). As such, discursive psychology was considered to provide a framework well suited to the aim of this study: to explore clinical psychologists' constructions of mental health and its perceived impact on their work with service users.

Methods

Data for this study comprised audio recordings from 11 interviews with clinical psychologists in the East Midlands region of the United Kingdom.

Participants

Prior to carrying out this study we received ethical approval from the Institute of Work, Health and Organisations at the University of Nottingham. We used a purposive maximum-variation sampling strategy because it was hoped that recruiting participants from various services would allow the range of positions and discourses available to speakers to be identified. Clinical psychologists known to us were sent information about the research through email. Eleven clinical psychologists volunteered to take part in the study, a sample size consistent with other published discursive studies designed to explore issues related to professionals' accounts of mental health (e.g., Harper, 1995). Potter and Wetherell (1987) noted that discursive psychology methods require smaller sample sizes compared to quantitative approaches because the success of such studies are dependent not on the amount of data but on the research question asked and depth of the analysis carried out. Indeed, the adoption of saturation as a generic quality marker for qualitative research has been argued to be inappropriate and, at worst, misleading (O'Reilly & Parker, 2013).

Because of the small number of participants, demographic information is offered across the sample to protect confidentiality and minimize the risk of identification. The sample consisted of 7 women and 4 men, 6 of whom had 0 to 10 years of clinical experience, 2 who had between 11 and 20 years, and 3 who had between 21 and 30 years of experience. In terms of age, 5 were between 31 and 40 years, 3 were between 41 and 50 years, and 3 were between 51 and 60 years of age. The participants worked in a variety of services, including primary and secondary care, forensic, community, neuropsychology, residential, and child mental health services.

Interviews

The use of semistructured interviews in discursive research is a contentious issue, and "naturally occurring talk" is frequently preferred (Potter & Hepburn, 2005); however, interviews enable researchers to purposely question a sample on the same issues, and were therefore considered to provide an appropriate framework for gathering data. Before conducting the interviews, we obtained informed consent that included permission to audio-record the interviews and to publish anonymized extracts. The interviews were aimed at eliciting a range of talk around mental health and were guided by an interview schedule covering participants' views of mental health and its effects on their work with service users. The development of the interview schedule was informed by a literature review and pilot study. Each clinical psychologist participated in one interview, the duration of which ranged from approximately 40 to 110 minutes, with an average session duration of about 72 minutes.

Transcription and Analysis

The interviews were recorded using a digital voice recorder and transcribed using a simplified form of Jeffersonian transcription notation (Rapley, 2007). Following Potter and Wetherell's (1987) suggestions, the analysis consisted of an iterative process whereby the transcripts were read a number of times while paying attention to patterns of language use in the data. Anonymized transcripts were discussed in detail in a series of data sessions and extracts relating to the different categories were then transferred into data files, which became the material for analysis. In particular, the different systematic ways in which mental health was talked about, the various discursive strategies used by speakers to construct their accounts as factual and cohesive, and the range of positions made available through the talk were considered.

Quality Issues

As noted, in this study we adopted a social constructionist epistemology, thus rejecting the notion of absolute truth

that logical positivist research is measured against. This epistemological difference has considerable implications for evaluating the quality of the study because the reading of the data is viewed as only one out of a number of possible interpretations. In line with the suggestion that the quality of qualitative research should be evaluated by the logic of justification associated with the study's epistemology, we aimed to meet the quality criteria set out by Madill, Jordan, and Shirley (2000) for discursive psychological research. We urge the reader to keep the criteria of internal coherence, deviant case analysis, trustworthiness, and openness to reader evaluation in mind as they consider and evaluate the study. We have included an outline of the measures taken to meet these in Supplemental Appendix SA (available online at qhr.sagepub.com/supplemental).

Analysis and Discussion

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

Mental Health as Psychosocial vs. Biological

Edwards and Potter (1992) noted that people frequently view others' accounts as invested to some extent, and that there is therefore a risk that an account is discredited on this basis. To manage such dilemmas of stake or interest, people deploy discursive strategies to demonstrate that their accounts are justified or warranted by facts rather than being biased or prejudiced. In the following two extracts, accounts of mental health are constructed through building up biological factors and psychosocial aspects as opposite ends of the spectrum, and speakers position themselves as distant from both of these extremes. This is achieved through the use of a number of discursive strategies that help clinical psychologists manage issues of stake, interest, and accountability.

Extract 1

Interviewer (I): yes:: yes erm it's a good opportunity to ask you what your understanding of mental health is?
Clinical Psychologist 2 (CP2): erm yes I mean it's funny because in the process of doing this I was kind of thinking what is my neat succinct answer to that question and I don't ha:::ha I can't think of one at all.
I: ha ha.
CP2: erm I would have said that=well not historically but maybe for me there is I would really li::ke it would really satisfy me to be able to dismiss the notion of any kind of illness kind of conceptualization
I: mmmm mmmm.
CP2: of and I am thinking about psychosis in this case erm it would really please me to be able to conclusively dismiss the fact that it's an illness and I think my approach is often informed by that drive
I: yes.
CP2: to kind of consider alternatives and think about okay well let's think about this person's kind of psychological resources=how they have been nurtured=their developmental experiences=their attachment style=what life has dealt them because sometimes you know people just get dealt a crappy hand
I: sure
CP2: and erm so thinking about how they respond to kind of psychological burden erm but it's the caveat to that is that it's then tricky when someone sits in front of you and says but it is an illness to me it is
I: mmmm

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48    CP2: and I was well before
49      my medication has helped
50    I: yes
51    CP2: and actually in a way I am
52      internally cursing them damn it
53      ha:ha:ha: I really wish I really
54      had you know, because I suppose
55      theoretically it's satisfying to be
56      able to conceptualize it purely in
57      terms of psychosocial? stuff but I
58      am not sure that we can and I think
59      maybe that's kind of a naïve erm
60      its just its that antipsychiatry
61      thing of just not wanting them to
62      be right
63    I: yes
64    CP2: erm I think ninety percent
65      they are not but there are times
66      particularly postqualification
67      when I have had you kno:w when you
68      think actually you do:: have to
69      consider factors like that
```

Notably, when asked about mental health, the speaker responds by constructing the dismissal of illness conceptualizations as an ideal to aspire to. This ideal is then explored by listing the "psychosocial stuff" which is presented as comprising the alternative to an illness conceptualization of mental health and is finally dismissed through the introduction of a case example on lines (LL) 44–45, which is used as a contrast to the psychosocial aspects of mental health. The use of such contrasts and lists has been noted to be powerful in producing factuality because it combines ideas eclectically from a range of theoretical viewpoints (Edwards & Potter, 1992). Similarly, the speaker communicates that she has no stake in what she is saying through constructing her stake as counter to the illness conceptualization represented by the case example, a discursive strategy known as stake inoculation. Thereby she positions herself as objective and constructs her account as factual (Potter & Hepburn, 2008).

The speaker explains that it "would be theoretically satisfying" to conceptualize mental health purely in psychosocial terms but that, through experience, she has come to think of this as "naïve" and just "that antipsychiatry thing of just not wanting them to be right." In this way, thinking of mental health in purely psychosocial terms is presented as a "naïve ideal" which the speaker distances herself from using case examples, creating a space between theory and practice and referring to the authority given by her experience as a clinical psychologist.

Horton-Salway (2001) suggested that rhetorical strategies are used precisely when there is a sensitive or contentious issue. It is therefore interesting that the case example is deployed following an account of psychosocial aspects of mental health, an aspect that is presented as incongruous with the illness conceptualization which it "would really satisfy" the speaker to "conclusively dismiss." Edwards and Potter (1992) noted how such case study format examples create the impression of a perceptual experience; i.e., as being factual and free from personal bias. The use of this example constructs the account as open to challenge and positions the speaker as reasonable. Indeed, if someone were to say that the speaker endorses an antipsychosocial understanding of mental health, one could point to the comment that she views it as the ideal conceptualization which, if it weren't for her personal experiences of evidence to the contrary, she would embrace.

In the last part of the extract the speaker makes use of various rhetorical strategies to account for the implication of biological factors in mental health and thus an illness conceptualization. First, the use of the qualifier "I think" followed by the numerical approximation "ninety percent" works to position the speaker as thoughtful and open to challenge while objectifying the implication of biological and psychosocial factors in mental health, thus giving them agency in their own right. The use of numbers is a common rhetorical device in empiricist accounts (Gilbert & Mulkay, 1984). Second, through referring to "postqualification" the speaker's talk is constructed as coming from a category (qualified clinical psychologist) of knowledge, and is thus presented as factual upgrade of knowledge.

It is likely that the interviewer's position as a trainee clinical psychologist prompted the speaker to make use of this device, because it might not have carried the same epistemic weight in a conversation with another qualified or senior clinical psychologist. This rhetorical strategy has been named category entitlement by Edwards and Potter (1992), who demonstrated how some individuals (category members) are expected to possess or have access to certain knowledge or skills. Thus, through referring to such category membership, speakers are able to position themselves as "possessing the truth."

Finally, on LL 65–69, the speaker describes how not just she, but everyone else also needs to take such biological factors into account. Through characterizing these

events as having a predictable and sequential pattern, the speaker makes use of a discursive strategy referred to by Edwards (1995) as script formulation. This helps to manage the speaker's accountability because it "scripts" the implication of biological aspects in mental health as an aspect that is to be expected or assumed, and therefore not the responsibility of the speaker.

As in the previous excerpt, although asked about mental health, the speaker in Extract 2 orients toward a conceptualization of mental ill health and constructs mental health, mental illness, and mental health problems as concepts that are taken to mean the same thing and can thus be used interchangeably, as indicated in the statement "whatever terminology you use" on LL 82–83. Through utilizing the impact of a scientific metaphor ("continuum") along with the powerful nomenclature of a scientific and medicalized discourse ("psychosis, mood regulation issues"), mental health is then constructed as real and as existing regardless of the previously mentioned diagnostic categories.

Extract 2

```
 70 I: that's er that's a good point to
 71    lead into erm what your
 72    understanding of mental health is I
 73    suppose.
 74 CP1: I am very much erm mmm:: my
 75    starting point I suppose is that I
 76    see most of the issues that people
 77    struggle with as being part
 78    of erm er: a continuum of human
 79    experience and obviously people who
 80    have got a diagnosis of a mental
 81    illness or a mental health problem
 82    however whatever terminology you
 83    use tend to be people who are just
 84    at the extreme ends of=of some
 85    continuum or other which we are all
 86    on somewhere
 87 I: yes
 88 CP1: erm whether it's erm
 89    obsessiveness or erm:: you know
 90    sort of relationship erm you know
 91    mood regulation type issues or
 92    whether it's erm anxiety or even
 93    psychosis? but I am not a I don't
 94    have a sort of radical position on
 95    erm the sort of the construction
 96    of=of mental illness in that I
 97    think it is legitimate for people
 98    for us to consider and for people
 99    to consider themselves to have what
100    might be described as an illness
101    with a kind of at least partially
102    physiological basis. I think there
103    is evidence or a genetic basis you
104    know there is evidence that=that
105    those factors are relevant
106 I: yes
107 CP1: however? I think that in
108    general the medical approach to
109    mental illness is probably erm in a
110    sense the least important part of
111    it and of the psychological and
112    social end of understanding of
113    somebody's experience and how their
114    difficulties have sort of
115    manifested and understood, erm is
116    kind of you know seventy-five percent
117    of the of what's worth working with
118 I: yes
119 CP1: So=yes medication might be
120    helpful yes it's important to bear
121    in mind there might be things that
122    aren't going to change through
123    social or psychological
124    interventions but I suspect on the
125    whole in mental health erm that
126    that's the sort of the least
127    important part of it very often for
128    a lot of people anyway.
129 I: yes.
130 CP1: erm so I suppose erm and I
131    don't want to put a label on it I
132    loathe to put a label on it but my
133    position would be although I am not
134    a radical antipsychiatry anti-
135    medical I do:: think that that's
136    not where most of the important
137    stuff goes on I guess I would say
138    that
139 I: yes.
140 CP1: or I would say that because I
141    am a psychologist
142 I: yes
143 CP1: but:but that's I suppose
144    where I position myself
```

In the second turn, the speaker positions herself as distant from any radical position before answering the question and corrects herself from "I am not a" to "I don't have a sort of radical position." This rephrasing is noteworthy because it changes the intentionality of the statement from being one that defines the speaker (the verb to be) into a position of choice (the verb to have), thus giving agency to the intentional and flexible nature of the stance. This statement serves to distance the speaker from

radical social constructionist views and works as a rhetorical disclaimer for the following sentence, in which biological aspects of mental health are emphasized. On LL 107–111, the speaker also distances herself from the "medical approach," instead emphasizing the importance of psychosocial aspects of mental health. The use of quantification to describe the extent to which psychosocial factors are implicated in mental health gives the account additional epistemic weight. As in the previous extract, through constructing her stake as counter to the medical approach, stake inoculation is used to protect the speaker from accusations that her account is invested or biased.

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

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

In Extract 2, the speaker restated her positioning as distant from both antipsychiatric and medical understandings of mental health, and then made reference to this positioning as being the dominant narrative within clinical psychology. Through voicing and acknowledging this dominant discourse, the speaker thus introduced her own personal agency and subjectivity into the narrative. This script formulation functions to construct accounts as ones that are to be expected from any clinical psychologist while emphasizing personal agency, thus positioning speakers as thoughtful, balanced, and reasonable. In the following extract the speaker draws on a similar account in explaining the factors that have impacted on his views of mental health.

Extract 3

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145 I: what ehmm::: would you say has
146   influenced your understanding of
147   mental health?
148 CP5: erm you know I suppose I am
149   somebody who tends to think that
150   most things are partly true just
151   as almost everything is partly
152   wrong as well
153 I: yes
154 CP5: it's the kind of models and
155   ideas that we think of that you
156   know I find it difficult to
157   entirely reject any erm but
158   difficult to entirely embrace any:
159 I: sure erm yes
160 CP5: at the expense of others if
161   you see what=I=mean so I am kind
162   of a natural erm fence sitter or
163   fudger or so ha::ha:: erm
164 I: ha::ha
165 CP5: but I suppose I defend that
166   on the basis that I think that's
167   how=I think that's how it really
168  works
169 I: yes::
170 CP5: you know I think we are a and
171   the experiences that we have
172   including the difficult ones=the
173   dramatic ones that we seek help
174   for
175 I: mmmm
176 CP5: are a combination of you know
177   what we are you know biologically
178   evolutionary speaking erm as well
179   as our more immediate erm
180   circumstances you know our
181   psychological and emotional
182   history our attachment histories
```

The speaker asserts that he subscribes to a variety of frameworks of mental health. Although this response implies that such a multifactorial account simply represents the way things really work, it can also be viewed as a rhetorical strategy and thus be examined for the effect that it achieves in talk. On LL 176–182, a range of theoretical frameworks of mental health is presented in a

five-part list, a discursive strategy argued to be effective in constructing factual accounts (Edwards & Potter, 1992). Through eclectically combining ideas from various theoretical viewpoints the account is given a degree of flexibility, which can be used to manage potential challenges, a feature described by Harper (1999) in his analysis of psychiatrists' accounts of the efficacy of medication. In this way, if the influence of biological factors on mental health were questioned on the basis that medical interventions have not had an effect on a person's mental health, then other frameworks can be drawn on as an explanation.

"Fence-sitting" accounts such as these rest on the liberal assumption that all points of view have some utility and therefore appear to be open to criticisms. However, although utilizing rhetoric of eclecticism and balance, they have also been argued to assimilate criticisms and thereby function to maintain the status quo (Billig, 1987). Indeed, one of the effects of fence-sitting accounts is that they can present a range of theories as equally valid but as fixed within a hierarchy. For example, Harper (1999) outlined how such accounts allowed psychiatrists to construct biology at the "core" of mental health problems, and to position psychological and social issues as the mere effects of underlying biological mechanisms.

In the following extract the speaker manages the dilemma of accounting for the efficacy of medication and thus the implication of biological factors after having constructed mental health in terms of psychosocial factors. This is achieved through presenting medication as being able to manage people's mental health on a "very surface level." Such metaphors of depth are a common feature of empiricist accounts and function to position clinical psychologists as experts with specific knowledge about the "realm below the surface." Because this form of knowledge cannot be verified but only assumed through paying attention to symptoms or surface signs, it functions as a type of category entitlement.

Extract 4

```
183 CP4: erm and I don't know you know
184     maybe that's true and I suppose
185     that's another example of
186     something that challenges my
187     reluctance to kind of engage in
188     biological models of illness
189    I: mmmmm::
190 CP4: and kind of chemical
191     imbalances and all those kinds of
192     things because I meet people where
193     medication really works for them
194    I: yes
195 CP4: and makes the difference and
196     therefore I can't say there is
197     nothing in it erm but I also think
198     that you have to be really
199     cautious around that so you know
200     of course somebody appears better
201     if they are sedated
202    I: yes
203 CP4: I erm yes I remember a
204     service user saying to me once
205     that you know of course you know
206     of course he was more tranquil
207     because he was having massive
208     amounts of tranquillizer but it
209     didn't mean that things had
210     changed for him necessarily
211    I: no
212 CP4: it just meant that they were
213     managed on a very surface level
214     and as yet, I suppose alongside
215     those people who I see take
216     medication it seems to be really
217     really helpful for them
218    I: yes
219 CP4: I also see a lot of people on
220     a lot of medication who have been
221     taking it for a long time and
222     nothing has changed for them
223    I: yes
224 CP4: and you know=so I always have
225     that I suppose it's not really a
226     dilemma but I always have that
227     kind of mixed view of maybe there
228     is something in the biology. but
229     maybe there isn't
```

Through constructing a multifactorial account of mental health, the speaker is able to account for the varying efficacy of medication and thus the implication of biological factors while the primacy of psychosocial factors remains unthreatened. Clearly, if the speaker would have constructed mental health in purely psychosocial terms she might have struggled to offer a solution to such challenges. In this way, such multifactorial accounts are able to neutralize challenges to a psychosocial account through the use of biological theories. Moreover, because the account is not tied to any particular theoretical model, it can be changed depending on the circumstances, thus further increasing its flexibility.

In the above extracts, mental health was constructed in biopsychosocial terms, allowing clinical psychologists to implicate biological factors while maintaining the primacy of psychosocial factors in mental health. These accounts draw on elements of eclecticism and balance to

appear flexible and to position clinical psychologists as being open-minded, liberal, and thoughtful professionals who weigh up arguments for and against in a balanced and rational manner. However, as outlined, such accounts might also paradoxically work to relativize challenges and criticisms and thereby function to maintain current practice.

These criticisms of the discursive effects of fence-sitting accounts are also echoed in the literature concerned with the implications of adopting a biopsychosocial model of mental health (Stainton-Rogers, 1991; Yardley, 1996). Engel (1977), the "father" of the biopsychosocial model of mental health, suggested that a "rational scientific approach to behavioral and psychosocial data" (p. 132) should be adopted to create standardized psychosocial measures comparable to biological variables. From this point of view, concepts such as cognitions and personality are to be seen as objective and value-free entities representational of an underlying psychological reality. In this manner, the biopsychosocial model is able to incorporate and assimilate psychosocial aspects of mental health while retaining an essentially biological perspective.

Rather than analyzing psychosocial aspects of mental health in biomedical terms, critics of the biopsychosocial model have proposed that the biological realm should be reinterpreted from a psychosocial viewpoint. From this perspective, mental health and biopsychosocial concepts are viewed as changeable notions that are constructed and maintained by social relationships, roles, and practices; for example, through the practices of clinical psychologists who advocate selective ideas about what mental health really is by outlining the "underlying" causes of the conditions that service users present with in clinical practice.

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

Negotiating Constructions: A Moral Discourse

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

Extract 5

```
CP9: and just it doesn't matter?
  what I believe you know what
  matters is the person's own view
  and their experience and I might
  be able to share some helpful
  ideas
I: yes
CP9: about that and they may take
  them on board and you know they
  might kind of buy into some of my
  theories around mental health erm
  or why they might be facing
  difficulties but they might reject
  that and I suppose part of the way
  that I integrate it into my work
  is by always making it clear that
  I have a kind of bit of a theory
  or a hypothesis and I make it very
  tentative
I: mmmm::
CP9: and I make it very gentle and
  I also invite people to reject it
I: yes
CP9: as much as I invite people to
  buy into it so you know quite
  often in sessions it's not unusual
  for me to say you know I have got
  an idea or it might be wrong and
  tell me if I am completely off the
  mark or you know
I: yes
CP9: I think I am very=I am very
  keen for the client to know that
  they are the expert on them
```

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

Another feature of this discourse is to present oneself as a responsible professional through providing examples of authoritarian clinical psychologists and then

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

Extract 6

```
CP9: I suppose I manage it by and
   I always manage it by taking a
   kind of not knowing position and
   taking a position of not having
   any certainty
I: mmmm::
CP9: So I would never impose on
   somebody that their view=you know
   their view is wrong or just
   because it's different to mine I
   don't see myself as an expert who
   knows more about their experience
   than they do
I: right
CP9: erm and I think that's really
   dangerous and in fact I was having
   a conversation with a service user
   not a client but someone who has
   used psychology services in the
   past recently and they were saying
   that they had a really awful
   experience of going to a
   psychologist who was very
   insistent on what the formulation
 was
I: yes
CP9: of the problem and that
   things that she had seen in her
   life as good the psychologist
   turned that so you know the
   formulation kind of made out that
   things had caused her problems
   that she actually didn't believe
   had caused her problems
   I: mmmm
   CP9: and had never thought about
   it in a kind of negative way
   I:    yes
   CP9: and you know I never want to
   be that psychologist basically you
   know I don't want to be someone
   that kind of imposes a view so I
   think if you take a position where
   you say let's think about what may
   have led to your current
   difficulties erm then you know
   then you can coconstruct
   something that's meaningful to the
   client?
```

In this extract, the service user's expertise is given agency through the assumption of a "not knowing" position. This account is then corroborated through the use of a case example which is strengthened through vivid and detailed descriptions and by the authority of personal experience, which positions the speaker as a credible witness (Edwards & Potter, 1992). The deployment of the extreme case formulations "really dangerous" and "really awful" functions to further emphasize the seriousness of the example (Pomerantz, 1986). The speaker strongly distances herself from those clinical psychologists who "impose" their views on others and places evaluative moral force in the word "impose," which constructs the behavior of such clinicians as morally unjustifiable and unethical. This distancing is also achieved through the use of the personal pronoun "you" and "you know," which works to co-opt the interviewer.

The deployment of the word "coconstruct" suggests a social constructionist discourse in which views about mental health might change depending on their situated-ness. Indeed, the reluctance to make use of the word "truth" and the use of words such as "ideas" and "views," which do not imply a singular, fixed, or neutral way of looking at things, were a prevalent feature of clinical psychologists' talk about the effects of their views about mental health. Gilbert and Mulkay (1984) noted that although the activity performed by participants' constructions cannot be known by analysts, theories about the functions of such accounts can nevertheless be developed through familiarity with the data. It seems that through presenting views about mental health within a social constructionist ontology, clinical psychologists are able to resolve the potential dilemma of having conflicting views and instead emphasize their primary concern: their ability to be helpful to service users through coconstructing narratives.

Extract 7

```
CP2: otherwise I am just pushing
```

```
CP2: and also when someone tells
you that that's how they view
who are we? to tell them that
are wrong?
I: yes
```

my agenda on them aren't I?
I: yes
CP2: by saying no=no it's all about stress=it's all about your psychological resources actually they don't want to hear that and it's not necessarily useful
I: yes
CP2: if they want to think of it as an illness then. and do you know what really annoys me about psychologists? actually who are=who do that and I am only thinking of a couple I am not saying this is a widespread occurrence but I do know a couple of psychologists who=who will push the psychosocial agenda on someone who views their experience as an illness because that's their agenda
I: mmmm:::
CP2: because they think that there is some inherent value in someone understanding it that way rather than that way and I always think that actually boils down to arrogance really
I: mmmmm:::
CP2: of thinking well no my idea is better than yours.
I: yes yes
CP2: and it's not for us to dictate is it you know if someone think of themselves as ill and that=that's not fundamentally undermining their recovery then why would we suggest that they are wrong?

As in the previous extract, the speaker uses a case example to position clinicians who "push their own agendas" as irresponsible and arrogant. This strong moral discourse is highlighted both in the first and the last sentence, in which rhetorical questions are asked as if to invoke common sense: Why fix something that is not broken? The use of consensus is a common discursive strategy to enhance facticity and functions to position the speaker as balanced and reasonable (Potter & Wetherell, 1987).

As we have seen, clinicians root their discourse and justify their decision not to challenge service users' views about mental health in a discourse of moral concern. This concern is perhaps unsurprising given its integral role in the therapeutic relationship and that it is widely considered to be closely linked to clinicians' credibility (Gibson, 2006). Nevertheless, the explicit concern with not imposing views of mental health on service users is interesting, because most schools of therapy offer resources for challenging service users' lifeworlds. As described by Gergen (2009), if a client talks about issues of sexual perversion the psychoanalyst moves on to enquire about childhood experiences, and if a client speaks about how everyone is laughing at him the cognitive therapist asks if they could be laughing at something else. These therapeutic responses serve to challenge the reality of the service user by communicating, "You thought it was this, but it is (or could be) that." Indeed, George Kelly (1969), doubting the alleged truths and insights resulting from psychotherapy, concluded that insights occur only when service users adopt the perspective of therapists.

Disclosing Views: A Moral Dilemma

As reflected in the following extracts, another prevalent feature of clinical psychologists' accounts was whether service users are aware of clinicians' conceptualizations, and whether these ideas should be made explicit.

Extract 8

I: ermm do you think that your the service users that you see that they come away with erm an idea about your views about mental health?
CP6: I would hope so yes yes:: I think I would hope that they would come away with an understanding of how I view it I would also hope they'd come away with an understanding that I am equally open and interested to know about their understanding of it and that even if the two positions are different then that doesn't mean that that's a problem
I: mmmmm::
CP6: and that that's okay
I: yes
CP6: erm so I think it's equally I would want them to come away with a clear understanding of how I view things so that they can disagree or not and likewise I would want them to go away with a very clear view that I am keen to know what their understanding is
I: yes=yes
CP6: of it and whether our views match or whether they don't

```
388 I: mmmm
389 CP6: and if that's a problem for
390    working together or if it's not
391    but I I am a believer in being
392    very explicit about these things
```

In this excerpt the speaker presents the issue of service users coming away with an idea of her construction of mental health as something desired, an ideal to be aspired to, while highlighting her interest in the service user's understanding. This view is justified through giving agency to the expertise of service users, because if they are aware of their clinicians' views they are also able to disagree with them. The speaker emphasizes that although conversing views of mental health could present problems, it would not necessarily do so. In the following excerpt, the speaker draws on a similar discourse of moral concern for service users in accounting for his decision to disclose his position. This is evident in the numerous benefits to service users that the speaker argues that such disclosures lead to, and the way in which he distances himself from "imposing" his views.

Extract 9

```
393 CP11: errm so that informs that so
394    I guess I try and=and I suppose
395    that partly informs why I give
396    people information about my views
397    on mental health I don't I like to
398    think I impose them but I think
399    that kind of if you can give it to
400    people in an accessible way then
401    they are able to make choices so
402    actually you know I think they can
403    put them that erm elevates their
404    knowledge and when people have
405    knowledge they can make better
406    choices I think for themselves
407 I: yes
408 CP11: so I suppose that's partly
409    thinking back to your earlier
410    question about why do I how do
411    people I see end up knowing what I
412    think erm: I do think that does
413    influence my practice that I am
414    trying if you like lay bare the
415    assumptions behind what people do
416    erm just so that then clients can
417    make better choices about the
418    kinds of help they want and have a
419    bit more agency in their care
```

The implication of this account is that clinicians who do not disclose their ideas deprive service users from having these choices. These constructions therefore give agency to service users' expertise and their right to make their own decisions regarding their care through emphasizing the importance of being transparent as a clinician. Moreover, as noted in the above extract, they also warrant the challenging of clinicians' accounts, thereby constructing service users as active agents. In this way, the disclosure of clinical psychologists' views of mental health to service users is presented as a moral necessity, an action performed out of respect for service users' autonomy.

By presenting the need to disclose views in a manner that positions them as responsible clinicians, clinical psychologists are thus able to manage the dilemma of self-presentation or impression management (Potter & Wetherell, 1987). Notably, through constructing the issue of whether to disclose one's views of mental health to service users in moral terms, the decision is converted from a neutral idea into a value-laden judgment call. This, in turn, was evident in the many explanations and justifications that the speakers offered for their decisions, as reflected in the following excerpt.

Extract 10

```
420 CP7: and I would have to explain
421    myself to a client to some extent
422    and I think that probably marks me
423    I'd be surprised if many clinical
424    psychologists erm are that clear
425    about it you know I mean=I think
426    there is an analogy to me you know
427    when a CBT[1] therapist socializes
428    someone in to the model I don't
429    really see there is anything
430    different in what they are doing
431    from what I am doing it's just
432    that we have different beliefs I
433    mean somebody who fully signs up
434    to CBT that is a satisfactory
435    model of a person and of course
436    they have a good ethical base in
437    doing it because it's grounded in
438    quite a lot of empirical support
439    so they can easily defend
440    themselves and say well what I am
441    doing is telling people what's
442    scientifically true about persons
443    erm:
444  I: yes::
445 CP7: erm so all I am=ermm=so
446    that technically I'm giving them
447    information erm and I guess my
```

448 views on people are you know not
449 the same as that but I guess you
450 know=you always give some
451 information about your views as
452 part of the practice I think it's
453 unavoidable

The speaker first positions himself as different from other clinical psychologists and then likens his decision to disclose his views about mental health to cognitive-behavioral therapists socializing service users to the model. This analogy could be seen as working to equate the speaker's actions with those prescribed by the socially sanctioned, evidence-based framework of CBT, thus presenting it as more acceptable and as something that "anyone would do." This account, then, functions to legitimize the speaker's initial positioning as different from the norm. On LL 445–446, the speaker corrects himself from "so all I am" to "so that technically." These starts are noteworthy because they minimize the speaker's decision to disclose his views and highlight the need for justification. Finally, the speaker introduces the idea that views are always shared, whether we like it or not. This construction can be viewed as allowing the speaker to manage issues of accountability because, if someone were to question his rationale for disclosing his views on the basis of it being similar to socializing service users to a CBT model, he could refer to his response that it is unavoidable to transmit some ideas.

As noted throughout this analysis, clinical psychologists negotiate the influence of their views of mental health on their work with service users through drawing on a discourse of moral concern. This discourse was recurrent in the arguments and explanations that the speakers constructed in responding to our questions, and it allowed their talk to be viewed from a moral framework where accountability could be managed within interactions. These were presented within a social constructionist ontology that functioned to highlight how, despite having different views about mental health, the clinical psychologists were nevertheless able to work with service users to coconstruct narratives. As well as being professional, such accounts might also function to reflect aspects of clinicians' ethical self, their need to know that they are benefitting service users rather than causing them harm.

Discussion

In this article we have presented a reading of clinical psychologists' accounts of mental health in which participants constructed biological factors and psychosocial aspects as opposite ends of a spectrum. By positioning themselves as distant from these extremes, participants were able to manage issues of stake and accountability and to present their accounts as credible. This construction legitimated the implication of biological factors while emphasizing the primacy of psychosocial factors, which was helpful in managing cases in which there was a lack of psychosocial evidence to explain a person's mental health. Consistent with Potter and Wetherell's (1987) observations, participants used a range of different rhetorical strategies to construct their accounts of mental health. In particular, stake inoculation, category entitlement, and case examples were used to present their constructions as factual and to manage issues of accountability.

The discursive strategies deployed by the clinical psychologists in this study are consistent with past discursively informed studies, showing a cross-topic relevance by demonstrating how clinicians rely on particular rhetorical devices to "get things done" in verbal interactions (Georgaca, 2014). For example, researchers has outlined how clinicians use such discursive strategies to construct their accounts as credible (Harper, 1995; 1999), to meet challenges to their constructions (Harper, 1994), and to manage issues of professional accountability in clinical interactions (Robertson, Paterson, Lauder, Fenton, & Gavin, 2010).

In this study we were also concerned with how clinical psychologists constructed the influence of their views of mental health on their work with service users. One prevalent feature of these accounts was participants negotiating the implications of having different views of mental health than their service users through drawing on a discourse of moral concern, which functioned to manage issues of accountability. The issue of how to manage power and collaboration is a common dilemma in psychotherapy (Frank, 1973) and, in line with this data corpus, previous discursive studies have demonstrated how clinicians manage the implications of challenging service users' beliefs through drawing on a discourse of collaboration (Messari & Hallam, 2003).

Another issue that was brought up by a number of participants was the ethical need to disclose views about mental health to service users so as to enable them to make informed choices in their interactions with services. This narrative is echoed by both the recovery movement (Andresen, Oades, & Caputi, 2011) and the Department of Health (2010), which have argued such transparency to be key to the empowerment of service users' and clinicians' professional accountability, respectively.

In this article we have shown various assumptions implicit in professionals' accounts and examined the consequences of these accounts, in particular for how clinicians and service users are positioned. As outlined in the literature review, clinicians' views and assumptions about mental health have been found to guide and inform their approaches to assessment, formulation, and intervention

(Harland et al., 2009) and to shape service users' views about their conditions (Ahn et al., 2009). This implies that there is a need for clinicians to be honest about the contingent and situated nature of their knowledge and language, to make their assumptions about mental health explicit, and to be mindful of the effects of their use of language on different stakeholders in talking about mental health.

Clearly, if clinicians are not open about such issues there might be a risk of service users passively complying with a process that they do not understand or feel they benefit from, thereby ethically compromising clinicians' practice. Moreover, such open and honest conversations are likely to strengthen the therapeutic alliance, a factor associated with positive outcomes (Martin, Garske, & Davis, 2000) and service user satisfaction (Roberts & Holmes, 1998) across therapies.

On a theoretical level, the findings demonstrate that there is a range of constructions of mental health available to clinical psychologists, and the analysis highlighted the variability and ambiguity of the participants' accounts. This highlights the various difficulties that individuals face in negotiating the concept of mental health and that, rather than relying on the a priori assumption that mental health is a consensual object of thought, future studies should be designed to capture this complexity. Finally, on a methodological level, to our knowledge this research represents the first discursive psychological examination of clinical psychologists' constructions of mental health and its effects on their work with service users. As such, not only does it fill a gap in the discursive analytic literature by examining the topic of mental health as an action-oriented discursive practice but it also offers a discursive space to examine the interactive actions performed in other controversial and contested issues.

The use of this novel approach is not without its limitations. In particular, the use of "artificial data" has been argued to decrease the ecological validity of findings (Potter & Hepburn, 2005). Although not epistemologically problematic, the method of data collection is likely to have impacted on the variability of the data. Given that mental health is an ambiguous and contested term, participants might have been conscious of how they would be perceived in constructing their accounts.

The presence of the interviewer is likely to have influenced the ways in which the clinical psychologists "did" professional accountability and how they defended their constructions of mental health and the choices made in clinical practice. As such, the views and constructions of the participants could be argued to be intersubjective, taking into account what they perceived to be the interviewer's views of mental health. Future studies might therefore consider how clinical psychologists present and negotiate constructions of mental health with service users and other professionals in clinical settings, thus providing the opportunity to compare the data from this study with naturally occurring talk.

Although the influence of cultural context was highlighted in analyzing the actions performed by clinical psychologists' talk, it did not focus on wider contextual issues as much as a different form of discourse analysis might. For instance, undertaking this study using Foucauldian discourse analysis would enable a more thorough consideration of the impact of historical and cultural context on clinical psychologists' discourse. Such an approach might help to identify and document the disciplinary discourses used by clinical psychologists to construct mental health and its effects, which would be helpful because it might lead to a rethinking of clinical psychologists' conceptual underpinnings in relation to mental health. In this study we focused specifically on clinical psychologists' constructions of mental health and its perceived effects. One question that has been left unanswered is how service users construct mental health and their experiences of how views of mental health are negotiated in their interactions with clinicians, which would be an interesting extension to this research.

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Note

1. Cognitive behavioral therapy (CBT) is a psychotherapeutic approach aimed at reducing psychological distress through changing the way people think and behave.

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