Counter-rhetoric and sources of enduring conflict in contested organizational fields: a case study of mental health professionals

ABSTRACT

As a means by which actors justify beliefs and practices, rhetoric has a key institutional role. In contested settings, where multiple groups and the logics associated with them interact, research has highlighted rhetorical strategies that exploit rival systems. The account we develop expands on these ideas and suggests they embrace forms of counter-

rhetoric, or arguments that delegitimize a rival's logic and refine and reframe others' values. We use these categories to explore the case of a local mental health service, an area of health policy known for problematic diagnosis and treatment. Here groups of medical and social-care providers were required to work together in a system of intensive inter-professional relations and clashing logics. Our analysis focuses on this interaction, exploring the language-based nature of logics and sources of conflict between logics that are asserted in counter-rhetorical forms.

KEYWORDS: Rhetoric; counter-rhetoric; institutional logics; mental health; health and social care integration

INTRODUCTION

This study examines linguistic uses particularly rhetoric within an institutional approach. It links rhetoric with institutional logics or those constellations of values, beliefs and practice that organizational groups identify with and define their outlook (Loewenstein 2014; Lok 2010). As a general observation, rhetoric and the logics perspective can be seen to intersect in various ways. Rhetoric is important for explaining how actors induce others to accept favored courses of action (Jarzabkowski et al. 2010; Erkama and Vaara 2010) and these forms of argument have been valuable in explaining how the values and practices of logics are justified and established (Brown et al. 2012; Kaplan 2008). The appeal of central kinds of rhetorical argument often coincides with the values that define commonly-held logics (Green et al. 2008) while both also emphasize 'macro-to-micro' linkages or how wider belief systems influence local situations. Professional groups in particular serve as preeminent examples of bodies that operate across many of these areas, transferring collective powers to situations on the ground (Goodrick and Reay 2011; Scott 2008) and employing strategic forms of persuasion to negotiate tensions between different groups, mediated by different logics (Currie et al. 2012).

Our specific focus is on contexts where multiple logics and the groups associated with them interact. In the institutional approach generally, though early work tended to focus on facilitating processes and the reinforcement of central positions, research attention has increasingly taken account of organizational fields where people experience competing demands and the requirement to negotiate a terrain defined by separate and

potentially conflicting logics (Andersson and Liff 2018; Fincham and Forbes 2015; Greenwood et al. 2011; Nicolini et al. 2016). What is often stressed here is the efficacy of the organizational work expended in 'forms of cultural claims-making' in response to challenges (Bos-de Vos et al. 2019: 129). However, less is known about how groups actually fight for organizational position and the means by which they defend the occupational identities and priorities encoded in logics. Some researchers in this area have drawn attention to more adversarial settings, focusing on how actors' logics are asserted through language forms. Where jurisdictions overlap interaction between logics often occurs via polarized encounters and 'intense efforts by actors to assert their point of view' (Jarzabkowski et al. 2010: 222). In such situations rhetoric can provide the means to defy adverse demands and adapt groups' interests (Bednarek et al. 2017; Erkama and Vaara 2010). Others have explored forms of argument that creatively exploit the tensions of opposition and that, for example, reflect the negative strategies of antagonists, and the weaving together of positive and negative themes (Riaz et al. 2016; Ruebottom 2013; Symon 2005). However, many of these still tend to be partial accounts, often the end point rather than the beginning of analysis and generally underspecifying different language forms involved.

In this context, we attempt to build on extant literature and address the theory gap by focusing more explicitly on *counter-rhetoric*, or the rhetorical forms that oppose others' claims. This approach serves to foreground exchanges that define these often-contested settings and to explore the role of oppositional strategies in intensifying an overall discourse. These include strategies aimed at delegitimizing a rival that are developed alongside a group's own legitimacy claims; it also includes strategies that feed

directly on others' rhetorical claims, sometimes even turning their values against them. We derive this approach partly from theoretical considerations based on extant literature but also in part as an emergent factor from a case study of a local mental health service. Mental health is an area where judgments about appropriate practice can be problematic given the risks attached to treating sensitive conditions in the community. It is also an area that is far from being institutionally unified; health itself is renowned as a 'mixed' field (Denis et al. 2013) and mental health perhaps even more a focus of competing professions (Abbott 1988).

In the service we studied, various medical and community groups were required to work together. Each had concerns around professional standing, occupational identity and responsibilities to patients, although groups broadly aligned with distinctive logics of 'health' and 'care'. The former asserted the primacy of medical expertise, the management of risk and treatment of sensitive conditions in confidence – the latter a set of priorities about engaging with service users' wider problems, sharing information and modifying risk to facilitate recovery. Service integration intended to usher in joint working was thus defined by clashing inter-group logics associated with which was a range of complex uses of language. For example, creating images of others designed to exclude them from professional spheres was a clear strategy. But staff also anticipated criticism – mimicking critiques others may make, and reframing criticism in order to prepare the ground for denials. In explaining uses like these we propose that rhetoric takes on new and distinctive forms; it becomes reflexive and reactive and is continually framed by responses to others' rhetoric.

We focus on two research questions concerned with how groups use counter-argument in a multiple context. First, as rhetoric defines a given field, how do logics reframe other logics and incorporate these images and animate and intensify them? This approach focuses on how logics are adapted within rhetorical exchanges and provides a dynamic and critical view that complements the more usual emphasis on logics as forms of simple institutional prescription (e.g. Nicolini et al. 2012; Thornton et al. 2012). Secondly we further highlight the implications for inter-group and inter-logic conflict. Where logics are asserted through counter-rhetoric and evolve as mutually-defining systems, we explore how these counter-images and constructs of other logics remain sources of conflict, even where organizations are coping at some level with incompatible demands. This extends studies of multiple fields that describe various institutional arrangements but underspecify how interactions actually take place (e.g. Greenwood et al. 2011; Suddaby and Greenwood 2005).

LOGICS AND RHETORIC

Institutional logics represent values that groups and individuals invest in relationships and that 'underpin actors' frameworks for reason and belief' (Suddaby and Greenwood 2005: 35). Logics are thus core elements of any institutional environment – serving as guides to sense making or scripts available to reduce wider uncertainties (Thornton et al. 2012). However, the logics perspective is not purely or even mainly about field coherence, but about the dynamics of pluralist fields conceived in terms of multi-logic groups and contending forces in play (Bos-de Vos et al. 2019; Green et al. 2008). Such diversity reflects the fragmentary nature of many organizational fields and the separate

systems of value and reasoning they embrace (Hartman and Cosler 2019; Fincham and Forbes 2015). For example, the levels of disparity between logics, where they diverge across their whole range and interests are specific and unambiguous, have shown the limits of actors' discretion in reconciling conflict (Greenwood et al. 2011: 332). These dynamics are linked to organizational skills including the use of language-based means such as rhetoric.

The focus on rhetoric and the groups who use it explains how logics that permeate a field transpose into language and are knowable across individuals and time. Logics are invoked through terminologies and vocabularies which define their boundaries but which are not just simple codes for describing expert concepts and practices, but a central 'basis for forming systems of meaning' (Loewenstein 2014: 67; also Loewenstein et al. 2012). Within collective groups such as professions, vocabularies are key means through which logics are maintained and defended, becoming important mechanisms in explaining how changes emerge. Rhetoric in particular denotes distinctive speech acts that supply guarantees through the production of evidence; as such, rhetoric has been viewed as 'a total system of persuasion, reinforcement and reassurance' (Carter and Jackson 2004: 470) and a mainstay of broader discourses. For example, Suddaby and Greenwood (2005: 35) posit a model that links institutional logics as structures that sit between purposeful rhetoric and outcomes in organizational change: 'the strategic use of persuasive language, or rhetoric, is the means by which shifts in institutional logics are secured', and which then 'function to attach or deny legitimacy to new organizational forms'.

This approach is also usefully informed by discussion of professional powers and practices. Here Scott's (2008) seminal account first identified expert occupations as

important agents of institutional change and, in particular, focused on each group's 'distinctive institutional logic' (Scott 2008: 232) as a defining feature governing conduct in an area of work. Others building on this analysis stressed the affinities between professional and institutional projects which are developed and adapted in much the same ways (Suddaby and Viale 2011); in particular, they have explored in detail the means professional forces employ to create institutional and organizational changes (Muzio, Brock and Suddaby 2013). Here Muzio and Kirkpatrick (2011) identify the professions' central aim to expand or preserve control over work in specific organizational sites which

'inevitably involves jurisdictional disputes and negotiations with other professions and aspiring occupations equipped with alternative forms of cultural capital and rhetorical claims to expertise' (Muzio and Kirkpatrick 2011: 332).

Others similarly focus on rhetorical strategies used in interactions between the logics traditional in many professions and other logics that may invade workplaces. For example, Currie et al. (2012) found examples of medical elites who preserved their organizational position and status by successfully defining risk as the field central problem. These groups were able to conceptualize their expertise as the guarantee of safe practice, and define worst-case scenarios only they were able to manage.

Different rhetorical styles define what makes an argument persuasive. Classic Aristotelian rhetoric highlights universal types of appeal that explain how appropriate action is supported. These include the rational use of evidence (*logos*), an appeal to ethical and communal values (*ethos*) and an appeal rooted in emotion and experience

(*pathos*) (Brown et al 2012; Erkama and Vaara 2010). Other styles of rhetoric are available in interaction and include devices such as the transcendence of contrary arguments (Bednarek et al. 2017; Whittle et al. 2008), alignment of the macro with the local, and the defining of problems to which one can supply solutions (Brown et al. 2012; Erkama and Vaara 2010). Almost invariably in real-life contexts actors will, more or less skilfully, draw on and mix up various of these strategies, and use language to trim and modify logics in order to make appeals more compatible. For example, Hartman and Cosler (2019) investigated the 'persuasive messaging' employed in the field of human egg donation. These researchers found opposed altruistic and instrumental logics in the appeals to donors to help infertile couples. This rather surprising mix was nevertheless blended and was bolstered by other rhetorical approaches, such as the use of formal medical terminology in a skilful 'layering of multiple logics'.

Despite this emphasis, however, power effects are not unconstrained. Strategies typically create congruence out of opinions that may be disparate but are still signed up to central values – for example, showing how actors cultivate groups from which compliance is sought (Lounsbury and Glynn 2001; Sillince and Brown 2009), or how they create and disseminate viable identities (Brown et al. 2012). Contested contexts are potentially different again and apply further constraint; here who is being persuaded is less certain, and indeed, some actors (notably an antagonist) may be almost impervious to persuasion. Nevertheless, researchers still emphasize rhetoric in changed circumstances albeit in terms of more assertive or deliberative means (Jarzabkowski et al. 2010). These approaches recognize that rhetoric is partly about creating credible arguments to exclude others. But these forms tend to construct the interests of rivals as an exogenous genre, or

take context for granted and play down how systems of reasoning develop and interact. We seek to build on these insights by specifying types of counter-argument that systematically exploit the ways in which groups reference some opposite or other.

Firstly basic legitimizing rhetoric supports the core values and narratives that unite groups; here a similarity of concerns enables actors to 'persuade themselves and others that they share important qualities, values, and interests' (Whittle et al. 2008: 103). However, also advantageous are forms of 'dissociation' (Golant et al. 2015) that unite speaker and audience by distancing them together from some other; these are claims about competence and judgment that are framed by the deficiencies of logics that others adopt. Researchers have sometimes laid greater emphasis on justifying rhetoric – the creation of positive self-images being seen as actors' first preference while reframing the images of others is secondary (Kaplan 2008: 741). But the evidence for this is mixed. Groups may even prefer negative constructs to 'success stories' as the former allow them to avoid artless claims to status (Fincham 2002). Depending on who they implicate, failure stories can be oddly persuasive. For example, Riaz et al. (2016) describe how bankers responded to threats to their authority in the wake of the financial crisis of 2007-8. They made the expected claims to trustworthiness and expertise but did not try to absolve themselves from blame (which in the circumstances of a banking crash might lack credibility) but preferred to deflect blame and lower estimates of others' abilities.

Accounts that distance the self from failures assigned to others, moreover, can also be used in combination with justifying rhetoric. The 'coupling' of arguments sets up comparisons through which claims gain in effectiveness. Here Sillince and Brown (2009) refer to a rhetorical strategy of 'paired oppositions'; also Ruebottom (2013) points out

how sympathetic and differential rhetoric bring primal themes into play and allow 'a more connotative and evocative use of language' (Ruebottom, 2013: 113). Combining arguments can also be a vehicle for implicit content. As Fairclough (1995: 5) notes this works through a process of 'presupposition', the unspoken part being supplied by the audience such that its credibility is taken for granted.

Finally certain claims and kinds of argument themselves contain the seeds of opposition (Kaplan 2008: 738; Symon 2005: 1646). This assumes that behind any logic there are values perceived as appropriate in a given context but too much of any one becomes inappropriate. As an example consider the possession of expertise; usually a powerful legitimizer, this can be turned on its head and rather than challenge someone's standing as an expert the value of expertise itself can be be called into question (it can be defined as impersonal or overbearing). In this sense, counter-rhetoric trades on the obverse reaction that the assertion of great powers or virtues breeds. Each of the above arguments also draws on complex kinds of 'intertextuality' (Fairclough and Wodak 1997: 262) where statements are linked together and others' assertions and claims (or refinements of them) are brought into arguments. In contested situations there are likely to be many more opportunities to refine and subvert others' values in this way.

FIELD LOGICS

Our research site was as already indicated a mental health service. Located in central Scotland this had been designed as an 'integrated service' in response to policy changes at national level. In the UK, health provision tends to be equated with the free-at-the-point-of-delivery National Health Service (NHS) but less intensive services are also

provided by Local Authorities or Councils. Integration of these areas – health and social care – has been on and off the policy agenda for many years, but while pockets of good practice do exist hoped-for improvements have rarely been achieved. This has earned integrated care the soubriquet of a troubled relationship recurring throughout repeated cycles of policy (Cameron 2015; Toth 2010). A policy push from the Scottish Government sought to readdress these problems; instead of 'service silos' that pass patients from one provider to another the aim was to 'work with a shared understanding of needs and… a greater emphasis on systems of care' (Scottish Executive 2003: 38). Our case was just such an attempt at service integration in one Council region. NHS day care in psychiatry, psychology, occupational therapy and mental-health nursing was reorganized with Council teams in community mental health and community access. These groups had worked with a looser awareness of each other but new norms required a more unified workplace. Crucially too, the changes brought institutional logics of 'health' and 'care' closer together.

These were in effect field-level examples of the meta-logics of professionalism and community (Scott 2008; Thornton et al. 2012) and are well-documented as ways of defining practice (Dunn and Jones 2010). The so-called medical model views mental problems like any other illness; diagnosis is carried out by a doctor (general practitioner or psychiatrist) and treated through clinical intervention, often involving medication. The care model emphasizes social/environmental causes of illness such as domestic violence, addiction and housing, while therapies are administered by workers trained in complementary techniques (Beresford 2002; Roberts and Wolfson 2004). These models were embedded in logics of health and care and, as with all logics encapsulated core

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values, authorizing narratives and existing practices, all homed in specific groups. The health logic enshrined as it was in professional powers was legitimized via knowledge of physical causes and its associated group was NHS practitioners. The logic of care saw good outcomes achieved by normalizing mental health and treating the 'whole person' while the home group was care workers. These can be seen simply as 'alternative philosophies' (Beresford 2002: 582) but when co-present there is considerable potential for conflict. Medical skill, welcome in cases of serious need, may be said to lack social understanding (which *can* be supplied through holistic care); or the claim to bring holistic benefits may impede the control of risk (the specialty of medical experts).

Our study identified two further critical interfaces between logics. Here rhetorical attack and counter attack were couched in discourses that related to core problems of the area. The first of these was around the sharing of information, and the second was around the so-called recovery agenda.

Patient confidentiality vs. information sharing

Policy thinking has long averred cultures of information sharing to be essential for joint working, although in a health context the information in question is patients' records which remain highly sensitive. Policy-makers are therefore equally clear about the need 'to reassure service users that personal information will be treated sensitively and stored securely' (Scottish Executive 2000: 25). This was a dilemma that reverberated within the integrated service. While a 'seamless service' was a priority, the sharing of patient data directly confronted NHS ethics of confidentiality; conflicts were thus felt both by groups

who felt pressed by inappropriate demands for data and those for whom just demands were not being met.

Risk vs. recovery

Logics were also differentiated by perceptions of medical risk. Here it has long been a criticism of psychiatric theory that it harbours views of maintenance and decline in the progression of illness, and places undue stress on the risks attached to chronic conditions and the inevitability of poor outcomes for most people (Lester and Gask 2006). The response has been a more reassuring emphasis on 'recovery'. Themes here allow for a more relaxed view of quality of life, even if this means accepting a higher risk of relapse (Bonney and Stickley 2008). However, these remain very much open questions and psychiatry has never accepted this critique as anything more than a 'caricature' of its profession (Roberts and Wolfson 2004: 45). In any event, these wider debates were at least partly consolidated on the ground; for health professionals symptoms were often signs of worsening conditions, whereas re-engagement with normal life proved central to the care logic.

DATA COLLECTION AND ANALYSIS

Our analysis of language use relied on interviews with service members. As key data sources, these lent themselves to a qualitative and interpretive approach well suited to exploring discursive constructs such as institutional logics and helped to show how rhetoric framed the values and narratives that comprised logics. At the time of the research the service numbered around 45-50 staff of which a total of 22 were

interviewed. The main professional groups were constituted as follows: there were five service managers (from this group the number interviewed, n=5), an elite group of four consultant psychiatrists and psychologists (here n=3), 12 mental health nurses (n=3), four occupational therapists (n=3), six community access workers (n=4) and seven community mental health workers (n=4).

The large majority of the participant group (19 out of 22) were female reflecting the demographic details of the service as a whole and groups such as nurses, community workers and occupational therapists in particular. Interviews were conducted face-to-face, lasting between 40 minutes and one-and-a-half hours and generating in excess of 350 pages of single-spaced transcript. They followed a schedule of thematic questions focused on respondents' experiences of change within the network of inter-professional relations; these included the different images of healthcare and how these were communicated among groups in the field, the effects of working arrangements on group relations, and how workplace integration was supported or resisted. The co-authors conducted all interviews jointly, and compared and discussed the generated data items until a shared understanding was reached, in order to ensure the links between quoted materials and their interpretation were likely to be stable.

The analysis was guided by a number of theory-data links. In describing logics, certain well-known and well-reported settings are known to constitute 'grand institutional regimes' (Meyer et al. 2014: 867) and provide links to professional backgrounds. In our case these helped in identifying the field logics and provided a starting point for defining, separating and exploring analytic dimensions. But the process of assigning data items and extracts to aggregate dimensions needed to take account of other factors; as well as

legitimating accounts that supported a given logic there were attacks on others' ways of working and attempts to deny attacks others might make. Sequences of assertions and counter-assertions (and even counters to the counters) were characteristic of the data, and they led to a search for different rhetorical elements within an emerging theory framework. This began by recognizing that while logics are partly inwardly facing, critiques of others' claims were no less important. A further category reflected claims that were not asserted separately but were contrasted and juxtaposed in speech forms that simultaneously conveyed meanings. At the same time, assaults on others' values represented a means of turning a perceived antagonist's strengths into weaknesses, as well as framing one's own values. These categories provided substantive descriptions of rhetorical forms and were the basis of an emerging pattern of connections between logics. They were used in conjunction with descriptions of respective logics in terms of their main narratives plus the twin discourses of information sharing and recovery identified earlier.

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Table I

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Table 1 summarizes the analysis. The process we followed was adapted from the idea of a 'signature matrix' (Creed et al. 2002: 482) for describing institutional logics. Although designed for describing unique logics, the underlying approach of sorting idea elements into categories and highlighting inter-relations and unifying themes worked well in exploring a multiple organizational field, and provided a useful framework for describing how the health and care logics played off each other. This involved identifying examples that were assigned to separate categories of rhetoric and cross-referencing them

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with the opposed narratives, combinations and counters. We thus sought to explore how groups presented their logic and others and their logic based on links between a logic and its associated group. Data items were arranged so that claims about any logic and arguments directed at another were voiced consistently from one group, and in this way clusters of data items defined the scope of the respective health and care logics. These categories form the basis of the discussion that follows.

CATEGORIES OF RHETORIC

Legitimizing accounts

Groups' interpretive work in support of their logics stood at the base of legitimacy claims. The basic authorizing narrative of the health logic relied on the practitioner's role and on explicit images of professionalism. These emphasized expert knowledge and judgement and tended to be couched in a language of diagnosis, treatment and assessment and working within highly skilled teams.

> I don't think by the very nature of psychological or psychiatric difficulties there is ever an easy answer but we have systems for managing that. We have a process that we follow, and within that we can manage the complexity, so there's nothing about being able to see somebody and decide instantly what is wrong and what needs to happen. That sometimes happens but it is often an emerging process which is where the team helps that we review people. (Consultant Psychologist #2)

However, the logic was not monolithic, and there could also be degrees of variation around the references to these norms. For example, this sometimes reflected a dispassionate, almost mundane focus on doing the job that could potentially emphasize the professional aspect even more, suggesting abilities that needed no further justification.

> I'm the medical person obviously… and one of the things I'm paid for is having a broad overview of mental health and all the different potential interventions. (Consultant Psychiatrist #1)

Or professional expertise could also be filtered through values that were in some respects in tension with an overly medical approach.

> Maybe this is something to do with psychology but I tend to avoid kind of medical terminology. I don't really talk about pathology or diagnosis even. I don't work that way. In fact a lot of the time probably the way I would speak would be more in terms of the social aspect. Yeah, I mean that's one part of the role is to bring that kind of perspective, as well, and to work alongside you know the medical profession. (Consultant Psychologist #3)

Nevertheless, their role in coping with the uncertainties surrounding cases and as managers of risk was central to the health groups' claims. Concepts of medical risk (or the chances of lapsing into a severe condition) were bolstered by references to the

inherently complex nature of the work, or to difficult cases and reminders that any check in a patient's progress may mean a referral back to psychiatric services: '…if anything gets too tricky for people they refer it to [us]' (Occupational Therapist #2).

Claims associated with the care logic struck a very different note. These reflected distinctive but overlapping care principles including the commitment to a holistic engagement and a return to family, friends and work (often amalgamated in references to treating the 'whole person'). Other important principles included the normalization of people's problems and social inclusion, which were frequently activated through the mechanism of the involvement of clients' in services.

Well, I think for us here it's kind of service user led, you know, people telling us what they want. We have a huge service user impact in our working life or our working day, all the time, because we get really good feedback. We ask for feedback constantly after every group, after we see people we're asking them what they want, what was wrong with the hand-outs, what was wrong with this, what was wrong with that. So that kind of shapes what we do. (Community Access worker #4)

And while these arguments drew on underlying principles, they often boiled down to simpler issues of compassion, understanding and common-sense empathy, or simply 'how you treat people'.

Delegitimizing accounts

Alongside these positive claims there also existed attacks on others' logic. In defence of their logic, health professionals drew on criticisms of standards under siege and of those not trained to high standards. Ways of countering the care logic played on communal values as a by-word for well-meaning ineffectiveness, while the inclusiveness that care staff prided themselves on could become a lack of specialist skill.

> There's just this sense that someone comes in from the outside with a rather mysterious agenda and it all looks like it's going to be turned over to a bunch of amateurs from the community. That would be a very unkind way of putting it, but basically the [social care] people were very interchangeable and they could all do each other's jobs. (Consultant Psychiatrist #1)

For their part, care workers initiated corresponding attacks on health values. They openly advocated a 'non-clinical approach' and drew on vivid alternatives to the medical model. Medical know-how was defined as a kind of one-way street between practitioner and client, and there were constant references to the value of keeping people out of hospital (which was slightly disingenuous as NHS provision was supplied from a day centre), as well as direct attacks on the expertise myth of medicine.

> …a general culture as far as mental health [is concerned] is that people in health are the experts; they have got the expertise, they are the be-all and end-all of mental health. (Service Manager #4)

These conjured images of the overuse of knowledge and of power asymmetries invoked by expertise, and hence of unwanted divisions between providers and users. Here the macro-setting arguably took on extra significance. The stigma often attached to mental problems meant that clinical methods ('giving people full psychiatric assessments') were sometimes seen as unwarranted even by clinical groups. Indeed, the very term 'medical' has been seen as a way of labelling doctors and classifying conditions as problems suitable for treatment in unjustified ways (Beresford 2002). In this sense, references to 'the medical model' and practitioner expertise generally, when spoken in certain contexts by certain groups represented an attack on professionalism.

Coupled accounts

These narratives were also paired so that simultaneous legitimating and de-legitimating accounts gathered strength and sharpened respective claims. In some respects, explicit examples of such rhetorical coupling may have only been the most conspicuous cases. Even where people seemed to be simply justifying their own values and practices they could be invoking implicit references. For example, care staff's stress on 'how you treat people' represented an unspoken rebuke of expertise. Similarly, having command of medical interventions highlighted by health groups implied criticism of those whose knowledge wasn't formalized.

Still, people were also practiced in making comparisons explicit. Health staff, for example, tended to define work identities through the professional hierarchy, and pitted their position at 'the peak' of a tiered service against others' lay skills.

We provide the mental health services for [the region]. It's how I see us, and I think we wouldn't necessarily see that [care services] as a mental health problem. That's why they're separate. So, yeah, lots of people here feel lucky that we are who we are because we get on, we feel like we provide good service. We feel that we value each other, but I'm not too sure we bother about the tiers below us. (Consultant Psychologist #2)

On the care side, clinical values came under fire, for example, through highlighting the gulf between a rule-driven medical approach and a less restrictive culture of care.

[With NHS services] it was, we will take you there, we will make sure you do this, we'll make sure you do that, instead of giving the people freedom of choice. But with the social side they were more looking at the person as a whole, if they had a housing issue, if they had this issue, if they had that issue that was getting dealt with. These things got in the way, and that person wasn't allowed to move forward, whereas it didn't matter with the NHS, we'll treat the illness; we'll get you through, whereas the person couldn't really do that because the other things were fuelling the fire. (Community Access Worker #1)

This type of usage involved quick-fire comparisons and a switching back and forth of ideas, a process assisted by rhetorical strategies of 'compression' that seemed emergent and characteristic in participants' responses. The definitive forms of these often came down to individual terms which served almost as keywords that were freighted with

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meaning and brought specific values and practices into play. Terms that stood for a medical approach such as 'patient', 'symptom', and 'treatment' were deemed to be exclusionary by care workers, while their priorities of 'community', 'inclusion' and 'involvement' could signal unprofessionalism to health staff. Condensed language forms supported a range of simple but powerful comparisons. Examples included paired claims designed to stress the importance of managing risk: 'If they go there [social services] and they're too unwell, then they need to come back up here.' (Occupational Therapist #1). Equivalent assertions in support of the care logic, for instance, elicited worries about giving people medical labels: 'We don't talk about patients; they do.' (Service Manager #4). Or again, comparisons that paired the care logic with supposed negative outcomes of risk: '[We should] talk about wellness rather than illness.' (Service Manager #3). In these examples, assertions seemed to be compounded so that individual claims bracketed each other, stabilizing the overall claim and appearing more credible.

INFORMATION DISCOURSE

A key area of divergence between logics related to the sharing of sensitive information and the rhetorical claims associated with this central discourse. Specifically, health groups invoked worries about patient data being 'passed from different parts of the service' positioning themselves as safe-guarders of this relationship: 'Confidentiality's something that is drummed into you the minute you decide to become a nurse' (Community Practice Nurse #2). But while being grounded in patient ethics, it seemed clear these claims were also about preserving professional interests. Medical histories were generated from health-group assessments, and patient files formed a tangible

symbol of expertise, so allowing this information to circulate in unfiltered form would have meant sharing hard-won knowledge.

In contrast, the approach that care staff embraced was much more consistent with the give-and-take of client data. Here justification arose partly through a quite different interpretation of data, one that saw it as a common good and something that was actually appropriate to share for the benefit of all, clients included. Thus obtaining information on clients, particularly detailed clinical data was deemed beneficial and matched by a willingness to pass back any information that would make other's jobs easier. But (as with health) there were also underlying processes at work that derived from professional contexts. Data sharing on the care side implied the involvement of a range of providers and agencies in decisions on individual cases. Essentially a stakeholder model based on the managed dissemination of case files, this was embedded in practices established throughout social care. Attitudes were thus supporting patterns that care staff were familiar with and had links to wider institutional bases.

> We've worked now with quite a lot of clients and we liaise with each other as well, so if we're working, you know, we're both working with the client or working in partnership with other people, it's important that we do have that connection where we all know what each other's doing. (Community Access Worker #2)

Counter-arguments in this area also made use of strategies of 'expansion' into stories and anecdotes that facilitated the communication of claims. In the case of health

staff they shrewdly framed the disclosure of information in terms of its sensitivity (their strong suite) and the likely histories of people with mental issues. In particular, they challenged access to full client data by means of a distinctive 'need to know' counter. Thus allusion to a readily identifiable approach to restricting sensitive information effectively turned the claim for free data sharing on its head. This particular story was widely taken up by health staff and wove together a number of threads: what information was strictly needed outside professional circles and what were the motives of those who wanted access to data they were not trained to assess?

> The problem is that people are coming to a psychiatric assessment and sharing lots of information about them [clients]. And all of us here don't think lots of people need to know that, you know. So our question was why do they [social care] need to know that? If they're dealing with a mild issue, with a presenting problem and we've assessed them and they just need this wee bit of information, what are they going to do with that other information rather than just know it? (Occupational Therapist #1)

The reverse claim from care staff reflected another widely circulated story, one that effectively attacked health's Achilles heel of risk-averse practices. This homed in on the experiences service users were purported to have in dealing with the NHS's statutory system. Users were pictured being 'fed up' with having to repeat their story and keen to have their details passed on in the system – the result of being beset by form-filling and of having to go back to square one to have their case histories re-checked.

I don't know if you've ever gone to the GP and been referred, you know, to a clinic and then on to somebody else, and they ask you the same questions about twenty times. Now if you're patient, that's fine. If you're, you know, struggling with your mental health, or you're an elderly person, that's very frustrating (Community Mental Health Worker #2)

These two stories neatly thus framed quandaries about who should be the arbiters of information. They appealed to powerful sources of legitimacy in user interests and linked different texts or refinements of statements in various ways (such as putting words into others' mouths, or placing a text inside a text). They represented classic counter-rhetoric, being less about disputing a claim than challenging the whole basis on which a claim was made.

RISK/RECOVERY DISCOURSE

Professional concerns also played out in the conflicts between medical risk and recovery. We noted above how professional debates have shaped competing truths about the nature of progression in illness, and these were issues that were consolidated on the ground in our case. The dominant claims from health were based on presenting themselves as guarantors of safe practice and playing up the risks of illness progressing.

The opportunities for receiving care at different levels are better, where you might be experiencing a mild kind of mental health problem, but we know that the kind

of research that's done into health is that folk at that stage are folk that are likely to develop more moderate then severe and more complex social issues and everything else. So the ability to intervene at an early stage is better, I think. (Community Practice Nurse #1)

In contrasting claims, care teams entertained no doubts about recovery norms and owned these ideas very effectively. The priorities of a return to social networks and rebuilding individuals' confidence were fully in accord with their logic and were articulated in a simple, practical language that itself spoke of empathy with service users' wants and needs.

…we've got a great story from somebody who's used the services and been able to link into a whole package of support that has brought him from a very bad place to, you know, really quite a good place. (Community Mental Health Worker #1)

Counter-arguments to each of these constituent claims played as before on respective strengths and weaknesses. Social care teams cautioned against too much reliance on elite expertise, slowing down service users from being able to restart their lives, while the matching counter from health alluded to chances of relapse.

However, there were some interesting and significant differences between the two main discourses of information and recovery. Unlike other areas, attitudes seemed to be more blurred within the recovery discourse and to accommodate more common ground.

As well as being impelled towards risk-averse roles, health groups themselves made some progressive claims while a basic 'language of recovery' was something all subscribed to. These differences were detectable at the rhetorical level. Even though it was in theory possible to conceive of claims about the risks to patients who had moved on to rehabilitative care, there seemed little evidence of any extensive circulation of myths and stories about the chances of relapse, which seemed to reflect a choice not to press rhetorical claims. Possibilities of patient relapse tended to be treated pragmatically, while for their part care workers conceded an ultimate reliance on psychiatric inputs. These understandings of mental health, which we explore further in the discussion, appeared to be conditioned by the sheer appeal of concepts of wellness that all groups in some contexts internalized.

DISCUSSION

The above account explored the systems of reasoning and belief, or logics associated with groups of mental-health professionals. In an institutionally diverse setting logics were asserted through rhetorical claim and counter-claim, both generated locally and imported from wider systems of meaning. Logic based on the safe treatment of illness identified health groups as custodians of this code, while a logic of helping people regain normality served to stake the care groups' claims. In addition, our analysis specified a number of often complementary counter-rhetorical strategies. Based on contested logics, counter-arguments that disowned others' values and denied their practices were worthy of wider adoption were key elements of both systems. Delegitimizing accounts (negative labelling, failure stories) aimed at a rival's values were no less important than arguments that

supported a group's own claims. Further opportunities for combining with justifying rhetoric produced arguments that were 'compounded' and gained in coherence and credibility; these were facilitated by themes being compressed and crystallized in local cultural accounts. And counter-rhetoric was also sometimes based on the 'conversion' of other groups' central values into negatively-assessed qualities. Here forms of argument were communicated though expansion into stories and thematic narratives often reflecting great ingenuity in devising persuasive claims.

Our research questions focused, firstly, on implications of the analysis for the scope and significance of logics. Prior research identifies various ways in which competing institutional logics are not confined solely to the legitimacy claims encoded in them but may 'creatively iterate' (Bevort and Suddaby 2016: 20) with oppositional logics in order to adapt to new institutional pressures, or may embrace strategic ideas from another logic in other forms of 'divergence from the home logic' (Andersson and Liff 2018). Our findings further suggested that refined images of other logics, identities and frames may also be embraced; thus in contested situations logics were partly defined by their opposites and by powerful sets of contra-identities and forms of counter-argument. Logics grounded in rhetorical forms thus encompassed central problems of the field and were embedded at fundamental levels of knowledge, critical for how practitioners understood their roles. For example, issues around medical data reflected arguments that powerfully asserted cases both for the hoarding of information and information sharing, while issues of risk-versus-recovery centred on dilemmas about the progression of illness (whether ill people normally got worse or got better).

Secondly, while studies have shown how multiple organizational fields embrace rival work practices (Greenwood et al. 2011) we advanced further reasons why they remained sources of enduring conflict. Where logics were asserted through counter-rhetoric, adversarial attitudes became integral to any given logic and not relinquished without giving up part of the logic associated with one's own identity. Relations between groups were also defined to a significant degree by processes of mutual definition; processes of reframing and refining others' claim drew logics into tightly connected or interlocking sets of values, narratives and practices. These effectively formed the separate poles of distinctive 'dialogical' discourses (Symon 2005: 1646) and a system of logics that constrained any ability to reform cultural differences.

We sought to develop these insights as a framework of related strategies, but there is no claim this was an overarching framework that excluded other rhetorical styles. The health logic, for example, can readily be seen to reflect *logos*-type values of evidence and assessment; equally the care logic it vied with was defined by *ethos*-type communal values, and both overlapped with *pathos* and a passionate commitment for and against logics. Analysis could have also focused on language devices. Transcendence, for instance, was a common claim: medical logic held that diagnosable conditions provided an 'overview' of mental health while the 'normalizing' of people's problems served much the same function for social care. Similarly, there were degrees of variability that could be observed in the patterns of action and reaction between logics. Not all pressures from wider structures were reproduced locally and nor was rhetoric always fashioned out of available tools. Language forms in this sense presented 'a system of options' (Fairclough 1995: 5) to be adapted for a given situation.

Amid a contested environment for health and care this variability was valuable in suggesting areas of accommodation that were able to co-exist with conflict. Perhaps the main example involved the risks around relapse; although there seemed to be a potential for rhetorical narratives to evolve here, these issues were treated pragmatically on the whole. Thus the sharing of patient data was never wholly accepted (certainly clinical files were never circulated) but issues around risk-versus-recovery proved less of a flash point. Corresponding to these differences, our findings indicated the hoarding and sharing of data both being supported through well-circulated narratives, but medical risk elicited much less of this kind of support. In explaining these differences factors that reduce disparities between logics are useful (Greenwood et al. 2011: 332). Here prior evidence suggests where medical groups dominate a professional field they frequently claim to be able to manage both risk and recovery (Dunn and Jones 2010), and these ideas locally may have helped in reducing disparities and resetting group boundaries.

Such partial transitions carried implications for research and practice and suggest areas where managerial efforts to create joint outcomes might be concentrated. Thus Nicolini et al. (2016: 242) suggest that more stable arrangements between logics, at field level, are attainable wherever a broader 'institutional landscape' is aligned and supportive. Similarly, these processes were akin to what Carter and Mueller (2002: 1350) have termed an 'internal critique' to facilitate dialogue and the retaining of valuable perspectives. Unlike in a more medically-oriented model, the integrated service supported a range of approaches to understanding and treating mental health, which is a field where few universal methods exist. Given the problems associated with healthcare integration any such gains seem all the more impressive.

CONCLUSION

Cases of polarized relations have been seen to 'heighten the visibility' (Kaplan 2008: 732) of efforts to maintain systems of values and practices. Our focus on language use helped in exploring the conflicts integral to an organizational field and the connections to wider institutional forces. We specified a number of distinctive forms of counter-rhetoric which enabled groups to deal with opposing institutional work and fight their corner in a contested setting. Taken together these strategies differed from rhetoric more typically directed at a potentially receptive 'audience'. Groups were hardly audiences for each other in the case explored here, while intentionality was more often internally directed. This was more about maintaining boundaries and arguments being 'fed back' in order to enrol colleagues and retain enthusiasm for the work, rather than merely preaching to the converted. Even though logics dictated very different interpretations of how outcomes should be achieved, they were still mediated through goals of good outcomes for service users and under specific conditions requirements to work jointly were accommodated.

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Table 1. Signature matrix of health and care logics

Rhetorical categories	Health logic constructs	Care logic constructs
Core legitimizing and delegitimizing accounts	Basis of legitimacy claim: The practitioner's role and application of a professional knowledge base. An expert logic, this stresses models of diagnosis, assessment and treatment and the role of managers of risk of last resort Counter-rhetoric: Critique of the care model as being unprofessional and its practitioners as having little real expertise	Basis of legitimacy claim: The normalization of people's problems. A holistic logic, this stresses social/environmental causes of illness and treating the 'whole person' Counter-rhetoric: Critique of the narrow focus of medical expertise. An expert monopoly of knowledge has negative consequences for wellbeing
Patient confidentiality vs. information sharing	Basis of legitimacy claim: Retaining patient data within a tight professional circle (information hoarding) guarantees the confidentiality of personal medical histories and trust in the practitioner Counter-rhetoric: Patient consent is undermined by models of care in which their personal data circulates. Less qualified staff have a limited 'need to know'	Basis of legitimacy claim: Information sharing is the basis of improved care and decisions about treatment. Also an essential ingredient of integrated working Counter-rhetoric: Within medical bureaucracies, clients become 'fed up' with having to continually repeat their case histories
Risk vs. recovery	Basis of legitimacy claim: The importance of medical intervention in order to minimize risk of relapse. Symptoms are regarded as early signs of more severe and enduring conditions Counter-rhetoric: Patients who have moved on to rehabilitative care remain at risk of relapse	Basis of legitimacy claim: Images of mental health that stress the normality of recovery. Emphasis on therapies that provide for the consolidation of gains and links to family, community and work Counter-rhetoric: Clients condemned to dependency on medical experts preventing people from moving on with their lives