Expressed Emotion and supported accommodation for sufferers of severe mental illness: an ethnographic study of four community based houses

by

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Abstract

The concept of Expressed Emotion (E.E.) is now over 30 years old and has proved remarkably effective in identifying family care environments which invoke high rates of acute relapse in schizophrenic patients. However to date there has been very little work which has attempted to relate E.E. to residential care settings. This study undertook ethnographic analyses of four community based houses which catered for sufferers of severe mental illness; two sites were within a voluntary 'not for profit' care organisation and two within a chain of Health Board rehabilitation houses. The study sought to establish the existence or otherwise of face-to-face interaction patterns similar to those found in high E.E. families and subsequently to gain an understanding of the social processes which were involved in creating and maintaining the observed patterns. Three central data collection methods were employed: four ten-week periods of participant observation; the administration of a standardised environmental measure, the Sheltered Care Environment Scale (Moos R 1988); and a review of the internal literatures of the participating organisations.

The study found that Critical Comments and displays of Hostility were present within all the research sites, however, the frequency of such interactions differed markedly between the houses. Virtually all of the observed high E.E. interactions were between co-residents as opposed to staff and residents. The qualitative data analyses revealed that in order to gain an adequate understanding of the stressor effects of high E.E. interactions it was necessary to locate the exchanges within their social context and to look at the implications of the interactions for the parties involved; in turn this necessitated recourse to the prevailing norms, values and common-sense-knowledges within the setting. Beyond this, in addition to high E.E. exchanges, certain organisational aspects of daily life within the houses were found to have the potential to heighten the level of stress experienced by residents (e.g. communal meals, household cleaning/shopping and house meetings); again the meanings of such events for participants were found to be of central importance. These findings are shown to have significant methodological implications for future attempts to relate E.E. to residential care.

This study's findings also point to a tension between residential care settings offering very low levels of stress and/or E.E. and their encouraging residents to exercise meaningful choice and control in their lives. It is argued that the communal nature of residential settings involves important social processes which place limits upon the flexibility available to front-line workers when responding to the individual needs of any one client. Accordingly it is suggested that residents may need to move between resources as and when their personal care needs change. It is advocated that the most sensible policy is one which promotes a variety of residential and other care options together with a well co-ordinated path between resources.

Declaration

Except where specific reference is made to other sources, the work in this thesis is the original work of the author. It has not been submitted in whole or in part for any other degree.

Stephen B Pavis

Acknowledgements

Preface

The seeds of experience which were to germinate into this research project were sown during the autumn and winter of 1989/90; this period saw the completion of my social work training with my final nine month practical placement. During this time I came to know and work with several people who had been discharged from psychiatric hospitals and who subsequently came to live in hard-to-let properties on a local authority housing estate. My experiences with one client in particular led me to become acutely aware of both the extreme vulnerability of such people and startling lack of support services which were available in that part of the North East of England. Because of the profound influence which this case had upon my personal and professional development I have decided to commence this thesis by briefly recalling my experiences and involvement with this individual.

'John', a man in his mid fifties, had experienced multiple admissions to psychiatric hospitals resulting in him spending over fifteen years of his life in institutional care. My contact with him began when he was referred to the local patch based Social Work team in which I worked. The agency referral came simultaneously from two sources; the Housing department reported that his rent was in serious arrears, that there was significant damage to the property and that his mental illness was leading him to live in dangerous and insanitary conditions; his neighbours complained of the stench which was coming from his flat and the fact that he was persistently begging food, money and cigarettes.

My initial contact found John to be living in a flat without gas, electricity and water supplies. All his windows had been broken, his front-door kicked in and graffiti sprayed over both the inside and outside of the house. Local youths had vandalised the electricity meter and striped all of the copper water piping from the property. Despite the property's lack of a water John had continued to use the toilet, thus creating a foul stench throughout the flat. The housing department later estimated that there was between ten and twelve thousand pounds worth of damage to the property. John possessed only the clothes he was wearing and despite receiving invalidity benefit had no money whatsoever; this resulted from a combination of systematic

extortion and his poor budgetary skills. By way of furniture and bedding he possessed only a cooker, one arm chair and a sleeping bag. John's dangerous insanitary conditions, together with the distress his social situation and his visual and auditory hallucinations were causing him, required immediate action. The decision was taken to try to find John alternative emergency accommodation.

It was in attempting to support John and deal with this desperate situation that I was first introduced to the severe lack of support and understanding which often exists for people who experience long term mental illness. In particular securing accommodation which was appropriate for his needs and requirements proved extremely difficult. John himself was very frightened of returning to hospital, fearing that he would again be detained for a long period. Assessments by a General Practitioner, Approved Social Worker and Community Psychiatric Nurse confirmed that although he was experiencing on-going and serious mental illness this did not necessitate his compulsory detention under the Mental Health legislation.

Within the local area in which I worked the Social Services department did not have any available places in supported mental health accommodation. Several voluntary sector agencies were approached but either did not have any available beds within their establishments or would only accept John if he was prepared to return to hospital and undertake a rehabilitation programme in order to improve his personal and social skills. In the event due to the critical nature of the situation John was admitted to a local authority residential home for elderly people. Initially this was intended as an emergency measure whilst his own home was fumigated and repaired, and negotiations were undertaken to stop the court actions which were threatened by the gas and electricity boards. In reality John remained in the elderly persons' home for over four months while the Social Services and Housing departments 'discussed' who was responsible for the repairs to the property and subsequently for providing him with future accommodation.

Eventually, John did return to his original home. Various charities supplied money to clear the fuel debts and provided furniture and clothing. The Social Services department provided home care services, cleaning, laundry and meals on wheels. John was also offered, but declined, a day placement at a local authority resource. Initially the care package worked well, however, the combination of further youth vandalism and victimisation, together with John's on-going mental health difficulties and

lack of budgetary and self care skills, eventually led to a near replication of the initial crisis situation. Unfortunately, in the early spring of 1989 John left his home and contact with the social work team ceased. This case remains with me as a painful reminder of the plight of many people who experience on-going mental illness in modern day Britain.

Contents

Introduction

In October 1990 I received funding from the Economic and Social Research Council to undertake research in the broad area of service provision for the mentally ill. During the first year of this three year studentship my extensive reading led to an interest in the social psychiatric concept of Expressed Emotion (E.E.). An in depth review of the theory of E.E. is presented in Chapter One. However, in brief, previous work in this area suggests that people who suffer from schizophrenia are unusually vulnerable and susceptible to certain aspects of their social environment. The theory of E.E. points to a particular association between family care settings characterised by high levels of criticism, displays of hostility and/or interpersonal relationships which are overly intense and deny sufferers the opportunity to control their levels of social intercourse, and increased rates of schizophrenic relapse; importantly, these central relationships have proved remarkably robust both over time and across geographical location (Kuipers 1992).

However, despite the apparently impressive record of the family studies of E.E. and the potential therapeutic value of the concept, to date there is a stark lack of research which has attempted to look at the applicability of E.E. to residential care settings. In fact, at the time of beginning this project a computer aided literature search revealed only one paper which explicitly sought to relate E.E. to residential care settings (Berkowitz and Heinl 1984); whilst completing this thesis two additional papers have been published (Ball, Moore and Kuipers 1992; Moore, Kuipers and Ball 1992). These innovative studies have offered interesting insights into the potential applicability of E.E. to residential care settings but they also contain certain theoretical difficulties. The work of Berkowitz and Heinl, and Ball et al. is reviewed in Chapter One. It must be noted, however, that both these teams have treated the transfer of the E.E. concept to residential care settings as theoretically unproblematic and have not taken adequate account of the significant differences between families and collective care environments. Neither research team therefore explicitly addressed the differences in the relationships between family members, and those of professional carers and collective care setting residents; they did not openly consider the importance of the greater complexity of interactional patterns created by having several

patients and several carers within one setting; nor did they adequately address the possible influence of organisational and managerial factors upon the emotional displays and interaction patterns within their study sites. These are all issues which this thesis addresses and accordingly, although this project was initiated prior to the publication of Ball et al's work, it can be viewed as supplementing and building upon the previous studies. This thesis attempts to contribute to our understanding of the concept of E.E. by looking empirically and theoretically at its applicability to residential care settings.

At the outset it should be noted that the exploratory study reported herein does not aim to be an outcome study which proves a link between high E.E. interactions and mental health deterioration. Rather, this work is essentially ethnographic and aims to provide an in depth understanding of the processes of care within two organisations and four front-line residential care settings; the data reported herein therefore provide a snap-shot of the ways in which the study sites were working at the time of field-work (July 1991 to October 1992). The obtained ethnographic understanding of the sites is then related to the observed levels of face-to-face high E.E. interactions within the four care settings, with the goal of providing insight into the meanings which lay behind the social actors' behaviours and the central organisational and cultural factors which either contributed to or negated such interactions. The central aims of this research project can be stated more formally, but still in brief, as being: firstly, to establish the existence or otherwise of face-to-face interaction patterns within the research houses which were similar to those reported in the earlier family studies of E.E.; secondly, to gain an understanding of the social processes within the care settings and the factors which contributed to or negated high E.E. interactions; and thirdly to look theoretically at whether high E.E. interaction patterns within residential care settings are likely to have similar detrimental effects to those found in family care settings. These research questions are expanded and spelt out in greater detail in Chapter One.

The two care organisations which took part in this study are referred to throughout the thesis by the aliases of Alpha and Beta organisation; this is done in order to protect the anonymity of the sites. Alpha organisation operated within the voluntary 'not for profit' care sector, whilst Beta organisation consisted of a chain of four relatively self contained hostels attached to a Health Board psychiatric hospital. Both organisations catered

for a group of people who were experiencing on-going and serious mental health problems which made it extremely difficult for them to maintain a tenancy independently. Moreover, both organisations attempted to provide their clients with homely and worker supported group living environments situated within ordinary properties in local residential communities. Support within Alpha organisation was provided by workers from various professional and non-professional backgrounds, whilst Beta organisation offered clients twenty-four hour nursing care. An in depth review of the type of support and care offered by the two care organisations, their respective ideologies and envisaged ways of working, is presented in Chapter Three.

This study utilised a triangulated methodology which involved four ten-week periods of participant observation, a review of the internal literatures of the care organisations and the administration of a standardised environmental measure (Moos and Lemke 1988). The design of this study is also indebted to the previous sociological work of Berger and Luckmann (1979) and particularly their important theoretical insights into the ways in which daily reality is socially constructed, maintained and legitimated (see Chapter Two).

THE SOCIAL POLICY CONTEXT

This thesis is written against a post war social policy backdrop which has seen at first gradual and then accelerated policies aimed at the closure of large psychiatric hospitals. In order to set the scene and provide the reader with an understanding of the policy context within which the two care organisations involved in the study operated, it is necessary very briefly to review the historical development and associated policies of 'community care'. As Abrams has warned, however;

> To those with a passion for conceptual tidiness the whole field of social care must be exceptionally frustrating; within that field community care is perhaps the least tidy corner (Abrams 1978 p. 78).

Historically, academic discussion of 'community care' has been marked by significant confusion and disagreement concerning the way in which the term itself should be used. Thus Abrams notes, somewhat frustratedly, that the

journal 'Community Care' repeatedly uses the phrase to refer to three quite distinct groups of services; firstly, services provided in relatively client centred residential establishments; secondly, services provided by professionals who are placed within the community; and thirdly, services provided to people in their own locality by residents on a voluntary and quasi-organised basis (Abrams 1978 p. 78). For Abrams, at least, academic discussion would be eased if the phrase 'community care' was kept solely for the latter of the above three usages. The confusion within academic circles concerning what is to count as 'community care' has also found parallels within successive governmental policies. Therefore whilst community care has normally meant some combination of informal care, locally based residential facilities and services provided by community based professionals, the emphases within policies concerning these individual elements, as well as the available financial resources, have varied significantly (Clark, Langan & Lee 1980 pp. 188-92). Moreover, as Townsend writes, historically:

> There has been no sustained attempt to define and measure the need for community care, to set policy goals and relate the goals to the scale of need and the allocation of resources (Townsend 1981, see Walker 1982 p. 16).

Within governmental literature the phrase 'community care' is first found in the 1957 report of the Royal Commission on the Law relating to Mental Illness and Deficiency. In this report the term was primarily used to spell out the rights and responsibilities of local authorities under section 28 of the National Health Service Act (Jones, Brown & Bradshaw 1983). In this context 'community care' was therefore seen to include,

> all forms of care (including residential care) which it is appropriate for local health or welfare authorities to provide (Royal Commission of the Law Relating to Mental Illness and Deficiency, 1957 p. 208).

However, as the statement below made by the Minister of Health in 1959 illustrates, even at this early stage the reality of community care for the mentally ill meant policies aimed at the closure of large mental hospitals. Indeed the most glaring constant in post war policies towards sufferers of mental illness has been the persistent closure of in-patient hospital beds.

one of the main principles which we are seeking to prove
is the reorientation of mental health services away from
institutional care towards care in the community (Minister for
Health, 1959, speaking in the House of Commons, quoted in
Walker 1982 p. 15).

The late 1950s and 1960s saw an unusual coming together of significant advances in the medical treatment of mental illness, the publication of several influential works in the fields of radical psychiatry and sociology, and several high profile cases of patient abuse within psychiatric institutions. Thus the late 1950s saw the development of important new neuroleptic medications, which promised the possibility of the movement of many sufferers of psychotic mental illness out of large hospitals and back into local communities. On the academic front 1954 saw Stanton and Schwartz's classic study of a mental hospital in which the authors argued that certain relationships and interaction patterns between hospital staff and/or staff and patients could affect the observed behaviours and symptomatology of patients. In 1960 Laing published 'The Divided Self' in which he attempted to look phenomenologically at the experience of psychosis. In 1961 Erving Goffman published his seminal work 'Asylums' in which he described the ways in which 'total institutions' segregated inmates from mainstream society and treated them in 'batch oriented' ways, often leading to the loss of important cultural skills and an 'assault upon the self'. As Muijen (1992) notes these developments resulted in a rare alliance between the public, professionals and legislators concerning the undesirability of institutional care.

By 1961, the then Minister of Health, Enoch Powell, in an impassioned speech, talked of 'the defences we have to storm' and 'setting light to the funeral pyre' as he announced the intended run-down and closure of half of the country's 150,000 mental hospital beds by 1975, (Jones, Brown and Bradshaw 1983). However, despite such political rhetoric the movement towards the closure of mental hospitals and the provision of alternative community based support remained gradual throughout the 1960s and early 1970s. As Titmuss (1968), Langan (1990), and others have noted, even during the relatively prosperous post war period the resources for community care invariably lagged behind the political rhetoric and many patients, even then, were discharged into the care of relatives with little or

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no follow-up support. At the same time, however, the steady increase in the share of the national income devoted to personal social services did allow for some increase in publicly provided community based services for the mentally ill; thus 1955-1976 saw a fivefold increase in the share of national income devoted to the personal social services (Langan 1990).

The Labour government of 1975-79 heralded the beginnings of tight public expenditure controls, with the incoming 1979 Conservative government continuing the financial squeeze through its promotion of monetarist economics and an ideology of rolling back the welfare state (Clark, Langan and Lee 1980). In parallel with these political and economic changes the late 1970s and 1980s saw a dramatic increase in the rate of in-patient psychiatric bed closure. Thus the period between 1972 and 1983 saw in-patient psychiatric beds reduced from almost 100,000 to an estimated 69,000 (House of Commons 1985); and the four year period between 1982 and 1986 alone saw a reduction of 10,000 psychiatric in-patients (Langan 1990). Overall the 1980s saw the closure of half of all in-patient beds in Britain's psychiatric hospitals.

In Scotland the process of in-patient psychiatric bed closure has been somewhat different, although the same general policy trend is discernible. Thus over the last twenty years the resident population of Scotland's psychiatric hospitals has fallen by twenty percent whilst at the same time the proportion of residents over sixty-five rose from forty-five percent in 1970 to sixty-six percent in 1988 (Scottish Office 1992). As Pullen (1993) notes, the number of elderly people in Scottish psychiatric hospitals accounts for much of the difference in bed numbers between England and Scotland.

During the period of rapid closure of in-patient psychiatric beds there was not, however, a concomitant increase in the provision of alternative community based services; therefore 1982 to 1986 saw the number of local authority day centre places rise by only 543 and the number of residential places increase by only 399 (Health and Personal Social Services Statistics, see Langan 1990 p. 62). In reviewing the history of community care for the mentally ill throughout the 1980s, Tudor (1990) has argued that the Conservative government's true purpose in commissioning the Griffiths report (1988) was fiscal and driven by concerns over the escalating costs of residential care for the elderly, rather than by a desire to promote alternative community based mental health services.

Neither did the period of rapid in-patient bed closure coincide with a significant reduction in the incidence of severe mental illness. Thus Birchwood et al. writing in 1988 suggest that in Britain at that time there were approximately 100,000 people suffering from schizophrenia and that one-third of these were likely to experience on-going difficulties requiring significant support (Birchwood et al. 1988 pp. 13, 173). Similarly, Jennings (1983) estimated that for every 100,000 of the population aged fifteen to sixty-four in 1979, between twenty-four and thirty-six were likely to become newly recruited long-stay psychiatric patients.

Norman and Parker (1990) have argued that the persistent push to reduce psychiatric in-patient beds without sufficient provision of alternative community based services has created an 'emerging problem'.

> Evidence suggests that even when long-stay patients are discharged, few achieve full independence from hospital services [Hyde et al 1987, Howart & Kontny 1982]. Thus mental hospitals and psychiatric units in general hospitals have continued to accumulate a number of long-stay patients who require continuous care, despite the current policy of community living [Mann & Cree 1976], (Norman & Parker 1990 p. 1037).

The 'emerging problem' was in fact recognised as early as 1975 in the DHSS publication 'Better Services for the Mentally Ill' (Norman and Parker 1990). Within this document it was suggested that a possible solution to the 'problem' of the small number of adult psychiatric patients who remain in need of continuing care, may lie in the further development of hospital-hostels. This position was again reiterated in 1985 by the Social Services Committee report (House of Commons 1985) which suggested that hospital-hostels may be best placed to provide care for those in need of 'asylum' from the pressures of everyday life.

The 1980s and early 1990s have also witnessed significant changes in the respective roles of the organised care sectors; that is, the statutory, voluntary 'not for profit' and private care sectors. As Langan (1990) has pointed out, during the post war period the vast bulk of organised welfare services were provided by the state, with the voluntary sector primarily involved in either the initiation of new areas of service provision, or in acting as pressure groups on specific issues. The 1980s and early 1990s have, however, seen an important Government sponsored shift to a situation whereby voluntary

sector agencies have increasingly become involved in the front-line delivery of services; this is particularly evident in the recent initiatives embodied in the white paper 'Caring for People' (DHSS 1989) and subsequent NHS and Community Care Act (1990). Under the new proposals local authorities are to maintain a lead role in community care with responsibility;

> in collaboration with medical, nursing and other interests, for assessing individual need, designing care arrangements and securing their delivery within available resources (Caring for People 1989 p. 6).

However, the white paper also suggests that local authorities should no longer see themselves as the primary direct providers of services but should rather take on an essentially enabling and administrative role. Thus the white paper states;

> Local authorities will be expected to make maximum use of the independent sector. The Government will ensure that they have acceptable plans for achieving this (Caring for People p. 6).

At the same time, in following the recommendations made by Sir Roy Griffiths (1988), the Government calls for changes in the way in which local authorities support the activities of voluntary 'not for profit' agencies in order to promote the further development of this sector. Thus the previous system, under which local authorities often made block grants to charitable or voluntary sector agencies, is to become increasingly replaced by a system of contractual funding.

> Authorities should seek to move towards contractual funding in partnership with the voluntary sector. Voluntary organisations may need to make major changes in their working methods and there is likely to be considerable advantage for both sides of the partnership if the voluntary sector can be involved at an early stage in negotiation over the contents of the contract (Caring for People p. 24 paragraph 3.4.13).

It is then against this policy backcloth that the two care organisations which took part in this research project operated. Alpha organisation operated within the voluntary 'not for profit' care sector and as such

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represented one example of the development of a voluntary sector agency in the direct provision of care. Beta organisation represented the type of hospital-hostel advocated by the 1975 DHSS publication 'Better Services for the Mentally Ill' and the 1985 Social Services Committee report (House of Commons 1985).

THE STRUCTURE OF THE THESIS

Chapter One of this thesis reviews the historical and theoretical development of the concept of Expressed Emotion. It is argued that the concept is of significant interest due to its apparent durability across cultures and time and impressive predictive value in identifying family care settings associated with high rates of schizophrenic patient relapse. The previous studies that have attempted to relate E.E. to formally organised collective care settings are reviewed and it is suggested these previous works have failed to take account of the actual and theoretical differences between family care environments and residential units. The position of this study in addressing these issues is made explicit and the research questions elaborated. Chapter Two presents the methodological design of this study and the rationale for the selection of the research organisations and sites.

Chapter Three of the thesis undertakes a review of the internal documents of the two care organisations. Primarily this is a context setting exercise aimed at providing the reader with information to aid the comprehension of the main data presentation chapters that follow. Within the chapter the formally stated goals of the organisations and their managerially envisaged ways of working are presented. The differences between the two organisations' care ideologies are drawn out and made explicit. Finally, by drawing upon the review of the organisations' internal literatures predictions are made concerning the levels of E.E. thought likely to be found within the two organisations.

Chapter Four presents qualitative data on daily life within the houses and the observed levels of face to face high E.E. interactions. This data is presented around three central themes; domestic daily living tasks, communal meals and house/community meetings. These themes are selected for two central reasons; firstly, they represent the times of most interaction between house members; and secondly, they represent activities that were common across the sites, therefore aiding the possibility of comparative

analyses. Within this chapter it is shown that careful observation revealed differing levels of face to face high E.E. interactions across the four houses. However the observed levels of E.E. are shown not to have been in the directions anticipated by the review of the two organisations' internal documents.

Within Chapter Five the results obtained from the administration of the Sheltered Care Environment Scale are presented (S.C.E.S., Moos & Lemke 1984). During the administration of this standardised environmental measure certain important methodological insights were gained concerning the validity of the instrument. The chapter is therefore written in a way that allows for both the presentation of the results and discussion of the methodological difficulties encountered during the use of the S.C.E.S. In essence it is argued that the findings from this study point to the scale's standardised questions carrying different meanings and normative connotations within the two care organisations; questions are therefore raised concerning the validity of undertaking across organisation comparisons using the S.C.E.S.

Chapter Six of the thesis goes behind the observed levels of E.E. within the four research sites and presents data on the social construction of daily life within the houses. It is argued that in order adequately to understand the observed differences in the levels of E.E., it is necessary to comprehend the common-sense-knowledges and meanings of the various groups of social actors within the houses. Data is therefore presented pertaining to the front-line workers' interpretations and operationalisations of their organisations' key aims and care ideologies and insight is provided into the collective norms and values of the resident groups within the sites. These insights are then related back to the observed levels of E.E. within the houses.

Chapters Seven and Eight contain the conclusions to be drawn from this research project. The first of these chapters focuses upon the methodological implications of this work for future attempts to assess the levels of E.E. within residential care settings. It is argued that it is crucial that future researchers take account of all of the relationships and interaction patterns that residents within specific settings are subject to and not merely the client/key worker relationships. It is suggested that stress is experienced when an individual perceives the demands of the environment to exceed his/her ability to respond adequately. High E.E. interactions are recognised as placing certain demands upon the parties involved in the interaction. It is

therefore argued that, when attempting to assess the likely stressor effects of a high E.E. interaction within a collective care setting, it is important to locate the exchange within the wider context of the shared norms, values and common-sense-knowledge of the setting, so as to gain insight into the meanings that the interaction has for the individuals involved.

In the final chapter of the thesis the discussion is broadened in order to consider the implications of this study's findings for the future design and management of residential care for people experiencing long term mental illness. Within the chapter it will be argued that there exists a tension between the type of care environment implicitly advocated by the theory of E.E. and what might be termed the residents' wider social needs or quality of life. A discussion is offered concerning the ambiguity inherent in the concept of human need and the role that care organisations and front-line workers play in determining what are to count as the clients' legitimate and meetable needs. Finally, it is argued that, due to the complexity of the needs of people with severe mental illness and the organisational and managerial requirements of collective care settings, the most sensible policy path is one which promotes a variety and range of residential options for those people who experience long term mental illness and are unable to maintain a tenancy independently.

CHAPTER ONE

Expressed Emotion: the development of the concept and the position of this study

INTRODUCTION

This chapter undertakes a critical review of the concept of Expressed Emotion (E.E.) and beyond this, looks at the concept's potential relationship to collective care settings. Due to the voluminous literature which now exists in relation to E.E. it is imperative to impose some order upon this review. Accordingly, the chapter will be split into two broad parts. The first half will undertake a chronological review of the seminal works that have contributed to our present understanding of the concept of E.E. This section will begin by looking at the initial enquiries of George Brown and colleagues and then review the major developments and insights offered by Julian Leff and Christine Vaughn. Attention will then turn to the works that have looked at the face-to-face interaction patterns within high and low E.E. families and the studies which have sought to reveal the mechanisms which intervene between high E.E. interaction styles and statistically higher rates of clinical relapse/deterioration. It will be shown that the E.E. studies provide strong evidence that certain emotional/interactional factors in family care environments have an important impact upon the community survival of discharged schizophrenic patients. Previous works will be shown to suggest that high E.E. families may induce a state of chronic stress and/or hyper-arousal in the patient and that possibly this is the intervening factor between high E.E. families and the increased risk of schizophrenic relapse or mental health deterioration.

In the second half of the chapter the two central works which have attempted to relate E.E. to collective care settings will be reviewed and evaluated. It will be argued that these works have offered some interesting insights but that they also contain certain important theoretical and methodological problems. In essence, it will be suggested that both works suffer from a failure to take account of the significant theoretical and actual differences that exist between families and collective care settings. It will be

argued that the group nature of collective care necessitates that an adequate assessment of the level of E.E. take account of all of the interactions within such a setting; that is, of the emotional displays and behaviours of all carers and all residents. Beyond this, attention will be drawn to the potential impact of a collective care setting's organisational structures, goals and resultant worker and client cultures in the determination of the level of E.E. The chapter will conclude by drawing together the themes that have emerged within it and explaining the role and position of the study reported herein.

THE DEVELOPMENT OF THE CONCEPT AND INDEX OF EXPRESSED EMOTION

The original work of Brown and his colleagues

Retrospectively the initial phase in the development of the E.E. concept can be seen to have spanned a twelve year period commencing in 1958. This period saw three major studies carried out at the M.R.C. Social Psychiatry Unit. The first of these was by George Brown, Morris Carstairs and Gillian Topping, who followed up 229 discharged male psychiatric patients (two thirds of whom were diagnosed schizophrenic). At this time Brown himself was new to the Social Psychiatry Unit with a background training in social anthropology rather than psychiatry. This initial investigation was, as Brown acknowledges, quite unfocused taking the form of semi-structured interviews with discharged patients and their relatives (Brown in Leff and Vaughn 1985 p.12).

The most striking finding from this initial investigation was that schizophrenic patients were more likely to relapse if they returned to live with parents or wives than if they went to live in lodgings or with brothers and sisters. This finding was true only for those diagnosed as schizophrenic and not for 73 of the 229 patients who had other diagnoses such as 'depression', 'epilepsy' or 'psycho neurosis'.

All of the patients in this original study had been hospitalised for at least two years and the majority for at least five years. Due to the patients' length of stay in hospital it was not surprising that over a quarter returned to quite different households to those that they had left. The data revealed that those patients that returned to changed households were less likely to relapse than those that returned to an unchanged family setting. Beyond this, it was found

that, for patients who returned to live with their mothers, outcome was highly related to whether the patients, their mothers, or both, worked outside the home. Patients were shown to have a much higher relapse rate when both they and their mothers were unemployed. In situations where the mother worked, even if the patient was unemployed, the patient tended to fare much better.

In short, this initial investigation led Brown and colleagues to suspect that there was an environmental element at work in the prognoses of discharged schizophrenic patients. As Brown notes;

> ...the anomaly was the link between relapse and type of living group. This in terms of retroductive logic, could be explained if relapsing patients were reacting adversely to close ties, and they would be sensitive in this way if, for reasons inextricably linked to their illness, they were particularly susceptible to too much emotional arousal. In strictly psychological terms, they would be suffering from sensory overload (Brown in Leff & Vaughn 1985 p. 16).

The second study began in 1959 and was dominated by methodological concerns (see Brown, Monck, Carstairs, and Wing 1962). Essentially, the study of 128 male schizophrenic patients over a period of 12 months, aimed to rule out the possibility that there was a third variable intervening between the quality of family relationships and outcome; the most obvious candidate here was seen to be the severity of the patient's condition at the point of discharge. All patients were assessed just prior to leaving hospital using two scales; one related to mental state and the other to socially embarrassing behaviour, displayed on the ward over the preceding week.

The study was prospective in design in order to rule out the possibility of interpreting the data to fit the theory. It was decided that an instrument should be designed which attempted to measure 'family atmosphere' (Leff and Vaughn 1985 p. 19); this scale subsequently became known as the 'Emotional Involvement Scale' (E.I.S.). The E.I.S. measured the amount of emotion both positive or negative, and the degree of hostility and domination, displayed by a key female relative in an interview situation. The interview focused on the patient's return home, his relationship with relatives, and his plans for the future. Families were interviewed two weeks after discharge and again at the point of readmission or after the 12 month

study period and rated simply as being 'highly emotionally involved' or otherwise.

The results revealed that, during the year following discharge, patients returning to highly emotionally involved families stood a significantly higher chance of deterioration (76 percent as opposed to 28 percent).[1] Controversially, however, the study also found a correlation between the severity of symptoms at discharge and subsequent deterioration in patient behaviour. This relationship raised the possibility that high emotional involvement might result from an understandable reaction to severely disturbed behaviour; as opposed to emotional involvement triggering or precipitating the patient's symptoms. As Leff and Vaughn (1985 p. 78) point out, this finding and its implications cast a dark shadow over many of the later studies.[2]

Interestingly, in this second study it was also found that patients who returned to lodgings rather than to families actually had a higher rate of relapse. Brown suggests that this may have been due to the role of life events. (The literature and definition of life events will be briefly discussed below.)

> We speculated that this was due to the fact that they stood a greater risk than those living with others of experiencing 'life events' that they had fewer resources to deal with. This still seems to me a plausible explanation, but the matter remained open, as indeed did the complex issue of the relationship of family atmosphere, life events and relapse. Jim Birley and I have suggested that there was some inkling of a case to be made to for an additive effect. Patients coming from a home that we had just characterised as containing long term 'tension' more often experienced such an event in the 3 weeks before onset (Brown and Birley 1968) [Brown in Leff & Vaughn 1985 p.20].

In preparing for the third and final study in the initial series of investigations, a study of 30 families, George Brown combined with Michael Rutter to develop an instrument capable of measuring the range of feelings and emotions expressed in 'ordinary' families. As Birchwood (1983) has

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[1] Behavioural deterioration was assessed using the same instruments as those used at discharge. When readmission was used as an alternative measure of outcome the relationship between Emotional Overinvolvement and deterioration persisted (58% and 21% respectively).

[2] For an elaboration of this argument see MacMillian, Gold, Crow et al. (1986) and Birchwood (1983).

pointed out this study marked a departure from previous works. The emphases in the new interview schedule shifted away from direct questions about the patient's return and its impact upon family life, to more general aspects of family activities and events, quality of relationships and unprompted expressions of affect between key family members. In fact the first format of the interview schedule was not designed with particular reference to families containing a schizophrenic member.[3]

Within the final Brown et al. study, ratings were made on literally hundreds of scales. Relatives' and patients' attitudes and behaviours were assessed in individual as well as joint interviews. Only the salient measures that related to relapse were retained. These predictive ratings all concerned relatives' responses when interviewed alone. The key measures for this first version of the Camberwell Family Interview (C.F.I.) were, Warmth, Number of Positive Comments, Number of Critical Remarks, Severity of Criticism, Dissatisfaction (eight scales) and Hostility [See Brown and Rutter, 1966; Rutter and Brown, 1966]. The interviews were non-scheduled but standardised and took between four and five hours to complete. Ratings concerning positive and critical remarks were made essentially intuitively, albeit skilfully, (inter-rater reliability was high at r>0.8) and mainly on the basis of tone of voice and intensity of speech.

> Our approach was therefore to describe all forms of emotional expression that we sensed in the families that we met. We were not bothered if the emotions appeared to be closely linked. ... We were using *ourselves* to tell us which forms of emotional expression should be distinguished, and as long as we could make ratings reliably, the only relevant criterion of validity that we recognised was that the measure should ultimately be related to relapse (Brown in Leff & Vaughn 1985 p. 23).

The interview itself was concerned to gather data on two distinct areas, namely 'objective events' and 'subjective feelings'. The 'objective events' element was concerned to gain an understanding of the actual events that had happened in the family over the three months prior to hospital admission.[4]

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[3]Having noted this, after the piloting of this instrument within families with a schizophrenic member one new category was added. The new category was Emotional Overconcern.

[4]The period of three months was chosen because it appeared to be long enough to obtain an insight into events and behaviours that happened relatively infrequently while not being so long as to induce inaccuracy in accounts.

In relation to these events the interviewer was allowed to cross-examine and point out any inconsistencies or contradictions within accounts. The aim in this element of the interview was to gain the most accurate account possible of events and behaviours.

The second element in the interview (subjective feelings) consisted of the measurement of family members' feelings about each other, recent events and behaviours. Here it was recognised that a respondent might well experience conflicting feelings about the same person and thus the interviewer was not permitted to point out contradictions or to cross-examine. Unipolar scales were used that measured emotion directed to a specific person rather than bipolar scales or more general measures of emotion. Thus a person's demonstrated warmth to another family member was rated rather than their warmth as a person per se (Leff and Vaughn 1985 p. 29).

The results of the study demonstrated that patients returning to homes rated as high in E.E., mainly those making seven Critical Comments or more, had a substantially higher rate of relapse than those in the low E.E. group (58 percent versus 16 percent).[5] This was statistically independent of the patients' levels of disturbed behaviour. Low levels of patient/relative contact time were also shown to have a protective effect.

The individual elements of the C.F.I. related to relapse in the following ways. When relatives made six or fewer Critical Comments 26 percent of patients relapsed compared with 57 percent for those relatives that made seven or more such comments. If relatives expressed Hostility at the initial interview 50 percent of patients relapsed compared to 32 percent in the absence of this emotion. Warmth showed a complex relationship to relapse. At the upper end of the scale relapse was high as it was associated with Emotional Overinvolvement, at the lower end of the scale relapse was also high as it related to relatives who were critical. If a relative displayed warmth that was unrelated to either Criticism or Overinvolvement then the patients tended to do well, only nine percent of this group relapsed in the follow-up period.

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[5]Two definitions of relapse were used for this study. Type i. relapse was defined as a change from a normal or non-schizophrenic state to a state of schizophrenia. Type ii. referred to those patients that had been discharged with persisting psychotic symptoms and was defined as a marked exacerbation of these symptoms. (See Brown et al. 1972)

The replication of Brown and colleagues' 1972 study

Julian Leff and Christine Vaughn joined the M.R.C. Social Psychiatry Unit in 1972 and proposed a replication of the final Brown et al. study (1972). In addition to attempting to replicate the results of the earlier work, Vaughn and Leff endeavoured to ascertain whether the relationships observed in the E.E. research were unique to schizophrenia. Accordingly they undertook a comparative study involving 37 schizophrenic patients and 30 patients with depressive neurotic conditions. Independent assessments were undertaken, using the Present State Examination (P.S.E.), in order to ensure consistent patient diagnoses.

For their initial study Vaughn and Leff (1976a) developed an abbreviated version of the C.F.I.. The interview schedule now covered the areas of, Psychiatric History, Irritability/Quarrelling, Clinical symptoms, House Hold Tasks/Money Matters and Relationships, Amount of Face-to-Face Contact and Medication. Rating were made in the same way as the 1972 study. The scales used concern the emotion expressed while the key relative was talking about the patient. Tone of voice, content of speech and gestures were used to assess the amount of emotion expressed. Where there was more than one relative in the household both were interviewed and the higher score used to determine the family's level of E.E.. The shortened version of the C.F.I. took one to two hours to administer. The scales in the abbreviated version of the C.F.I. were/are of two kinds.

> 1. Frequency counts. Two scales involve a recognition of particular comments ('critical' and 'positive') and consist of a count of all such comments occurring at any point in the interview.
> 2. Global scales. While the three scales of Emotional Overinvolvement, Hostility, and Warmth involve the recognition of particular kinds of comments, their rating involves more than a simple summation. The rater must make an overall judgement about the degree to which the emotion was shown, taking into account the interview as a whole ... (Leff and Vaughn 1985 p.37).

<u>Results of the replication study Vaughn and Leff (1976a)</u>

Schizophrenic patients

Leff and Vaughn found that it was not necessary to use the measure of Hostility to allocate schizophrenic families to the high E.E. sub-group. This was due to displays of Hostility not being found in the absence of Critical Comments. Thus the high E.E. sub-group comprised of relatives who made seven or more Critical Comments and/or scored four or five on the Emotional Overinvolvement scale.

The results revealed that patients who returned to high E.E. households had a 50 percent chance of relapse compared to 12 percent for those returning to live in low E.E. homes. When the cut off point regarding Critical Comments and inclusion in the high E.E. group was lowered to six Critical Comments differences in relapse rates were even more marked, (48 percent for high E.E. group compared to 6 percent for those classified low E.E.).

Beyond this Leff and Vaughn combined their cohort of schizophrenic patients with the data from Brown et al.'s (1972) study, giving a total sample of 128 participants and looked at the effects of face-to-face contact and compliance with maintenance medication upon relapse. Leff and Vaughn demonstrated that low face-to-face contact had a protective effect in high E.E. families. Thus, 69 percent of those in high E.E. families with more than 35 hours contact per week relapsed compared to only 28 percent of those with less than 35 hours per week. Further, compliance with maintenance medication was also found to reduce the chance of relapse in both high and low E.E. families. For those patients who returned to high E.E. households, had more than 35 hours per week face-to-face contact with the key relative and were not on regular medication, relapse was almost inevitable, (92 percent after nine months). The additive effects of high E.E., high face-to-face contact and non-compliance with maintenance medication are depicted in the diagram below.

Table 1.1

Nine month relapse rates of schizophrenic patients from the Brown, Birley and Wing (1972) and Vaughn and Leff (1976a) studies.

		Total group (n=128)			
Relatives' E.E.	Low (n=71) 13%		High (n=57) 51%		
Face-to-face contact			<35 hrs. 28%	>35hrs. 69%	
Subgroups	1	2	3	4	5	6
Regular drug use	Yes 12%	No 15%	Yes 15%	No 42%	Yes 53%	No 92%
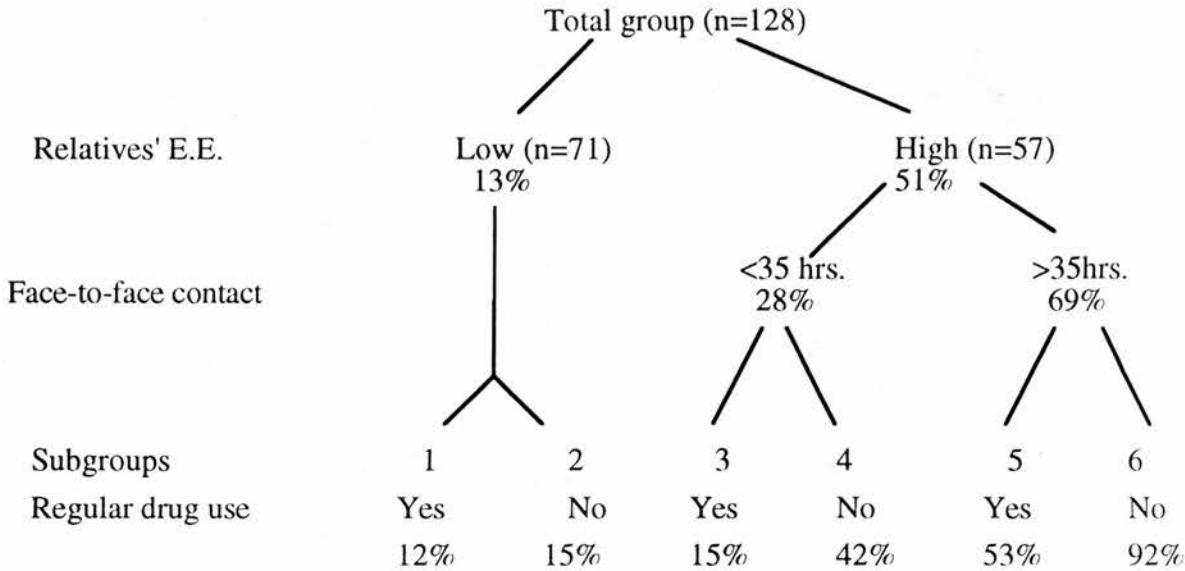
Reproduced from Leff and Vaughn 1985 p. 91

Depressive patients

In relation to patients who were diagnosed as suffering from depression Leff and Vaughn found that their relatives were just as likely to engage in Critical Comments as the relatives of schizophrenic patients; however, there was a marked absence of Emotional Overinvolvement, or Hostility in the absence of Critical Comments.[6] The team therefore related Critical Comments to relapse rates and found that at a cut off point of seven Critical Comments relapse rates for the high and low groups were 60 percent and 50 percent respectively. This was not significant. Further analysis revealed that a cut off point of two Critical Comments gave a much better prediction of

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[6]Leff and Vaughn explain this by the fact that the majority of the relatives were spouses as opposed to parents, (28 out of a total of 30). Overinvolvement is almost exclusively found in parents as opposed to husbands or wives.

relapse. Those patients returning to relatives that made more than two Critical Comments had a 67 percent chance of relapse compared to 22 percent for those returning to relatives that made less than two such remarks.

The Los Angeles replication of the British studies

All of the preceding data refers to work carried out in one small area of the South East of England. In 1977 work began on a replication of the British studies in California U.S.A. (Leff and Vaughn 1985 pp. 97-111). Essentially the methods that were used replicated those of the British studies however there were certain factors that differed and these appear worth noting. The Study was of 69 patients who were all assessed using P.S.E. and P.A.S. (Psychiatric Assessment Scale; Krawiecka, Goldberg and Vaughn, 1977) two weeks after admission. The assessment was repeated at discharge and again at the nine month follow-up or at re-admission, whichever came first.

The sample population differed from the British cohorts in that 72 percent of the Los Angeles sample were young unmarried males compared with only 29 percent in the British studies (combined n=139). Further, nine out of every ten of the American sample were living in parental homes at the time of key admission, whereas the living arrangements of the British participants were far more heterogeneous. The Los Angeles sample were also less likely to be first admissions (17 percent versus 54 percent) and more likely to have had three or more previous admissions (55 percent versus 16 percent), (See Leff and Vaughn 1985 p.101).

Due to the large numbers of patients that were experiencing active symptoms at the point of discharge the definition of relapse also became problematic. The researchers therefore used three categories in order to determine whether relapse had occurred, 'exacerbation-relapse', 'improvement-remission', and 'not-rateable'. The final decision concerning relapse was made by two psychiatrists who had not administered the initial mental health examinations and were not aware of the patients' status; that is whether they were in a high or low E.E. home.

The results reveal that the California sample had a poorer clinical outcome at the nine month follow-up (43 percent had no relapse compared to 66 percent for the combined results of the British studies). Leff and Vaughn

suggest that this may have been due to the greater chronicity of the American sample. In relation to the emotional response of the relatives the data revealed that the Los Angeles relatives were more likely to fall into the high E.E. categorisation. In the British studies 48 percent of relatives were rated as high in. E.E., in the American study this figure was 66 percent. (Leff and Vaughn 1985 p.102).

The analysis of the relationship between relatives' E.E. and relapse revealed that for the total sample of 54 patients, 56 percent of those in high E.E. families relapsed compared to 17 percent in the low E.E. sub-group. In relation to those patients that spent the whole of the follow-up period in the care of their family the results were even more significant. Sixty percent of this group in high E.E. families relapsed compared to nine percent in low E.E. family environments.

The California replication study again demonstrated that maintenance medication had a protective effect on patients returning to high E.E. families. Further, although not statistically significant, the data also revealed that patients from high E.E. homes that spent more than 35 hours per week in face-to-face contact with relatives had a higher chance of relapse than those that spent less time, (77 percent versus 46 percent).

> The California results differed, however, in suggesting that regular medication and reduced contact are interactive, as opposed to additive, in protecting high-EE patients against relapse. In London the high-EE relapse rate was reduced somewhat if at least one of the two protective influences was operating. In Los Angeles this was not the case; the high-EE relapse rate remained high unless both factors were in effect (Leff & Vaughn 1985 p.109).

To summarise, the evidence from the initial seminal studies of Brown et al. and Leff, Vaughn and colleagues suggests that there is an environmental factor involved in the community survival of schizophrenic patients who return to a family care environment. Further, the central results of the studies reviewed have been successfully replicated by a number of other independent researchers (see for example; Barralet, Ferrero, Szigethy, Giddey, & Perlizzer 1990; Karno et al. 1987; MacMilian, Gold, Crow,

Johnson, & Johnstone, 1986; Moline, Singh, Morris, Meltzer, 1985; Nuechterlein, Snyder, Dawson, Rappe, Gitlin, & Fogelson 1986).[7]

The relationships described in the E.E. literature also appear to hold across cultures and over relatively long time periods. It should be noted however that there are some differences in the interview responses of relatives across cultures and across studies. Halford (1991) has argued that the use of the composite measure of E.E., consisting of, Critical Comments, Emotional Overinvolvement and displays of Hostility, has tended to mask the differences found across studies. He points for example, to the fact that Leff et al. (1987) found, in a study of 93 Hindi speaking Indian patients with a clinical diagnosis of schizophrenia, that it was very rare for relatives to engage in high Criticism or Emotional Overinvolvement. In this study only displays of Hostility related to relapse rates. In contrast in the Los Angeles study (Vaughn et al. 1985) Critical Comments were found to be the factor most commonly associated with patient relapse.

The data presented in the E.E. studies does not relate interview responses to socio-economic grouping, nor is there an adequate analysis of the different responses of male and female relatives. Class and gender are not factors that the researchers deemed to be of significance to the interview responses.

It is important to note that the evidence reported in the above studies relates to a correlation between relatives' interview responses (displays of Critical Comments, Hostility, and Emotional Overinvolvement) and subsequent patient relapse/deterioration. None of the studies described above observed the behaviour of relatives and patients in a naturalistic family setting. This evidence does not therefore prove that Critical Comments by relatives to patients in face-to-face situations cause clinical relapse/deterioration.

The C.F.I. interview does, however, appear to highlight homes where the family atmosphere may have a potentially detrimental impact upon the patient's mental health. In turn, George Brown suggests that home

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[7] To date four main studies have failed to replicate the Leff and Vaughn, Brown et al. results, these are; Hogarty et al. 1988; Kottgen, Sonnischen, Mollenhauer, & Juryth, 1984; McCreadie & Phillips 1988; and Parker, Johnstone, & Hayward 1988. As Halford (1991) points out however three of the above studies contained significant methodological variations from the work of Brown and hia colleagues, and Leff and Vaughn, and these appear likely to account for the lack of replication. The study conducted by Parker et al. (1988) did, however, closely follow the methodology of Leff and Vaughn's seminal work and this failure in replication does raise some questions over the construct's validity.

atmospheres consist of the events that have taken place in the home over the preceding three months and the family members' feelings about these events and each other. Questions are therefore raised as to the relationship between the responses relatives give to C.F.I. interview and their behaviours, displays of emotion and interactions within the household.

THE RELATIONSHIP BETWEEN THE INDEX OF E.E. AND RELATIVE/PATIENT INTERACTION STYLES

To date there have been several attempts directly to observe patient and relative interactions in order to assess whether the differences in high and low E.E. responses reflect genuine differences in interaction patterns. Most commonly these attempts have used the Affective Style Measure (A.S.M.) which assesses the verbal responses of relatives during family problem solving discussions on dimensions derived from the E.E. concept (Doane, West, Goldstein, Rodnick, & Jones, 1981).

Using the A.S.M. Miklowitz et al. (1984)[8] studied 42 patients and their families (30 male and 12 female), in order to assess their interaction style and the content of family conversations during a ten minute problem solving exercise. The results revealed that high E.E. parents used a significantly larger number of negative appeal statements than did low E.E. relatives. Somewhat surprisingly the two high E.E. sub-groups (i.e. those rated as high in E.E. due to Critical Comments and those rated as high in E.E. due to Emotional Overinvolvement) were not found to differ significantly in their use of negative comments. However, as Miklowitz et al. note, the correlation between the direct interactions of high E.E. families and the categories of the C.F.I. was far from perfect.

> The relatively large standard deviations... indicate that, despite the difference in means, there was a certain degree of over lap in the distribution of scores. The larger standard deviation for the high E.E. sample suggests that some but not all the parents in this subgroup express high E.E. attitudes in direct interchange with their psychiatrically affected off spring. Some behave in a similar way to low E.E. parents. On the other hand all parents who expressed a notable level of negative affective behaviors came from the high-E.E. group (Miklowitz et al. 1984 p. 485).

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[8] Also see Strachan, Goldstein, & Miklowitz, 1986; Miklowitz, Goldstein, & Doane et al. 1989.

Hahlweg, et al. (1989) utilised the Five Minute Speech Sample (F.M.S.S.) developed by Magana et al. (1986)[9] to allocate families to high and low E.E. groups and then compared the patient's and relative's verbal and non-verbal interactions. This team again found that high E.E. status on the F.M.S.S. correlated with high rates of: relative criticism, disagreements with patient statements, and negative non-verbal behaviour. Hahlweg et al. also note that during direct interactions high E.E. families tended to negatively escalate verbal and non-verbal responses; they describe the way in which spirals of negative behaviours were observed which resulted in escalating negative affect and psychological arousal (Halford 1991).

Leff and Vaughn (1985 pp. 112-122) have also attempted, via an analysis of relatives' self reported behaviours and family interactions (gathered in the American and British studies) to address the issue of the relationship between relatives' interview answers and concrete family interactions. Their conclusion was that the interview transcripts suggest that relatives that are high in E.E. do indeed employ different interaction patterns and coping strategies from those that are used in low E.E. households. Leff and Vaughn suggest that these interactional characteristics concern,

> 1) a relative's respect for the patient's relationship needs;
> 2) the relative's attitude toward the legitimacy of the illness;
> 3) the relative's level of expectations for the patient's functioning; and 4) the relative's emotional reaction to the illness (Leff & Vaughn 1985 p. 112).

Thus Leff and Vaughn argue that relatives that rated as low on the index of E.E. tended to recognise that patients often found close relationships difficult (in both the physical and emotional sense), even in the absence of family stress or tension. These relatives appeared to have adapted their interaction demands according to the needs of the patient; to have accepted the situation and developed a respect for the patient's wishes/needs for social distance. Leff and Vaughn's, analysis also revealed that low E.E. relatives clearly recognised that certain difficult behaviours resulted from illness; however, these relatives still attempted to seek rational explanations for the

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[9]This is a brief method of assessing the level of E.E. in a family. To date there is no published data on the relationship between the F.M.S.S. and schizophrenic relapse. The measure does however correlate highly with the C.F.I. (Magana et al. 1986).

behaviours. Due to the relatives' recognition of the state of illness they tended to accept low levels of patient functioning and refrained from being overly critical or demanding.

Further, low E.E. relatives painted a picture of themselves as being exceptionally calm and self contained even in the face of very 'agitated or bizarre' behaviours. They also appeared to have a calming effect, not only on the patient but on all family members. In summary, Leff and Vaughn note that low E.E. relatives showed a great deal of flexibility and sensitivity to the needs of the patients. (Leff and Vaughn 1985 p. 118).

By contrast, relatives that were rated as high in E.E. tended to make repeated attempts to contact the patient, these attempts were also often shown to be of a very intrusive nature. Such relatives tended not to respect the privacy of the patients and tended to monitor the patients' routine activities, such as washing and dressing, they also offered a lot of unsolicited advice. Further, highly critical relatives tended to deny the legitimacy of the illness, were intolerant of 'sick talk' and believed that the patient could control his/her behaviours if they so desired. These attributions led to the patients being held accountable for their actions and very few allowances were made concerning the patient's level of functioning. Such relatives tended to make statements to the effect that the patient did not make any effort and could do much better if they would only try.

The social intervention studies

Evidence from the social intervention studies provides further support for the assertion that there are real differences in the interaction patterns of high and low E.E. families, (see Falloon et al. 1982, Leff et al. 1982, Berkowitz et al. 1980, Anderson et al. 1980, Doane, Goldstein, Miklowitz et al 1986, Leff et al. 1989). Thus Leff, Kuipers, Berkowitz, et al. (1982) attempted via an intervention package to reduce the level of E.E. in 12 high E.E. families. The interventions sought to change the interaction patterns of high E.E. families and/or the amount of face-to-face contact between the relative and patient. The content of the interventions was largely intuitive, reflecting the lack of knowledge concerning interaction patterns in high E.E. families. As Birchwood (1988) points out the non-prescribed/documented nature of some of this study's interventions has meant that replication is difficult.

For the Leff, Kuipers, Berkowitz, et al. (1982) study, the known information, concerning the differences between high and low E.E. families (reported above), was supplemented by an analysis of the focus (in preceding studies) of relatives' critical remarks. This analysis revealed that only 30 percent of relatives' Critical Comments related to the positive symptoms of schizophrenia, while 70 percent were directed at negative symptoms such as, apathy, inertia, and lack of affection. Beyond this, it was found that negative symptoms were more often viewed as long standing personality traits, that were under the control of the patient and not as manifestations of illness.

The intervention programme consisted of three information giving sessions (covering the areas of diagnosis, symptoms, aetiology, and the course and management of schizophrenia), attendance at a relatives' support group (one and a half hours every two weeks),[10] and family therapy sessions (mean 5.6 sessions per family).[11] The team also attempted to reduce the amount of face-to-face contact for those high E.E. relatives that were spending more than thirty-five hours per week together.

After the completion of the intervention package relatives were again interviewed using the abbreviated version of the C.F.I. and their level of E.E. rated. The results revealed that six of the twelve families had moved from the high to low E.E. banding. This compared to two from the control group, with whom the team had had no contact over the nine month trial period.[12] Further, five of the families that were subject to the interventions managed to reduce their face-to-face contact to below thirty-five hours per week. Low face-to-face contact was also found in three of the control families, however, this was for differing reasons to those that had received the intervention. In the control families one of the patients' husbands had left her and one patient had taken to spending long periods in his room. In the intervention group the lower contact resulted from attendance at day hospitals and through gaining employment. In nine out of twelve families the intervention was successful, in that E.E. and/or face-to-face contact was

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[10] It was intended that there would be a higher proportion of low E.E compared to high E.E. relatives at this group. The reasoning being that the low E.E. relatives would teach the high E.E. families appropriate coping techniques. In the event this was not achieved as it proved difficult to encourage low E.E. families to keep attending as they felt (not surprisingly) that they had already found satisfactory ways to deal with the problems under discussion.

[11] No one view of family therapy was adhered to and the therapists used structural and behavioural approaches as well as dynamic interpretations of individual behaviours and family relationships.

[12] The control group received the standard hospital follow up services. Leff and Vaughn suggest that these services did not address the control groups level of E.E. and that the change in status of these two relatives was spontaneous.

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lowered (75 percent), and none of these patients relapsed. The relapse rate for the intervention group as a whole was 8 percent as opposed to 50 percent for the high E.E. control group.

To summarise, the evidence from Miklowitz et al. (1984), Hahlweg et al. (1989) and Leff and Vaughn (1985), together with data from the social intervention studies, (see; Falloon et al. 1982, Berkowitz et al. 1981, Leff and Vaughn 1982) suggests that real differences exist in the interaction patterns and coping strategies of high and low E.E. families. There is also evidence to suggest that the attributions made concerning the causes of difficult behaviours vary significantly in the two types of families. The difference in relatives' attributions appears particularly marked in relation to the negative symptoms of under activity, apathy and lack of affection.

THE RELATIONSHIP BETWEEN STRESS AND ACUTE SCHIZOPHRENIC ATTACKS IN VULNERABLE INDIVIDUALS

A central question arising from the above literature review concerns the exact relationship between high E.E. family interactions and the observed statistically increased chance of clinical relapse/deterioration. That is to say, why is it that high E.E. family interactions are so detrimental to the patient's community survival? In attempting to address these issues and identify a possible causal intervening factor, writers in the field of E.E. have tended to turn to the literature on stress and hyper-arousal. Essentially, these arguments rest on definitions of stressors that define them independently of the organism upon which they impinge, (see Turping and Lader, in Katschnig eds 1986). The hypothesis that stress might induce the onset of an acute schizophrenic attack is by no means new; thus in 1964 Wing et al. reported that intense efforts to stimulate chronic withdrawn patients, as part of a rehabilitation programme, led in some cases to the re-emergence of positive florid symptoms.

Life events

Significant evidence for a connection between stress and relapse in vulnerable patients comes from the work into the impact of 'life events'. A life event is seen as an event in a person's recent history that causes a significant change in routine and acts as a stressor upon the individual. Brown and Birley (1968) distinguish three types of life events. 'Dependent

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life events' refer to events that were caused by the patient's own behaviours; 'possibly independent events' refer to events that remain within the patient's control while not being brought about by any unusual patient behaviour; and 'independent life events', are those clearly outside of the patient's control and not brought about by their actions.

Brown and Birley (1968) retrospectively measured the frequency of life events in the lives of schizophrenic patients leading up to an acute attack and compared this to the average for a 'normal' British sample. They found that 60 percent of the schizophrenic sample had experienced at least one life event in the three week period before relapse, compared to 19 percent of the control sample. As Birchwood (1988) points out there are some problems in the sampling techniques used in the Brown and Birley (1968) study. Brown and colleagues deliberately excluded 60 percent of patients for whom the timing of the onset of the illness was unclear, thus skewing the sample. Further, the retrospective nature of the study raises the issue of how many patients experience 'life events' but do not relapse? Even with these qualifications in mind, however, Brown et al.'s work does appear to support the assertion that the timing of schizophrenic attacks is influenced by life stress.

Leff and Vaughn (1985) also provide evidence to suggest that the occurrence of life events has an impact upon the timing of acute schizophrenic attacks. They draw the distinction between chronic stress and acute stress and argue that high E.E. families may be a source of chronic stress, whilst life events are a source of acute stress. By using the data from their 1976 replication study and 1982 social intervention study, Leff and Vaughn attempted to ascertain the effect that independent life events played in relapse. The results revealed that relatively few of the patients from high E.E. families (6 of 21, 28 percent) experienced a life event in the three months before relapse compared to the majority of those from low E.E. families (11 of 16, 68 percent). Leff and Vaughn interpret these findings as evidence that either living within a high E.E. family or the experience of a life event leads to a statistically higher chance of relapse in vulnerable patients. Beyond this, Leff and Vaughn analysed the nature of the independent life events using a scale developed by Bebbington (see Brown et al., 1973) and found that all of the schizophrenic patients who had relapsed had experienced a 'threatening life event'. This provides further evidence to support the assertion that it is the stress factor in the life events that

precipitates the observed relapses/clinical deterioration. The following statement is offered by Leff and Vaughn as a summary of their analysis concerning the impact of life events and their relationship to E.E. and maintenance medication:

> Those individuals living with relatives in the community are vulnerable to two main varieties of stress: acute stress in the form of threatening life events, and the chronic stress involved in living with a high-E.E. relative. In patients who are unprotected by medication, one or other form of stress is sufficient to precipitate an episode of illness. ... Patients on regular medication are protected against one or the other type of stress, but not against a combination of acute and chronic stresses (Leff & Vaughn 1985 p.192).

Although the notion of stress used by Leff and Vaughn has intuitive appeal, the authors make no attempt to define exactly what they mean by the term stress or its sub categories acute and chronic stress. They do not address the issue of perception in stress; that is to say the active role that the individual plays in experiencing something or someone as a stressor (Cox 1978). Neither do they confront the fact that individuals have differing tolerance levels to the same stimulus. Instead the reader is left with a view of people suffering from schizophrenia as being different from the majority of the population, in that they do not have to perceive something as stressful for it to have a detrimental effect upon them. Further, it appears from the literature that Leff and Vaughn view all sufferers of schizophrenia as having the same low tolerance levels to acute and chronic stressors; again the individuality of the sufferer is lost.

PSYCHO-PHYSIOLOGY AND E.E.

Further evidence also exists within the field of psycho-physiology to suggest that the intervening variable between high E.E. family interactions and increased rates of relapse/deterioration may be stress. This evidence is, however, not very conclusive and questions have arisen concerning the physiological measures used and their relationship to stress. There are also some inconsistencies in the results obtained by different researchers. As Halford (1991) points out, the stimulus for recent work into psycho-physiological factors connected to E.E. stems from the results of Tarrier et

al. (1979) and Zahn et al. (1981); both of these teams found that autonomic hyperarousal is characteristic of schizophrenic patients prior to and during acute psychotic episodes.

Work in the field of psycho-physiology and schizophrenia is however much older than the more current work relating to E.E.; for example, in 1962 Venables and Wing employed skin conductance measures and suggested that socially withdrawn schizophrenics remained highly aroused. Since Venables and Wing's study an extensive literature has developed concerning physiological response, arousal, and schizophrenia. Ohman (1981) reviews this literature and argues that the evidence suggests that there is a relationship between electrodermal activity and vulnerability to schizophrenia.

Tarrier, Vaughn et al. (1979) attempted to ascertain whether there was a direct relationship between exposure to a high E.E. relative and increased electrodermal activity. The research sample consisted of 21 out of the original 37 patients in Vaughn and Leff's 1976 study; the remaining 16 patients either could not be traced or refused to take part in the study. The trials were conducted in the patient's own homes with sweat gland activity and heart rates being measured. For the first twenty minutes of the experiment recordings were made with only the experimenters present, the key relative was then asked to enter the room and a further twenty minutes recording taken. The aim was to see if face-to-face contact with the relative caused a change in physiological arousal.

The results revealed that both high and low E.E. patients had higher base rate (spontaneous skin fluctuations and heart rate) than the control group of 'normal' patients. Moreover, high and low E.E. patients did not habituate during the 15 minutes before the entry of the relatives. This failure to habituate is abnormal but is not unique to sufferers of schizophrenia (see Toone, Cook and Lader 1981). The base line rates for high and low E.E. groups were not found to differ significantly.

The entry of the key relative was associated with an increase in activity in all three groups (High E.E., Low E.E., and Control) but was significantly higher in the high E.E. group than the low E.E. or control group. The higher rate of the high E.E. patients did not decline or habituate before the end of the 15 minute trial period. By contrast, once the low E.E. relatives were in face-to-face contact with the patient, the patient's spontaneous fluctuation fell steeply for five minutes until it reached the level of the

control group. The lower rate of the low E.E. group over the 15 minutes following the entry of the relative is interpreted by Leff and Vaughn as evidence of the calming effect of the low E.E. relatives (Leff and Vaughn 1985 p.198).

It is interesting to note that the pattern of activity described was only found on the first recording session. In two subsequent sessions the patients from both the high and low E.E. groups habituated normally, that is, in the same way as the control group. Leff and Vaughn suggest that this resulted from the patients, in subsequent sessions, being accustomed to the apparatus, the experiments and the procedure. The failure to repeat the results suggests that the presence of the high E.E. relative alone is not enough to induce the higher spontaneous fluctuations. The calming effect of the low E.E. relative is not however challenged by these findings.

In a second study Sturgeon et al. (1984) looked at the electrodermal activity of the patients who took part in the Leff et al. intervention study (1982). This group of patients were tested in order to establish their levels of electrodermal activity during the acute stages of the condition (the original Tarrier et al. study had studied patients during 'remission'). In all 30 patients took part in this study, 11 from low E.E. families and 19 from high E.E. homes. The results revealed that the base line reading for the high E.E. group was significantly higher than that for the low E.E. group. Leff and Vaughn argue that data from P.S.E. examinations suggest that these findings did not reflect a greater severity of illness in the high E.E. group. In contrast to Tarrier et al. (1979), Sturgeon et al. (1984) found that in both the high and low E.E. groups there was a reduction in spontaneous fluctuations over the entire 30 minute test period (fifteen minutes prior to the relative's entry and fifteen minutes afterwards). The differential results concerning the entry of high and low E.E. relatives and the calming effect of low E.E. relatives were thus not reproduced by Sturgeon et al.

Beyond this Sturgeon et al. (1984) attempted to ascertain whether the patient's move from the high E.E. to the low E.E. grouping following psychosocial interventions (see Leff and Vaughn 1982) was accompanied by a change in spontaneous fluctuation rates. Here the team reasoned that;

> Since the intervention was successful in lowering E.E. in a proportion of experimental relatives, and since this was paralleled by a significant reduction in the relapse rate of experimental patients, some effect on the patients'

psychophysiology should be demonstrable (Leff & Vaughn 1985 p. 207).

In the event the research team were unable to find a significant difference in the spontaneous fluctuation rates of patients. Although the numbers in this study were small these finding force consideration of the possibility that the electrodermal activity measured is not the intervening variable between high E.E. families and clinical deterioration/relapse.

Summary

To summarise, within the first part of this chapter, the development of the concept of E.E. has been traced. It has been shown that, particularly in the early stages, the concept has been empirically driven, with the method of measurement (C.F.I.) and the concept itself being closely intertwined. The E.E. concept has, however, provided some very useful insights into the effects of carer/patient interactions and has proved very robust, with successful replications of the central results being achieved across time and cultures.

The theories concerning the relationships between the answers that relatives give to the C.F.I. and their actual interactions in the family setting have been later in coming. There is now a growing body of knowledge to suggest that there are indeed real differences in the interaction patterns of high and low E.E. families. Analysis of the substantive answers to C.F.I. questions, together with the social intervention studies, and research into family problem solving and communication techniques, have provided important insights into the interaction patterns of high and low E.E. families. However, as these studies have all relied upon either interview data or exercises based within laboratory settings, their results must be treated with caution; that is, the lack of direct observation of the families casts some doubt over the validity of the findings.

The research concerning the exact mechanisms that link certain interaction patterns to statistically higher rates of relapse/deterioration is more problematic. There is some evidence to suggest that stress may provide the connection between interactions and relapse, however, this work is only suggestive. Leff and colleagues' attempts to relate the work on life events and E.E., through the linking notion of both being stressors, appears to suffer from a failure to offer an explicit definition of stress. Work

concerning psychophysiological responses suffers from a related problem, as the relationship between the physiological measures that are used and stress remains unclear. Further, the results of the psycho-physiological studies are contradictory on some central points.

EXPRESSED EMOTION AND COLLECTIVE CARE SETTINGS

To date there have been two attempts to relate the work on E.E. to collective care provision. The first of these studies, by Berkowitz and Heinl (1984), was a small scale exploratory study involving twenty-two nurses (nine charge nurses, five staff nurses, two state enrolled nurses, three nursing assistants, and three student nurses). The participants came from several wards; twelve nurses came from general psychiatric wards, five from locked wards, and five from chronic long stay wards. Berkowitz and Heinl utilised the method of case vignettes in order to gain an understanding of the way in which nurses reacted to certain patient behaviours.

Due to the exploratory nature of Berkowitz and Heinl's study there are certain methodological problems, which necessitate that their findings be treated with some caution. The nurses that took part in the study were all volunteers and there was not a 100 percent response rate from any of the wards involved in the study, this raises the possibility of a skewed sample. The use of case vignettes also raises questions concerning whether the nurses actually behaved in reality in the ways which they described in the interviews. However, having noted these methodological difficulties, the findings remain of interest. Berkowitz and Heinl conclude that;

> The differences between those nursing the acutely ill and those nursing the chronic patients were not statistically significant. Both groups mentioned most often the category of 'nurturing', acknowledging the patient's perspective, understanding the illness and helping the patient to get on with some other activity. One important aspect, acknowledging the patient's view, suggests that listening to patients expressing their distress may be very important (Berkowitz & Heinl 1984 p.29).

Berkowitz and Heinl argue that the reported care practices of the nurses who took part in their study bore significant similarities to practices and interactions that typify low E.E. relatives. Further, they suggest that the

nurses' good care practices resulted from the combination of their professional training and considerable experience.

> Firstly, the attitudes are positive, that is, there is little irritability or anger expressed by either nurses or low E.E. relatives, they are both able to acknowledge how the patient feels *now* and also hold out hope for future improvement. They both attempt to set realistic goals within the limitations of the patient's condition and to persevere at an equally realistic pace. Their own feelings are not as much in evidence as those of high E.E. relatives. Although there is not an example of low E.E. relatives dealing with their own feelings it is common for them to try to protect the patient from excessive emotion (Berkowitz & Heinl 1984 p. 30).

The second significant attempt to relate the concept of E.E. to collective care settings is the recent work of Rosemary Ball and her colleagues at the Institute of Psychiatry in the Maudsley Hospital (Ball, Moore and Kuipers 1992; Moore, Kuipers and Ball 1992). In this project the researchers attempted to compare the level of E.E. in two hostels, and relate the E.E. ratings to outcome at a nine month follow-up. Hostel A housed eight residents; hostel B had the capacity for twelve residents but during the study period only eleven patients were in residence. Hostel A was staffed by three personnel, one of whom was male, whilst hostel B had four female staff. The level of staff experience also varied across the hostels. In hostel A two of the three staff had over five years' experience working with the mentally ill (one in an occupational therapy department and the other as a psychiatric nurse), in hostel B one staff member had over ten years' experience in the hostel, the remaining three staff had not been in post for such an extensive period and had no previous experience of mental health work.

Ball and her colleagues attempted to measure the level of E.E. in the two hostels by administering a modified version of the C.F.I. The procedure involved the workers responding to C.F.I. questions in relation to their key clients; only workers who spent more than 20 percent of their working week with a particular client were interviewed. The result of this methodology was that 12 C.F.I.s were completed (five in hostel A and seven in hostel B). Here it is important to note that what was being assessed was specifically the client/key worker relationships and not the client's relationships with all their carers or all the social actors within a particular milieu. The completed C.F.I.s were rated in the standard fashion to ascertain their level of E.E.

The findings revealed that hostel A had produced only one C.F.I. that was high in E.E., whereas hostel B produced four such ratings. All of the high E.E. ratings were made on the basis of Critical Comments and/or displays of Hostility, no examples of Emotional Overinvolvement were found. The team concluded that hostel B was higher in E.E. than hostel A.

The analysis of outcome at the nine month follow-up revealed some significant differences. In both hostels, A and B, two residents were deemed to have relapsed. In hostel A two residents required two short admissions to hospital. On both occasions, however, the residents returned to the hostel within a month. In hostel B one resident was not allowed back into the hostel after a hospital admission, being considered 'a failure', and the second was still in hospital at the nine month follow-up.

In terms of comparative hostel discharge rates the study also produced some interesting results. During the study period only one resident was discharged from hostel A, as opposed to seven residents from hostel B. The one resident discharged from hostel A moved to a less supportive environment, whereas in hostel B, two residents were discharged for breaking house rules, two elderly ladies were transferred to nursing homes and two residents were discharged to hospital care. Ball and her colleagues summarise their central conclusion as follows.

> The reemergence of positive symptoms is a continuing risk for long-term patients. Whereas staff in hostel A accepted and monitored fluctuations in the residents' condition, the relapses experienced by patients in Hostel B were more prolonged, with the additional risk of a concomitant change in their living environment. A similar pattern is evident in the figures for discharge. The successful discharge from Hostel A would seem to illustrate the role of the staff in providing a supportive home for residents. This was less evident in Hostel B (Ball, Moore & Kuipers 1992 p. 37).

Difficulties that arise in the existing literature which attempts to relate E.E. to collective care settings

As is clear from the dearth of literature that attempts to relate the work on E.E. to collective care settings, the project remains in its infancy. The preliminary works by Berkowitz et al. and Ball and her colleagues offer some interesting insights; however, serious problems remain. Both the Berkowitz and Ball research teams have treated the transfer of the E.E.

concept to other care settings as theoretically unproblematic; that is, they have failed to address explicitly the fundamental differences that exist between families and collective care settings. In some ways this lack of explicit theoretical discussion is not surprising since the preceding literature review has shown that the development of the E.E. concept has historically been empirically driven. The concept of E.E. was originally derived by empirical observations with the theoretical input concerning the key relationships coming at a much later date, that is the work looking at the potential mechanisms that may intervene between high E.E. scores on the C.F.I. and the observed higher relapse rates.

In reality there are considerable differences between families and collective care settings. Beyond this, these differences potentially appear to have certain important implications for the direction of future work and the methods and methodologies that are employed when attempting to relate E.E. to collective care settings. Here these theoretical differences will be discussed under three subheadings.

i) The larger numbers of social actors and the resulting increased complexity of interaction patterns in collective care settings, compared to family care environments.

The larger number of people involved in collective care settings means that the interaction patterns found are somewhat more complex than those within the average family. Within collective care settings it is not a case of one patient interacting with one or two carers: rather there are normally several residents and several carers. Thus in reality, it may be that due to shift patterns or worker priorities a client may not have significant contact with a key worker for a number of days. Residents of collective care settings must therefore potentially deal with the emotional responses and behaviours of several carers and also those of their co-residents. Residents must, for example, deal with situations wherein a co-resident is unwell and expressing feelings of paranoia, or responding to auditory or visual hallucinations.

Beyond this, as Goffman (1961) illustrates through his use of the metaphor of drama, within collective situations people's actions and attributions are influenced by their institutional role, the audiences' reactions to them and the available 'props'. The relatively large numbers of residents and carers within collective care settings can easily lead to a situation whereby people are typified in accordance with their institutional status, and

responded to and expected to perform in accordance with their designated role.

The methods employed by Berkowitz et al. and Ball and her colleagues did not pay sufficient attention to the collective nature of group care nor did they address the question of whether the interactions of co-residents, and/or workers other than the key worker, affect the timing and/or severity of clinical relapse/deterioration.

ii) The significance of differences in the relationships of family members and paid carers and residents.

As has been shown above the exact linkage between the differing interaction patterns of high and low E.E. families and patient prognosis remains clouded; the creation of chronic stress, however, appears to be the most likely intervening variable. The reason that high E.E. family interaction patterns are stress inducing also remains unclear. One hypothesis however is that the interaction patterns are stressful because of the affective relationship between the parties involved, i.e. between spouses or parent and son/daughter. In relation to the task in hand (relating E.E. to collective care settings) this hypothesis raises certain important issues, as there are clear differences in the affective dimension of family relationships compared to paid carer/client interactions.

Within the family relationships are based, in essence, on affective ties. People involved in nuclear family relationships typically live together over quite long periods of time and display strong emotions towards one another, although these are not always positive (Friedan 1963). Family relationships are not essentially instrumental, in the sense of people coming together for a short period to achieve a specified task, rather they are about emotional attachment.

By contrast, the relationships within collective care settings are in essence instrumental. Staff are present to perform roles and tasks that are normally laid down in a contract. Staff are typically not resident and tend to leave and return to the setting at regular intervals. The residents within collective mental health care settings are there, by definition, for reasons of mental ill health and are often attempting to achieve certain rehabilitative goals in order to move on. They have normally not chosen to live together and do not typically view their relationships with staff and co-residents as

permanent. Relationships within collective care settings are therefore not essentially emotional and affective but rather instrumental and goal oriented. At the same time, however, it must also be recognised that in reality many sufferers of mental health problems live in collective care settings for many years. For long stay residents collective care settings may well become surrogate homes, with residents developing emotional attachments towards co-residents and staff; in the long run these relationships may become not that dissimilar to very close friendships, or even family relationships.

As has been shown in the preceding literature review, the model of stress that is utilised within the E.E. research is essentially one that sees stressors as acting upon the person independently of their perception of events. Writers in the field of E.E. do not use a model of stress that is interactive; that is, that allows for the fact that various patients may find differing stimuli stressful or have various stress tolerance levels. Within the existing literature therefore there is no evidence to support the hypothesis that patients perceive the high E.E. family interactions as stressors because they have a close emotional tie to their relatives. Rather, the E.E. literature suggests that there is something within the interaction exchanges/behaviours that the patients find difficult. However, as the work to date has been almost exclusively on family members' inter-relationships, the question of whether high E.E. interactions are only detrimental when the relationships involved are affective may not have arisen. Given this situation it appears prudent to consider whether there are enough similarities between the two carer/patient relationships for the applicability of E.E. to be likely to hold in collective care settings.

The least favourable position arises if it should be the case that the interactions between patients and carers are a form of chronic stress because of the affective relationship between patient and carer; that is to say, if the relative's reactions of intrusiveness, anger, distress, denial of the illness and low levels of tolerance of the illness, are stressful because the patient values the relative's opinion; that is if they are a significant other. Here the link between the stress that the patient experiences and the emotional reactions and behavioural patterns of the relative, may be the effect that the relative's reactions have upon the patient's self image and esteem. For the patient to be told that they are not really ill and are not trying to do things for themselves may be more stress inducing from a close family member than a relative stranger.

Clearly the paid carer cannot be a significant other in the same way as a parent or spouse. However, as Banton (1965) points out, structural role theories assert that certain members of society occupy roles based on achievement, for example, lecturers, doctors, social workers, psychiatrists, psychiatric nurses, and with this comes a certain degree of power. People who occupy achieved roles are defined socially as having expertise in that specific area, and accordingly have the ability to act as significant others within that small domain. Thus, whilst the paid carer will clearly not be a significant other in a general sense (as a family member might), they may well fill such a role in certain specific areas associated with mental health. Although the relationships between the carers and patients in the two settings are fundamentally different, it appears possible that within the collective mental health care setting psychiatric nurses and care workers may have considerable power, and that their reactions, behaviours and displays of emotion may potentially have a similar effect upon the resident to those of relatives within the home.

Phenomenological writers offer a similar argument in relation to interpersonal perception and the construction of self. Thus Laing points out that it is not only important how people perceive or define a situation or themselves but also how they believe that others perceive the situation or themselves. In terms of stress creation or reduction it appears that the individual's perception of the reactions of co-residents and staff will be important.

> My field of experience is, however, filled not only by my direct view of myself [ego] and of the other [alter], but of what we shall call meta perspectives- my view of the other's [yours, his, her, their,] view of me. I may not actually be able to see myself as others see me, but I am constantly supposing them to be seeing me in particular ways, and I am constantly acting in the light of the actual or supposed attitudes, opinions, needs, and so on the other has in respect of me (Laing 1966 p.4).

Sharp (1975) offers the following phenomenological view of the inter-relationship between the self and the wider group in his study of a therapeutic community.

> While an 'individual pathology' approach or psychological reductionism is thought to be untenable in explaining the

career of a mental patient in care, it is felt that there is a dialectical relationship between social and individual processes. That is, self and social are intimately related and a sufficient understanding requires cognisance of both levels. ... In Schutzian terms, the resident will bring to the situation in the therapeutic community certain sets of relevances and stocks of knowledge derived from his social biography. While his self image and identity are a product of his past interactions, the social processes as they are mediated through self and other interactions within the therapeutic community may reinforce, modify or transform "who he really is" (Sharp 1975 p. 114).

Within phenomenological theorising therefore there is some further support for the assertion that the reactions of staff and co-residents in a collective care setting will potentially impact upon an individual resident. These theories would appear to offer additional support for the applicability of E.E. to collective care settings. Importantly, however, the phenomenological writings also point to the importance of a research method and methodology that is capable of gauging the impact of all the interactions that are taking place within a collective care environment. In this sense the theories of the phenomenologists raise a challenge to the methods employed by Berkowitz et al., and Ball and colleagues, in their provisional attempts to relate E.E. to collective care.

A second hypothesis concerning the reasons why the interactions in high E.E. families are chronic stressors is offered by MacCarthy et al. (1986). They have argued that high E.E. families create a cognitively complex environment which the schizophrenic patient has difficulty in dealing with. In this hypothesis the stress does not emanate from the affective relationship between the interactants, but rather from a situation of cognitive overload. Thus Hemsley and Zawada (1976) have suggested that the positive symptoms of schizophrenia arise in highly stimulating environments because of the patient's inability to filter out redundant or distracting information. They argue that the cognitive deficits associated with the illness mean that the patient gives equal attention to all information and that this leads to a form of cognitive overload. Hemsley (1977) extends this hypothesis by suggesting that the negative symptoms of slowness and withdrawal represent an attempt by the patient to reduce the stimulation and therefore avoid the recurrence of the more distressing positive symptoms.

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Building upon these previous works MacCarthy et al. (1986 pp. 727-731) have suggested that high E.E. families create cognitively complex environments that are stressors because of their uncertainty and unpredictability. In their empirical work they found that highly critical relatives tended to display a high variability of response to problem behaviours. The relationship did not hold for those rated as high in E.E. because of Overinvolvement. If MacCarthy et al. (1986) are correct, and the reason that high E.E. environments are chronic stressors is because of cognitive complexity and unpredictability, then it would again appear that the concept and mechanisms of E.E. are potentially applicable to collective care settings. That is to say, there appears to be no reason why a collective care setting can not contain interactions and situations that are cognitively complex and unpredictable, and which in turn have a similar effect to the relationships found in high E.E. families. Again however, the work of MacCarthy et al. appears to call for a method of assessing E.E. in collective care settings that is capable of gauging the total cognitive complexity of the environment and all the relationships therein.

iii) The significance of collective care settings' organisational structures, goals and imperatives.

A third difference which exists between collective care settings and families is found in the organisational aspects of collective care settings. There exists a considerable literature which suggests that stable patterns of interaction are established within care organisations and that such patterns of behaviour are relatively robust and long lasting (Stanton and Schwartz 1954, Wing and Brown 1970, Sharp 1975). The continuity of behaviours observed within organisations appears to arise from the social actors' involvement in the twin processes of definition and interpretation of reality (Berger and Luckmann 1979). Organisational cultures therefore appear to mediate between the structural aspects of the organisation and the behaviours of individuals. In this way the cultures that arise within the collective care settings have an effect upon the emotional climate of the care environment. They serve to supply the individual social actors with a collective set of meanings and an interpretive framework within which to understand events and behaviours. They also shape the attributions that the social actors make concerning the causes of other peoples' behaviours and actions. Staff and patient cultures are not elements found within the family care environment

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but appear relevant when attempting to assess the emotional climate and stress impact of a collective care setting.

King et al. (1971) have argued that a useful distinction can be drawn between organisational managerial practices that are typically institutionally oriented (involving block treatment of residents, rigidity of routines, excessive distance between staff and residents, and depersonalisation), and practices that are resident oriented (characterised by a flexibility in meeting the resident's individual needs). Garety and Morris (1984) argue that concrete staff-resident interactions will be shaped by managerial and organisational directives. Within their study they found a strong correlation between a resident oriented managerial style and staff holding resident oriented and optimistic attitudes. Raynes et al. (1979) took this line of argument one stage further suggesting that;

> personality and individual differences pale as determinants
> of social behaviour when compared to the situation at hand
> (Raynes et al. 1979 p.25).

Rudolf Moos has argued that social care environments have particular characters or atmospheres and that these place limits upon the options available to the individual social actors. After reviewing the literature, he suggests that past researchers have highlighted the importance of six major dimensions in characterising a care environment's atmosphere. These dimensions he describes as: the *ecological aspects* such as geographical location and architectural characteristics; *behaviour settings* referring to the behaviours demanded of the setting's inhabitants (for example reading and writing in a classroom) and the effect of these demands on individual's self esteem and mood; *organisational structure* referring to such aspects as the size of the organisation, the staffing ratio, the control and managerial structures; *personal behavioural characteristics* referring to the characteristics of the individuals inhabiting the environments, age, socio-economic group, educational attainment; and the *psycho-social characteristics and organisational climate* referring to the perceived norms and general value orientations of the milieu (Moos 1974 pp. 3-31). Moos uses the term 'environmental press' to refer to the way in which these material and cultural aspects of the care setting combine to shape the actions of the setting's participants.

The social climate perspective assumes that environments have unique 'personalities,' just like people. Some people are more supportive than others; likewise, some environments are more cohesive than others. Order and clarity are important to many people; correspondingly, many social environments emphasise clarity and organisation. Just as people make plans to regulate behavior, environments have programs that regulate the behavior of the people in them. These environmental 'programs' or 'press' can be measured by asking participants about the characteristics of their setting. Descriptions of social-environmental press are based on the continuity and consistency of how people see otherwise discrete events (Moos & Lemke 1988 p 47).

Within his empirical work, Moos suggests that it is possible to characterise care environments along seven basic dimensions by asking the environment's inhabitants about their perceptions of the milieu. These seven dimensions are in turn subsumed under three headings; Relationship dimensions, Personal Growth dimensions, and System Maintenance and Change dimensions.

Relationship Dimensions
1. Cohesion- measures how helpful and supportive staff members are toward residents and how involved and supportive residents are with each other. (Do residents get a lot of individual attention?)
2. Conflict - measures the extent to which residents express their anger and are critical of the facility. (Do residents ever start arguments?)

Personal Growth Dimensions
3. Independence - assesses how self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self direction they are encouraged to exercise. (Are personal problems openly talked about?)
4. Self- Exploration - measures the extent to which the residents are encouraged to openly express their feelings and concerns (Are personal problems openly talked about?)

System Maintenance and Change Dimensions
5. Organisation- assesses how important order and organisation are in the facility, the extent to which the residents know what to expect in their day-to-day routine, and the clarity of the rules and procedures. (Are activities for the residents carefully planned?)

6. Resident Influence -measures the extent to which the residents can influence the rules and policies of the facility and the degree to which the staff directs the resident through regulations. (Are suggestions made by the residents acted upon?)

7. Physical Comfort-taps the extent to which comfort, privacy and pleasant decor, and sensory satisfaction are provided by the physical environment. (Can residents have privacy whenever they want?)

(Reproduced from Moos & Lemke 1988 p.48).

Interestingly, certain of Moos's care environment dimensions bear a close relationship to the individual elements of E.E. and the interaction patterns found within the research families. Thus Moos asserts that, care environments differ in terms of the level of participant Conflict and Self Exploration. Within the E.E. research the expression of Critical Comments and displays of Hostility during the C.F.I. have proved to be the best predictors of patient relapse at the nine months and two year follow-up periods. As noted, Miklowitz et al. (1984) also report a correlation between relatives rated as high in E.E. due to Critical Comments and their use of critical remarks in face-to-face interactions. A central difference between the Moos scale and the C.F.I. is that Moos is concerned with the extent to which residents express their anger and feelings, while the C.F.I. is measuring the carer's expressions of Critical Comments and displays of Hostility to the patient. However, as has been argued in the preceding section of this chapter, phenomenological writings tend to suggest that this difference may not be crucial, as both resident and carer expressions of emotion contribute to the emotional climate of the collective care setting. There appears therefore to be an interesting relationship between Moos's Conflict and Self Exploration dimensions and the Hostility and Critical Comments elements of the C.F.I.

Similarly, Moos's Cohesion and Independence dimensions appear to bear an affinity to the Emotional Overinvolvement element of the C.F.I. Moos states that these dimensions of the care environment are concerned with the degree to which residents are encouraged to be self sufficient in their personal affairs and how involved and supportive the social actors are towards one another. Leff and Vaughn state that one of the signs of Emotional Overinvolvement is extremely over protective behaviour that involves the parents not granting age appropriate levels of patient autonomy and independence. Emotional Overinvolvement is also said to involve the

relative exerting psychological and physical control over the patient, (Leff and Vaughn 1985 pp. 45-46).

The Moos System Maintenance and Change dimensions are not found directly within the components of the C.F.I. and point primarily to the organisational aspects of collective care settings. However within a family there is also a need for certain maintenance tasks to be completed, for example, the provision of financial/material resources, household tasks such as cooking, cleaning, shopping and the maintenance of interpersonal relationships etc. Leff and Vaughn note that rigidity in interpersonal relationships and a lack of flexibility in the relative's responses to the patient's needs and wishes are attributes of high E.E. families. In some senses Leff and Vaughn's rigidity of family relationships can be seen to have parallels within Moos's care environment dimensions of Organisation and Resident Influence. These dimensions are also concerned with rigidity, albeit at an organisational level, the importance of order and the degree of control over the resident's actions and influence.

As has been shown, Leff and Vaughn have argued that the high and low E.E. families involved in the Brown et al. (1972) research and their 1976 study offered descriptions of interactions that differed markedly from one another. Interestingly, Leff and Vaughn's definitions and examples of the four dimensions all relate to behavioural patterns by relatives. The dimensions are concerned with actions that relatives claim arise as a result of their feelings and attributions concerning the causes of patient behaviours. Leff and Vaughn suggest that these behavioural patterns are the interactional manifestations of the emotions displayed in the C.F.I. interview and that high and low E.E. families differ in terms of:

> 1) the relative's respect for the patient's relationship needs;
> 2) the relative's attitude toward the legitimacy of the illness;
> 3) the relative's level of expectations for the patient's functioning; and 4) the relative's emotional reaction to the illness (Leff & Vaughn 1985 p. 112).

It appears that theoretically, all of these dimensions could apply equally well to collective care settings and to interactions between staff and residents as to family members' inter-relationships. The exact patterns of interaction that are observed within a specific organisation, would in turn, appear to be shaped by what Moos has described as the care environment's social atmosphere. Thus specific collective care settings could theoretically vary in

terms of staff members respect for residents' need for space in relationships (both physical and psychological), staff and residents' attitudes towards the legitimacy of the illness and the attributions that they make concerning the causes of behaviours, and the expectations that social actors hold concerning the required level of resident functioning.

The fourth of Leff and Vaughn's dimensions (the relative's emotional attitude towards the illness) appears somewhat different. In effect they offer a tautological statement saying that high and low E.E. relatives can be distinguished in term of their emotional response. Leff and Vaughn's elaboration of this statement does however shed some light on their intended meaning. They comment:

> Over the years, however, we have been struck by the exceptionally calm and self-contained responses by low-E.E. relatives, sometimes in the face of extremely agitated or bizarre behaviors. Only very occasionally did this response style seem inappropriate, over controlled, or indicative of some denial mechanism at work. In most cases, these relatives simply seemed concerned without being overly anxious (Leff & Vaughn 1985 p. 117).

Emotional response therefore appears to refer to the relative's calmness of response in a crisis situation. Leff and Vaughn do not suggest that the emotional response dimension refers to a specific emotional relationship in the affective domain, rather they point, as in the other three dimensions, to relative behavioural patterns. It appears therefore that this dimension is also applicable to collective care settings.

Summary

To summarise, within the second section of this chapter the two previous attempts to relate E.E. to collective care have been briefly outlined and discussed. It has been argued that there are significant differences between collective care settings and families and that previous authors do not specifically address these issues. These differences and their potential significances have been discussed under three separate headings. Centrally, the point has been made that the larger number of participants within a collective care setting, together with the organisational structures and goals, and the existence of worker and client cultures, mean that the straight-

forward transfer of the C.F.I. may not be the best method to gauge the level of E.E. within relationships in such settings. Thus, the work of Berkowitz et al., and Ball and her colleagues, have been shown to suffer from the twin problems of not directly observing the interactions of staff and residents and not taking account of all the interactions that were taking place within their research sites. It has been shown that phenomenological writings point to the importance of taking account of all of the interactions that an individual is subject to within a particular environment.

On the theoretical level, it has been argued that the patterns of interactions that have been observed in high E.E. families may well exist within some collective care settings. Beyond this, it has been suggested that, although there are significant affective differences in the relationships between family members and social actors in collective care settings, there are theoretical reasons to believe that high E.E. interactions are likely to have a similar detrimental effect in both settings. The fundamental relationships that have been discussed under the rubric of E.E. therefore appear likely to hold within collective care settings; that is, certain types of interactions leading to chronic stress in the patient and subsequently a statistically higher chance of clinical relapse.

THE POSITION AND AIMS OF THIS STUDY

The study reported herein addresses some of the issues that have been raised within this chapter. Firstly, the above review suggests that it is now necessary to undertake an exploratory study involving direct naturalistic observation of interactions within collective care settings, with the aim of establishing whether face-to-face Critical Comments, displays of Hostility and/or Emotional Overinvolvement exist, and who these interactional exchanges are between. In this way it will be possible to establish whether the majority of face-to-face high E.E. exchanges are indeed between key workers and residents, staff generally and residents, or co-residents. The acquisition of this information is seen as vital in establishing the validity or otherwise of Ball and colleagues' attempts to assess the levels of E.E. in collective care environments through the administration of the C.F.I. to key workers. Beyond this, in the case of any observed inter-resident high E.E. interactions it appears necessary to try and gain an understanding of the role that staff play in either smoothing and dissipating, or provoking and

encouraging, such interactions. As noted above, work within the phenomenological tradition (Laing 1966, Sharp 1975, Mead 1952), with its emphasis upon the importance of significant others and the social construction of self, offers evidence to suggest that high E.E. interactions between co-residents or between staff and residents may potentially have a similar detrimental effect to those seen in patient and spouse or parent relationships.

Secondly, the review of literature has pointed to the potential importance of the inter-relationships between organisational structures, goals and philosophies of care, in shaping interaction patterns and ultimately potentially influencing the levels of E.E. within collective care settings. Moos (1988) has coined the term 'environmental press' to capture the way in which, within organised care settings, environmental characteristics may push social actors into certain types of behaviours and interactions; this point was expressed equally strongly by Goffman (1961) in his work on total institutions.

In the following chapter certain elements of the work of Berger and Luckmann (1979) will be reviewed. However, at this point it is worth noting that they argue forcibly that in order to understand the way in which empirical social reality is created, maintained and legitimated, it is necessary to understand the meanings that the social actors attach to their behaviours and to take account of the common-sense knowledge/s upon which they draw. Berger and Luckmann's work points, therefore, to the fact that in order to gain an adequate understanding of the observed level of E.E. within collective care settings it is necessary to understand the meanings which the social actors attach to their interactions and to locate the observed patterns within the particular historical context of the organisation with its specific common-sense stocks of knowledge.

Thirdly, the above literature review has shown that there are two central explanations offered in order to explain why high E.E. interactions are detrimental to vulnerable individuals. These are: that the interaction patterns in high E.E. families are a form of chronic stress for the patient and that it is chronic stress that leads to mental health deterioration (Leff and Vaughn); and/or that, high E.E. family environments are cognitively complex and lead to a form of cognitive overload due to the patient's inability to filter out redundant or non-important information (MacCarthy et al. 1986). In relation to applying the insights of E.E. theory to collective care settings these

possible linking mechanisms, between high E.E. and statistically higher relapse/deterioration rates, are important. The previous E.E. literature has not taken adequate account of the role of perception in an individual's experience of stress. At this point in the development of the concept it is necessary to redress this situation by locating high E.E. interactions within specific concrete situations and looking at the meanings that such exchanges have for the individuals involved. Within this study high E.E. interactions will be explicitly located within the wider context of the organisation and the associated common-sense-knowledges of the groups of social actors. In this way it is hoped to gain a more adequate understanding of the meanings of interactions and the reasons why they are experienced as stressful or otherwise.

Further, it appears theoretically possible that managerial practices and/or the care philosophy within an organisation offering residential care may lead to situations and interaction patterns which, whilst not being part of what we at present term high E.E., may nevertheless have similar consequences in that they may act as chronic stressors and/or are difficult for residents due to their cognitive complexity. This study will attempt to remain sensitive to the identification of such situations. Two brief examples, one from a previous empirical study and one hypothetical, may help to illustrate the the type of situation that the author has in mind here.

Rapoport (1960) in his study of a therapeutic community documents a care setting that appears to be potentially stress inducing and/or cognitively complex for both residents and staff. He describes how, in a specific organisation, certain organisational characteristics combined with a particular care philosophy to lead to a situation wherein any member of the group could be challenged, at any point in time, and asked to account to the group for his or her actions. In the care setting that he describes in addition to actual Critical Comments and displays of Hostility, the residents also had to cope with the fact that a personal attack might come at any time. The fear of being verbally or even physically attacked, or simply being constantly under threat to account for one's actions and behaviours, would appear to be a likely source of chronic stress, involving similar mechanisms to the interactional patterns discussed in the E.E. literature.

Somewhat similarly, an organisational policy or care setting expectation may be that residents must spend long periods in close physical and/or social proximity and engage in communal tasks. There may be little flexibility in

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these expectations irrespective of the particular needs of the individuals involved; for example, attendance at a sheltered workshop may be a condition of residence, meals may have to be taken collectively within a small dining area, or sleeping arrangements may involve people sharing bedrooms. Potentially, organisational structures and imperatives may deny people personal space and force them into social contact that they would rather avoid. Compulsory attendance at a day centre or at a communal meal may be extremely difficult if another member of the group is experiencing the positive symptoms associated with schizophrenia; for example, visual or auditory hallucinations and feelings of paranoia. Again both the experience of being in such situations and the apprehension that a person may feel before entering such a setting may act as a source of severe stress. As Leff and Vaughn note one of the attributes of high E.E. families is that they do not allow the patient to manage their level of social contact and relatives engage in intrusive and persistent attempts to make contact.

The research questions that this project attempts to address and which arise from the preceding literature review, can thus be summarised and stated formally as follows.

1) Do face-to-face high E.E. interactions exist within the collective care settings studied?

2) Which social actors are face-to-face high E.E. exchanges most commonly between and what is the role of staff in either dissipating or encouraging these interactions?

3) What contribution does the organisational and philosophical aspects of the care organisation make to the incidence and content of any high or low E.E. interactions?

4) Are high E.E. interactions between staff and residents and/or co-residents always and uniformly experienced as stressful? What is the role of organisational factors, such as, managerial practices, the organisation's care philosophy and/or the front-line social actors' common-sense-knowledge/s, in influencing whether a high E.E. interaction is experienced as stress inducing?

5) Do any aspects of the organisational structures and common patterns of interaction lead to social situations and interactions, which whilst not being part of what we at present view as high E.E. (Critical Comments, displays of Hostility or Emotional Overinvolvement), are nonetheless forms of chronic

stress for individuals or cognitively complex and thus invoke mechanisms closely related to those discussed in the existing E.E. literature?

Finally, before moving to the methodology chapter to follow, it must be emphasised that this study is a process study and not one that is aiming to look at the relationship between E.E. and patient outcome. This study aims to fill certain gaps and address some of the problems that have been identified in the preceding review. The emphasis here is upon gaining an understanding of the types and patterns of face-to-face high E.E. interactions within collective care settings and the factors that contribute to their existence and persistence. It is believed that at this point in the development of the E.E. concept these questions can most usefully be addressed through an ethnographic study of two organisations which provide supported accommodation for sufferers of mental illness. This study is necessarily small scale and exploratory and is attempting to break new ground by providing further insights to guide the development of the E.E. concept in relation to collective care settings.

The methodology for this study and the rationale of research site and research tool selection will be offered in the following chapter. Here however it is necessary to note that the researcher chose not to measure E.E. through the use of the C.F.I. This work thus makes a departure from many previous works in the field of E.E. The justification for this methodological departure rests in the exploratory nature of the study and the wish to address the differences that have been identified between families and collective care environments.

The methods and methodology that are employed within this study endeavour to remain sensitive to the totality of the interactions that make up the collective care setting's atmosphere; that is, to the interactions and emotional displays of all the carers and all the residents. The methods employed thus attempt to avoid the identified theoretical problems that are encountered when trying to gauge the level of E.E. in a collective care setting from key worker/resident relationships. As shown above the C.F.I. essentially relies upon the measurement of emotion expressed by a person in an interview situation to characterise the emotional atmosphere of a family care setting. The complex nature of collective care settings involving many carers and residents means that this tool has serious theoretical limitations in gauging the level of E.E. to which the individual resident is subjected. Within this study therefore the researcher chose to try and assess the level of

E.E. in the care settings studied through direct observation of interactions and the administration of a standardised care environment measure (Sheltered Care Environment Scale, Moos 1988).

It is believed that, at this point in the development of the E.E. concept, enough is known about the types of interactions that are common to high E.E. families for this exploratory study to rely upon accurate observations to determine the levels of high and low E.E. interactions. Thus, as argued above, Leff and Vaughn (1985 pp. 37-120) offer quite detailed data on the reported interactions in high and low E.E. families and detailed descriptions of typical Critical Comments, displays of Hostility and examples of Emotional Overinvolvement. Further, the work of Milowitz et al. (1984) and Hahlweg et al. (1989), supplement Leff and Vaughn's content analysis of the C.F.I.s with data on direct observations of high E.E. and low E.E. families engaged in problem solving exercises. In the light of these previous works this study will attempt through careful observation and the administration of a standardised environmental measure (Moos 1988) to rank the four research sites on observed levels of E.E.; and beyond this, will provide insight into the factors which combined and contributed to the observed differences between the care environments. (A discussion of the way in which Critical Comments, displays of Hostility and Emotional Overinvolvement were defined can be found in Chapter Four.)

CHAPTER TWO

Method and Methodology: the design of the study

INTRODUCTION

This chapter will provide an explicit description of the methodology and methods employed in this work. It will begin with a brief statement on the epistemological position of the study and present certain theoretical insights from Berger and Luckmann which were central to the design of the project. The rationale for research site selection will then be given and some basic data on the houses presented. The chapter will then turn to discussing the specific research tools that were used, the rationale for their selection, and the ways in which they were employed. Finally, the processes of negotiating access to the research organisations will be discussed.

THE THEORETICAL POSITION OF THE STUDY

Some of the most central and influential debates within sociology surround methodological prescriptions for the social sciences. The issues revolve around the existence and significance of differing epistemological positions, or in Kuhn's (1970) terms theoretical paradigms. The discussions thus centre around the fundamental nature of social reality and about what is acceptable knowledge about that reality (Giddens 1976, Cicourel 1964). In essence positivism is underpinned by the belief that the social world is an external reality that can be studied empirically in a manner similar to the natural world, whilst interpretivism (Wilson 1970) argues that the social world is of a fundamentally different nature to the subject matter of natural science. Interpretivist thinkers (for example Schutz 1964, 1967), point to the fact that human subjects attribute meaning to their social environments and actively construct them through social interactions; interpretivists suggest that the social world is thus not an inert system of regularities that is 'out there' waiting to be discovered but is rather essentially an on-going process of meaningful interactions.

As Bryman (1989) has shown the epistemological debate between positivism and interpretivism often also continues into the selection of research tools to be employed within empirical investigations. Thus as Morgan and Smircich write;

> the choice and adequacy of a method embodies a variety of assumptions regarding the nature of knowledge and the methods through which that knowledge can be obtained, as well as a set of root assumptions about the nature of the phenomena to be investigated (Morgan & Smircich 1980 p. 491, see Bryman 1989 p. 248).

The position that research methods reflect their epistemological base is however far from clear cut. It is an oversimplification to say that some methods are purely positivistic and others are solely interpretativist. Thus, for example, whilst previous work within the field of E.E. (Brown et al. 1972, Leff and Vaughn 1985) has used methods and criteria for validity and reliability that are strongly positivist, their underlying view of the relationships that are under study appear, in many ways, to be interpretativist. Previous researchers in the field of E.E. have thus tried to go beyond purely statistical correlations to gain an understanding of the way in which patients and relatives interact in family settings; they have undertaken content analysis of the Camberwell Family Interviews (C.F.I.) to gain insight into carer and patient behaviours, attributions, levels and types of social contact etc., and the effects of these social interactions upon the person experiencing schizophrenia. The work of Rudolf Moos (described in the previous chapter) concerning organisational environments provides another example of what might at first sight appear as a positivistic technique being used to attempt to gain an understanding of the social construction of organisational environments (i.e. an interpretativist based problem). Moos advocates the use of a structured self administered questionnaire to gather information about people's attitudes and opinions which he in turn sees as affecting the way that they interact within a care setting. It is argued therefore that although a clear view of epistemological debates is crucial to any piece of social science research it is over simplistic to assume that one's epistemological position determines the choice of research technique. Bryman summarises this position well when he writes;

... methods do not bring a trail of epistemological presuppositions in their wake. Each method should be appreciated for what it is: a means of gathering problem-relevant data. The methods associated with qualitative research have many advantages over quantitative research ... greater flexibility, better access to hidden aspects of organisations, a greater flexibility with process and change, good at generating new concepts and ideas and so on- but these are technical advantages which the researcher may wish to take into account in deciding the best fit between method and research problem. ... In the end, a method will be good or bad only in relation to the problem (Bryman 1989 pp. 253-4).

The study reported herein is situated within the broad epistemological paradigm of interpretativist sociology. In situating the present study within the interpretativist tradition the intention is not to deny or reject the importance of other more positivistic works, rather it is felt that the questions that are to be addressed in this research are in essence about on-going interaction patterns and various social actors' attributions and reactions to other social actors' (patients') behaviours. The research instruments to be described within this chapter have been chosen on the basis of their degree of fit to the research questions and not from the more dogmatic position that only qualitative methods can provide useful information about the social world. The research instruments to be described involve a triangulated methodology, although the emphasis is upon qualitative techniques. The position of the present study, in rejecting the idea that certain methods are mutually exclusive, also reflects the position of many modern methodologists (see for example, Silverman 1985, Denzin 1970, 1978, Bryman 1989, Hammersley 1992).

THE SOCIAL CONSTRUCTION OF REALITY

The theoretical work of Berger and Luckmann (1979) has contributed significantly to the design, implementation and analysis process of this research project. It is therefore deemed appropriate to draw attention to certain aspects of their work. The aim here is not to review the authors' entire writings but rather to draw attention to certain of their central conceptions and the implications of these for this study.

Berger and Luckmann argue that although social reality appears, in the 'natural attitude', as objective and external to the individual, it is in actual fact created by individual members of society in their daily interactions. Within the process of objectivation the subjective products of human expressivity become available to both their producers and other people as elements of a common world (ibid. p.49). Through the use of symbolic communication, and particularly language, the subjectively created constructions of social actors take on the appearance of having an existence outside of any one individual's consciousness. Thus, the social world appears dialectically as both objective and subjective.

> As a sign system I encounter language as a facticity external to myself and it is coercive in its effect on me. Language forces me into its patterns ... Put differently, language is pliantly expansive so as to allow me to objectify a great variety of experiences coming my way in the course of my life. Language also typifies experiences, allowing me to subsume them under broad categories in terms of which they have meaning not only to myself but to my fellowmen (ibid. p. 53).

Although, for Berger and Luckmann, social reality is constructed by individuals through their symbolic interactions, they also acknowledge that society exists temporally prior to any single person. People are thus born into a pre-existing society with its own shared stock of knowledge. The processes of primary socialisation are the ways in which social actors learn and internalise the society's common-sense view of the world.

Further, Berger and Luckmann argue that individual institutions within society originate through social actors' reciprocal typifications of habitual actions. They suggest that what is distinctive about interactions in institutional or organisational settings is that not only are the interactions often typified but so are the individual social actors. Here the position of Berger and Luckmann bears similarities to that expressed by Goffman (1961) in his analysis of asylums; this is particularly evident in Berger and Luckmann's emphasis upon the way in which institutions often control the individual social actor by channelling their behaviour in one direction as opposed to others that are theoretically possible.

> The typifications of habitualized actions that constitute institutions are always shared ones. They are *available* to all

members of the particular social group in question, and the institution itself typifies individual actors as well as individual actions. The institution posits that actions of type X will be performed by actors of type X (Berger & Luckmann 1979 p. 72).

Beyond this, Berger and Luckmann argue that organisations have their own shared common stocks of knowledge. They point to secondary socialisation as the processes whereby new members of the group are inducted into the collective ways of viewing and constructing the institution based 'sub-world'; this process involves new members learning the collective signs, symbols, norms, values and ways of behaving in that particular institutional setting.

Berger and Luckmann's position concerning the way in which what appears as objective social reality is in fact socially constructed on a daily basis, also points to the fact that social reality is a negotiated order. Social reality is seen as being in many ways quite precarious and in need of constant maintenance and legitimation. For Berger and Luckmann the primary means of maintaining and legitimating social reality are found in the processes of socialisation, both primary and secondary, and in the use of language. Other lesser used methods of reality maintenance are, 'therapy' entailing anything from exorcism to psycho-analysis, and 'nihilation' which involves the majority of group members assigning an inferior ontological status to the opposing definition of a social situation (Hudson 1986).

As Hudson (1986) shows, the work of Emerson (1973) provides a good example of the way in which social actors within gynaecological examinations utilise their shared stock of knowledge to maintain and legitimate the social scene of a medical examination. Thus Emerson points, for example, to the importance of, a shared language, the physical props of the setting, and the non-verbal communication between participants, to both maintain and produce the medical examination and also push out and reject other competing interpretations, (for example, that what is taking place is a sexual act).

As Berger and Luckmann themselves note their analysis of institutions, and the social construction of reality therein, has certain important methodological implications for organisational studies.

> If the integration of an institutional order can be
> understood only in terms of the 'knowledge' that its members

have of it, it follows that the analysis of such 'knowledge' will be essential for an analysis of the institutional order in question. ... The primary knowledge about the institutional order is knowledge on the pre-theoretical level. It is the sum total of 'what everyone knows' about the social world, an assemblage of maxims, morals, proverbial nuggets of wisdom, values and beliefs, myths, and so forth, ... (Berger & Luckmann 1979 p. 83).

In relation to the present study the work of Berger and Luckmann is felt to be insightful in several areas. Firstly, it points to the fact that in order to gain a satisfactory understanding of the interactions that are observed in a collective care setting it is necessary to understand the meanings and attributions that the social actors attach to their behaviours. Secondly, in order to understand the meanings that an individual social actor attaches to a behaviour it is necessary to locate that behaviour within the context of the shared stock of institutional knowledge. Thus, in order to fully understand high E.E. interactions within collective care settings it appears necessary to have some insight into the shared stock of institutional common-sense knowledge that the social actors are using in the creation of the observed empirical reality.

Further, it is necessary to recognise that the social actors within the setting will be both creating the common-sense knowledge and dialectically influenced by it. Certain actors will be called upon to perform certain acts because of their institutional roles. In Berger and Luckmann's terminology in order to gain an understanding of the way in which social actors act and perform habitual actions and typify one another in certain institutional ways it is necessary to understand their shared stock of common-sense-knowledge.

Beyond this, by gaining an understanding of the meanings of certain actions within concrete organisational settings it will be possible to gain further understanding as to why certain actions and reactions are stress inducing within certain contexts. To date, as shown in the preceding chapter, there is some evidence to suggest that people who suffer from schizophrenia are particularly vulnerable to stress. Leff and Vaughn (1985) suggest that high E.E. interactions are a form of chronic stress within family settings. It is believed that by gaining an understanding of the shared stocks of knowledge and the meanings that prevail within the research organisations it may prove possible to identify other further interaction patterns that residents find very difficult and that may prove as stress inducing, and hence

as detrimental, as high E.E. interactions. In this way it might prove possible to establish further patterns of behaviour that whilst not being part of what we at present term E.E. may nonetheless warrant further investigation due to their potentially detrimental effects.

The methodological importance that is attached within this study to gaining an understanding of participants' shared common-sense knowledge raises questions concerning the influence of the researcher's own common-sense knowledge and assumptions on the collection and analysis of data. Burton (1978) has referred to this as the problem of the 'personal equation'. As he writes;

> It is argued that the emotional and intellectual make-up of the sociologist will determine the type of moral judgement that is attached to events. Fear, anger and disgust as well as romanticism, compassion and concern are thought to create a moral veil which filters the emphases the report makes (Burton 1978 p. 167).

Becker (1971) in his discussion of a 'natural history' of methods has argued that researchers should explicitly address this problem by providing their audiences with an account of their own biases, the starting point of the study, the assumptions that they hold, the impact of their presence upon participants, etc. However, as Burton shows, it is in reality impossible to identify all of a researcher's common-sense assumptions and biographical characteristics which may impact upon the research processes. In spite of these practical and theoretical difficulties some writers have still taken Becker's plea to their hearts and,

> ... let the reader know they cried twice, made love fifteen times and changed their socks once a week while in the field (Burton 1978 p. 167, referring to Johnson 1976).

It is a reality that social scientists are people with their own, common-sense knowledge, physical attributes, gender, age, personality, professional and personal interests, etc. and these will to some extent influence the processes that are involved in the collection and analysis of data. This is equally as true for social scientists employing quantitative techniques, such as surveys and structured interviews, as it is for those using qualitative techniques such as participant observation and semi-structured interviews.

Thus the questions that are built into interview schedules and the interactions that take place during their completion, will be influenced by the researcher's own priorities, biographical characteristics and common-sense knowledge, as will the relationships formed and observations made during participant observation.

The call from Berger and Luckmann for empirical studies to take account of social actor's meaningful interpretations of their situations, has found echoes within many empirical works. Thus for example, in the area of organisational study and the relationship between policy making and the implementation processes, Barrett and Fudge (1981), Lipsky (1980), and Sabatier (1986), have all drawn attention to the importance of understanding the way in which ground level workers interpret and operationalize the mandates and directives received from above. Lipsky has gone as far as to argue that 'street level bureaucrats' actually make policy in many governmental organisations through the exercise of discretion in their dealings with the general public.

Sabatier (ibid.) has called for research to take account of both 'top-down' and 'bottom-up' approaches to understanding policy making and implementation. He argues, in a similar fashion to Lipsky, that an adequate analysis of policy implementation requires an understanding of front-line workers' actions and the meanings that they attach to them. For Sabatier, however, this type of analysis is only partial and must be supplemented by a more top-down approach. He argues that the directives from the bureaucratically higher parts of the organisation place important limits upon what front-line workers can and cannot do. Importantly, Sabatier shows that workers are influenced by top-down factors even when they do not themselves appear to be overtly conscious of them.

Sabatier's work, although more empirically based than Berger and Luckmann's, can be seen to have important methodological implications for the study of organisations. Berger and Luckmann's analysis of institutional life and their methodological prescriptions are made at the macro level of institutional analysis. That is to say, Berger and Luckmann offer methodological prescriptions for the study of whole institutions. Within this study the aim is to study the interactions that are taking placing within one part of an organisation; that is, the front-line workers' and clients' interactions and social creation of collective care settings. The strength of Sabatier's contribution to the methodology of studying organisations lies in

the fact that he points to the need for the researcher to be aware of the limitations that the wider organisational context and the directives from the bureaucratically higher parts of the organisation place on the front-line workers. In describing and analysing the organisations within this study, the researcher attempted to remain aware of, and take account of, the more objective organisational characteristics that placed limits upon the actions of the social actors in the various collective care environments.

THE DESIGN OF THE STUDY

The design of this study involved undertaking a comparative analysis of two organisations that offered supported accommodation for people with mental health problems and who were leaving hospital care; two research houses were selected within each organisation. The rationale behind the two organisations, four houses design was essentially three fold. Firstly, as has been shown, the research topic was one that was largely uncharted and therefore an exploratory study was needed in order to look at the level of and contributory factors to high E.E. interactions within specific collective care settings. Studying two organisations and four houses provided the opportunity to observe the levels of high and low E.E. interactions within specific care settings. Further, it also provided the opportunity to undertake a comparative analysis aimed at discovering whether the same organisational features had similar effects in differing settings, thus aiding the possibility of making theoretical generalisations.

Secondly, by selecting two organisations that differed considerably in their stated aims and organisational structures, but which served a similar client group, it was possible to isolate the effects of the organisational differences and relate these to the observed levels of E.E. That is to say, the selection of two differing organisations offered the opportunity to gain understanding of the relationships between the differing organisational structures and philosophies and concrete micro care interactions. Particular attention could be paid to the way in which differing organisational philosophies were translated and operationalised by the workers and residents in order to create concrete care interactions. In Berger and Luckmann's terms the intention was to gain an understanding of the organisations' shared stocks of common-knowledge, the workers' and residents' taken-for-granted views of the world, and to explore the

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implications of this objectivated reality for the creation of high E.E. and low E.E. interactions. Further, insights could be gained into the way in which the observed reality was maintained and legitimated by the social actors in order to produce regular, possibly habituated, patterns of interaction.

Thirdly, by taking two units from each organisation it was possible to go some way towards safe guarding against studying a house and drawing conclusions that were not representative of the organisation as a whole. At the theoretical level the observed empirical reality of all social settings appears to result from the interplay of the individual social actors' biographies and what might be termed more structural forces. By taking two houses from within each organisation a type of internal control was achieved; that is to say, it was possible to identify behaviours and interactions that were primarily the products of the organisational structure and regime, from those that resulted essentially from individual personalities or an individual's mental health at a particular time. The design of the study therefore allowed for the researcher to attempt to isolate the influences of the organisational structures from those of personality.

The choice of research organisations

During the first year of this project the researcher visited several organisations that offered supported accommodation for people who suffer from mental health difficulties and who were leaving hospital care. The final decision concerning which organisations to formally approach was made on the basis of the kind of care that was offered and their willingness to participate in the research project. At this point it appears beneficial to offer a very brief preliminary description of the two organisations that were finally chosen with the aim of further revealing the logic behind their selection.

Alpha organisation was within the voluntary, 'not for profit' sector. It offered supported accommodation for people with long standing mental health difficulties who were not able to maintain a tenancy without support. The following quotation from the organisation offers a good summary of Alpha organisation's aims.

> (Alpha's) supported accommodation aims to provide people with a 'home for life' where a tenancy cannot be sustained independently. The accommodation relies on

ordinary housing. (Alpha's) supported accommodation is person centred, based on the individual needs of the tenant, who has the same human rights as anyone else to live within the community with dignity and privacy. We do not attempt to change people and are concerned with the person not the illness. We provide space within which people are free of pressure to be other than themselves.

Staff employed within Alpha organisation came from a variety of backgrounds and were not required to have any formal mental health qualifications. It was argued that the selection of staff was made upon the basis of personal characteristics. At the point of access it was unclear exactly what constituted desirable personal characteristics. However, a strong belief in treating sufferers of mental illness as 'whole people', a respect for the individual, and a mistrust of the medical model and methods of treatment appeared central.

By contrast, Beta 'organisation' consisted of a relatively self contained chain of four psychiatric rehabilitation houses attached to a Health Board psychiatric hospital. Health Boards are administrative levels of the National Health Service used within Scotland. The houses were all situated outside of the hospital grounds and within a half mile radius of one another. Beta organisation was staffed by registered psychiatric nurses and nursing assistants, with a designated consultant psychiatrist responsible for medical care. The formally stated aim of Beta organisation was to offer residents planned treatment programmes aimed at improving personal and social abilities to a point where they could be resettled outwith the hospital. Personal problems tended to be viewed in terms of the person's mental ill-health or in terms of institutionalisation, with interventions being through broad behaviour modification techniques and/or medication.

As is apparent from the above description the Alpha and Beta organisations offered two radically different types of accommodation for people with long standing mental health difficulties. Thus in the Beta houses the emphasis was upon a medical model advocating treatment and rehabilitation whilst by contrast the Alpha houses were seen as long term homes with a stress on 'people first' over and above medical diagnoses. Alpha organisation, at least at the level of rhetoric, did not believe in the concept of formal treatment programmes or concerted attempts to change people: rather they were concerned with accepting people as they were at that point in time. Staff training and backgrounds also differed significantly

between the two organisations, as did the stated hierarchical relationships between workers and clients and the levels of bureaucratisation.

At the point of site selection it was tentatively speculated that Beta organisation's stated emphasis upon helping people to achieve a standard of functioning that would allow them to move into the community, together with the stated emphasis upon behaviour modification techniques and possible pressure upon staff from the hospital management to 'get people out', would be likely to lead to a greater number of high E.E. interactions than were found in the Alpha care settings. It was felt that Alpha organisation's emphasis upon the houses being the resident's homes and the fact that there were no overt treatment plans or goals to be achieved would lead to a lower level of high E.E. interactions.

The choice of research houses

In the selection of research houses efforts were made to ensure a level of similarity, in terms of size, client group and sex distribution in order to ensure the validity of comparative analysis. However, the practicalities of the limited amount of supported accommodation available and issues surrounding securing access meant that it was not possible to arrive at a theoretically perfect situation; for example, that held the variables of clinical diagnoses, numbers of residents, age and sex distribution constant whilst manipulating the variables of organisational structure and ideology. An effort was however made to gain as close an approximation as possible.

Tables 2.1 and 2.2 below present data concerning the number of residents and their age distribution within each of the four research houses. The figures in the tables that are separated by an oblique sign indicate that the numbers within the house changed during the ten week periods of research. As the tables show the number of residents within the houses varied between five in Beta Two and nine in Beta One, both Alpha houses had seven residents. The age range within the houses also varied slightly but the vast majority of residents were in the 45 - 65 years grouping. Alpha houses One and Two and Beta One all had broadly equal numbers of male and female residents whilst Beta Two contained solely male residents. The fact that Beta Two had entirely male residents during the research period did not result from a conscious policy decision by the organisation but occurred through chance; at the point of applying for access Beta Two did contain some female

residents but by the study period these women had moved to other accommodation.

Table 2.1 Number of residents in each house.

Organisation/ house	Number of residents	Males	Females
Alpha house 1	7	3/4	4/3
Alpha house 2	7/6	4/3	3
Beta house 1	8/9	4	4/5
Beta house 2	5	5	0

Table 2.2 Age distribution of residents within the research houses.

Organisation/ house	20 - 45 years	45 - 65 years	over 65
Alpha house 1	0	7	0
Alpha house 2	2	5/4	0
Beta house 1	2/3	5	1
Beta house 2	0	5	0

Medical diagnoses

Within Alpha organisation medical diagnoses were not used; in order to attempt to off set the effects of 'labelling' and to promote staff's perceptions of residents as 'whole people'. The researcher did not therefore have access to individual residents' medical diagnosis or history other than that volunteered by residents. During the negotiation of access to Alpha organisation it was made clear that the organisation itself would not be prepared to furnish the researcher with any information concerning their residents' diagnostic histories. In reality, however, the client group that were accepted into the organisation's houses were people that had been in contact with the psychiatric services for a significant period of their lives. Within the Alpha house One, six of the residents had spent over ten years in psychiatric hospitals, in Alpha house Two, three residents had spent over ten years in hospital and six of the residents had experienced two or more hospital admissions. The fact that the residents in Alpha organisation's houses had had such significant contact with the mental health services and had acquired accommodation within Alpha organisation is suggestive that many

of them had or were experiencing episodes of psychosis. This supposition was confirmed during the periods of participant observation when several residents were witnessed responding to auditory and/or visual hallucinations.

Although psychiatric diagnoses were available within Beta organisation the researcher did not obtain this data. There were two central reasons for this decision. Firstly, it was felt that access to such information may have altered the researcher's observations of people and events within the sites; labelling may have come into effect. Secondly, as the information was not available within Alpha organisation it appeared that methodologically it was of little use to obtain it for Beta organisation's population. Within the first Beta organisation house four of the residents had been in hospital for over ten years and of the remaining five residents two had experienced more than two hospital admissions. In the second Beta house, two of the residents had been in hospital for over ten years and one for over five years.

In reality it is also methodologically problematic to accept that psychiatric diagnoses made by differing psychiatrists are comparable. Psychiatrists do not always agree over the diagnosis that a patient should receive. In an attempt to off set this methodological problem many of the previous large scale studies in the field of E.E. have carried out their own independent diagnoses using The Present State Examination or the U.S.A. equivalent based on the Diagnostic and Statistical Manual III, (see for example, Vaughn and Leff 1976a, Leff and Vaughn 1985). Due to financial constraints and the views of Alpha organisation concerning mental health labels this was not an option open to this study. Clearly, diagnoses were crucial within previous works which had the aim of establishing the relationship between high E.E. and statistically higher clinical relapse rates for people who suffer from schizophrenia. The lack of information concerning the diagnoses of residents and the impossibility of carrying out independent assessments was also problematic within this study. What appears as an empirical social reality always results from the interplay of the biographies of participant individuals and what might be termed more structural forces, (for example, the geographical location, the institutional dictates and goals, the material resource level, the history of similar events and activities, etc.). The observed social reality of the care settings reported herein similarly resulted from the combination of the personalities and biographies of the individuals

involved and more structural factors such as the organisations' mandates and goals, participants' organisational roles, the physical locations and material resource levels, etc. To the extent that a patient's diagnosis is part of their biography and affects the way that they act, it also affects the observed social reality and the running of the care environment.

As noted above, the design of this study did attempt to address the issue of isolating organisational factors from those stemming from personality and/or an individual's mental health at a specific time. By taking two units from within each organisation comparisons could be made across sites within the same organisation as well as across organisations. In this way examples of high E.E. interactions that resulted from an individual's diagnosis or personality could be analytically separated from high E.E. interactions that resulted from more structural organisational factors.

This study has as its focus the relationship between organisational structures and displays of high and low E.E. interactions. The study aims firstly to discover whether high E.E. interactions exist within the research houses and then, beyond this, to ascertain what aspects of the organisational structure and shared organisational common-sense knowledge contribute to their maintenance and legitimation. This study is therefore in essence a process study and not one primarily concerned with outcome. It is thus not crucial that all the residents within the houses were diagnosed as schizophrenic. It is sufficient that the organisations and houses catered for this client group and that some residents did experience psychotic illness. While not all of the residents who participated within this study would have fulfilled Leff and Vaughn's very strict diagnostic criteria, some would and importantly in collective care settings all residents live within the same shared care environment.

Further, as was shown in the preceding chapter, there is evidence from the work of Moos to suggest that care environments are relatively stable in terms of their characteristics. If Moos is correct, then an understanding of the relationship between organisational characteristics and levels of E.E. has implications not only for the residents at present within the care settings, but also for those who may potentially move to those environments in the future. Thus an understanding of the effects of organisational characteristics upon levels of E.E. appears crucial for both the placement of future clients and also the design of future community care resources.

Staff/ resident ratios

Within Alpha organisation, in both research houses, there were two full time (thirty-seven hours per week) workers plus a team leader to seven residents. The team leader's time was split between working in two houses as well as carrying out various staff supervisory duties and administrative tasks. No staff were based within the Alpha houses at night: however, a paging system allowed residents access to duty staff during these periods.

The official staffing level for the four house rehabilitation complex that comprised Beta organisation was a total of 10.33 nurses, this being to cover both day and night shifts. The four houses within Beta organisation catered for thirty-three residents. During the period of the research project Beta organisation was operating with a total staffing complement of eight nurses; thus the staff team were working 2.33 nurses short during the ten week research periods. Hospital policy dictated that the minimum cover for the organisation was two staff per shift during the day and one at night. This minimum cover was rarely exceeded. In addition to the nursing staff Beta house Two was also served by a catering assistant between 7.30 am and 1.30 pm. (The role of the catering assistant within Beta Two is something that is discussed at some length in Chapters Three, Four and Six.)

THE RESEARCH TOOLS

The project reported herein employed a combination of research tools in a triangulated methodology. This involved the use of participant observation, semi-structured interviewing, the administration of a standardised environmental measure, (the Sheltered Care Environment Scale, Moos & Lemke 1988) and the reviewing of organisational literature and other documentary evidence.

Participant observation

The primary method of data collection used was participant observation. As Jorgensen (1989) has shown this method offers several distinctive features. The first three of these features he describes as being;

1) a special interest in human meaning and interaction as viewed from the perspective of people who are insiders or members of particular situations;
2) location in the here and now of everyday life situations and settings as the foundation of inquiry and method;
3) a form of theory and theorizing stressing interpretation and understanding of human existence (Jorgensen 1989 p.13).

Essentially, it was these three attributes of participant observation that offered significant advantages in addressing this project's research questions. Thus it was felt beneficial to undertake direct observation of interactions in naturalistic settings in order to establish whether interactions that resembled those described in the previous work on E.E. existed in the research settings. Further, as was argued above, in order to go beyond the mere recording and description of high E.E. interactions and the repetition of statistical correlations, it was felt to be necessary to attempt to gain an understanding of the meanings behind the behaviours of the social actors. That is, it appeared to be necessary to try and gain an understanding of the way in which the various social actors actively created the observed reality of the care settings. As noted, Berger and Luckmann suggest that the understanding of meaning and attributions within institutional settings requires an understanding of the social actors' joint common-sense knowledge and language and the way in which these are manipulated and used in order to maintain and legitimate reality. They suggest that it is only possible fully to understand the observed habitual actions and typifications of actors and actions when the institutional shared stock of knowledge is understood. The method of participant observation offered the researcher the unique chance to participate in natural social settings and to undergo the processes of secondary organisational socialisation and thus facilitated his attempt to gain an insider's understanding of the workings of the care environments.

The practicalities of employing participant observation
The researcher conducted a ten week block of observation within each of the four research houses over a total field-work period of sixteen months. The organisations were visited alternatively so as to aid comparison and offer the researcher the maximum sensitivity to organisational differences; the sequence of ten week observation periods was thus, Alpha house One, Beta house One, Alpha house Two, Beta house Two. The period of ten weeks was selected because of its close approximation to the period covered in the

questions in the C.F.I.; within the C.F.I. respondents are asked to recall events in the family for the preceding three months prior to hospital admission. On average, the individual periods of participant observation were three and a half hours per session and four sessions were conducted each week (normally between Monday and Friday, but some weekend visits were made). This amounted to approximately one hundred and forty hours of observation being completed within each of the four research houses. The times that the researcher visited the houses varied, ranging from 7am to 9pm. During the negotiation of access to Alpha organisation site One a request was made by residents that the researcher did not visit the house during the night, and this request was respected.

During the first two weeks of each observation period the researcher visited the houses at various times and acquired information on the usual patterns of activity and the times of the day when most interactions occurred. This process meant that during the remaining eight weeks of observation the researcher was able to tailor the times that he visited the houses in order to maximise his contact with the residents and staff. The time periods that were the most active varied between the houses and between organisations (see Chapter Four). Both residents and staff were kept informed of the times that the researcher wished to visit the house; the days and times were made available to staff and residents one week in advance.

A great deal has been written within methods books concerning the role of the participant observer during field work (see, Whyte 1955, McCall and Simmons 1969, Spradley 1980, Jorgensen 1989). Often concern centres on the effects that the researcher's activities have on the subjects and the patterns of normal interaction; questions are thus posed concerning the degree to which the participant observer affects the phenomena that he or she is trying to study. Clearly, this is a difficult issue and no clear prescriptions can be arrived at, however, the experience of previous projects points to the fact that the observer effect diminishes with the time that the researcher is in the field and the strength of the relationships that are established (see for example, Whyte 1955 and Strauss et al. 1964). Accordingly, within this project, during the analysis processes greater weight was given to observations of interactions during the latter stages of the observation periods.

The experience of this project points to the fact that the role of the participant observer is often a difficult one and one that is constantly

changing and under negotiation. As Hudson (1986 p. 69) notes, many of the difficulties that the researcher experiences stem from the inherent tensions within the role of participant observer, thus the researcher attempts to account for action from a detached position whilst at the same time learning what it is to be an actor in that social setting. During this research project the researcher did not take on an official organisational role in a covert fashion (for example, care worker, patient, domestic, etc.) and the participants were aware that the participant observer was a researcher; this position was favoured on both ethical and practical grounds. Thus it was felt that the research participants had the right to be informed of their participation in the project and accordingly refuse to take part if they so wished. In the event all of the social actors within the sites gave full consent to participating in the project. Further, it was felt that if the researcher took on a formal organisational role this was likely to adversely effect the information to which he had access. The danger appeared to be that if the researcher became identified as a 'member of staff' or as being 'on the residents' side' that this would affect the information to which he was privy. During the observational periods the researcher thus attempted to maintain a good productive dialogue with both residents and staff and avoid becoming associated with one or other group. It is believed that this balance was maintained satisfactorily.

Whilst in the houses the researcher attempted, as far as possible, to join in the activities and normal patterns of life in the houses, whilst also being careful not to direct patterns of action or influence significant decisions. Thus for example, the researcher often cooked and ate with residents and/or staff, helped with household cleaning, went with residents or staff for household shopping, on social trips to cafes and pubs or on organised days out, watched television and attended formal house meetings. Through engaging in the normal activities in the houses and by trying to be as approachable as possible it is believed that both staff and residents grew to trust the researcher and thus good quality data was collected.

Strauss (1969) offers a useful guide to what he terms 'field-work tactics', these are aimed at acquiring valid and reliable data. As all of the tactics that Strauss prescribes were used within this study and found to be beneficial a brief summary of some of his central points appears appropriate. Strauss points to the way in which during the initial period of enquiry the researcher can gain a lot of useful information by playing up his or her genuine naiveté

in the setting, encouraging the participants to instruct him in the ways of the organisation or setting. As Strauss points out however there is a limit to the time period that this tactic can be employed and during the latter stages of field-work it thus becomes necessary to employ other tactics.

Later phases of participant observation require the researcher to supplement his substantive observations with informal interviewing. Many of Strauss's field-work tactics can thus be seen as a guide to ways of engaging participants in focused conversations. The first such tactic that Strauss advocates involves the researcher in carefully challenging the participants' views and gently playing devil's advocate. Here the researcher presents the arguments of opponents with the idea of eliciting rhetorical assertions of the respondent's position. Clearly it is necessary during this process to be very careful not to persuade participants to another point of view but merely encourage them to defend their own. Within the present study, which involved the comparison of two organisations with radically different ideologies and views of mental illness, this tactic was particularly useful as the researcher could present the ideas of participants in one organisation to the other and observe and record the defences and justifications of ideological positions. A second tactic expounded by Strauss involves the researcher in posing hypothetical questions such as what would happen if actor X did action B. Again using this technique it is possible to test emerging hypotheses and gain further understanding of the respondents' common-sense knowledge.

Finally, Strauss points to the potential benefits of feeding back understanding and offering interpretations of events to respondents. This is a tactic that was used extensively within this study and particularly during the later stages of the investigation. The selective dissemination of the researcher's emergent understanding about events and people's intentions both offers the participants the opportunity to confirm one's understandings and to provide information which may well lead the researcher into new areas of enquiry and understanding. The feeding back of emergent understandings thus provides the researcher with a check on the accuracy and validity of his or her understanding whilst also encouraging further relevant information from the participants.

<u>The recording of data</u>

During the negotiation of access and at the commencement of the research periods the participants were informed that the researcher would be recording his observations in writing. Thereafter field-notes were recorded subtly with the researcher attempting not to openly write in front of the participants. In reality this meant that notes were written either during brief periods out of the houses or in places where the researcher would not be disturbed, (for example during frequent visits to the toilet). Notes were taken at periods no longer apart than forty-five minutes and often more frequently.

The reasoning behind the decision to record the field-notes semi-covertly was two fold. Firstly, as some of the participants within the study suffered from experiences of paranoia and feeling of persecution, it was felt that the open recording of notes would cause them considerable distress and ultimately threaten their continued participation in the research. Secondly, it was felt that the open recording of notes would generally intimidate participants and adversely affect the behaviours of the participants and the social situations that the researcher had access to. The subtle recording of notes appeared therefore to afford the researcher access to more valid naturalistic and representative observations.

The notes that were recorded in the field were necessarily brief, often consisting of brief memory jogging sentences, diagrams and the use of signs and symbols. Verbatim quotations were however recorded in situations of specific importance or interest. The brief notes that were taken in the field were extended into full field-notes within two hours of leaving the field.

Burgess (1984) has argued that during the gathering of field data it is extremely useful for the researcher to keep three differing kinds of notes; he refers to these as substantive field-notes, methodological notes, and analytic notes. He suggests that, substantive field-notes consist of a continuous record of the situations, events and conversations that the researcher takes part in; methodological notes deal with problems that are encountered, personal reflections and feelings as well as with some of the processes and procedures associated with field-work and; analytic notes focus on the development of preliminary analysis that are worked out in the field, and here preliminary questions and hypotheses to be tested are recorded.

Within this project all of these types of field-notes were recorded and found to be of value. However the neat theoretical distinctions offered by

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Burgess between kinds of notes were found to be more complex and less clear cut than he suggests. For this reason the researcher decided to record all three kinds of notes within one main chronological file, using differing type fonts to distinguish between substantive description and the researcher's impressions, hunches, preliminary thoughts and descriptions of his actions. The recording of substantive, methodological and analytic notes within one file further aided the researcher's on-going analysis, as it proved easier to relate the developing theoretical understanding and preliminary thoughts to the substantive observations that triggered the cognitive understanding processes. That is to say, the creation of one file containing the three types of field-notes meant that during the constant reviewing of data it was easier to relate theoretical insights to direct observations and ensure that theories were grounded in reality.

During the early stages of the field-work note taking was extensive as the researcher attempted to record as much information as possible; in this period of field-work the notes that were taken were primarily substantive and unfocused as the researcher attempted to orientate himself to the settings, build relationships and gather descriptive material on the physical settings, the social actors present and the common patterns of interaction. During this period one three and a half hour session of observation resulted in up to six single spaced typed A4 sides of field-notes. As the field work progressed and the researcher became more focused in his observations the volume of notes decreased somewhat and became more detailed in their content.

The analysis of data

The analysis of data in the method of participant observation and indeed in all broadly based ethnographic studies, is a complex process and one that is integrally entwined with the collection of the data. As indicated above it is over simplistic to see the researcher as firstly going into the field and gathering information and then, at a latter date, engaging in analysis. Jorgensen (1989) has used the expression 'the analytic cycle' to capture the process of analysis within participant observation. As Hammersley (1983) notes the recognition that data collection and analysis are closely linked processes lies at the heart of Glaser and Strauss's (1967) call for grounded theorising.

> In ethnography the analysis of data is not a distinct stage of the research. It begins in the pre-fieldwork stage, in the formulation and clarification of research problems, and continues into the process of writing up. Formally, it starts to take shape in analytic notes and memoranda; informally, it is embodied in the ethnographer's ideas, hunches, and emergent concepts. ... This is the core idea of 'grounded theorizing' ... the collection of data is guided strategically by the developing theory (Hammersley 1983 p.174).

The aim of qualitative analysis is to arrive at a systematic understanding of the social processes that are present in social settings and to tease out significant properties of the social setting and its participants. However, as Turner (1981) has argued, the reality is that social settings have an infinite range of characteristics and thus the challenge for the researcher is to specify the aspects of the social setting that are pertinent to the research questions. In this project the researcher aimed to gain an understanding of the aspects of the research organisations and their associated cultures and the common-sense knowledges that contributed to the creation of any observed high E.E. interactions.

> Some of the decisions about which facts to pursue are solved for the researcher by subconscious perceptual processes which influence what is observed, and other influences are exerted upon the direction of the analysis by the limited information-handling capacity of the human brain. The understanding which emerges from such research must thus be considered the product of the interaction between the researcher and the phenomena under study. This is true of all forms of research, including natural science investigations and quantitative social science (Turner 1981 p. 228).

To recognise explicitly the role of cognition within the processes of research is not however to argue that the systematic recording of observations and thorough reviewing and sifting of data is not required. Indeed it was the experience of this project that the methical sifting and reviewing of field-notes to uncover sequences of action, recurrent patterns of attributions, uses of language, etc. led the researcher towards understanding the processes that were taking place in the sites. As Jorgensen (1989) notes;

> Analysis is a breaking up, separating, or disassembling of research materials into pieces, parts, elements, or units. With the facts broken down into manageable pieces, the researcher sorts and sifts them searching for types, classes, sequences, processes, patterns or wholes. The aim of this process is to assemble or reconstruct the data in meaningful or comprehensible fashion. In making sense of the data, you are engaging in theorizing- the construction of meaningful patterns and organisation of facts (Jorgensen 1989 p.107).

Within this project the researcher was engaged in analysis simultaneously at two distinct but inter-related levels. As the research questions imply (see Chapter One), the researcher was firstly concerned to relate his observations of interactions to the previous work in the field of E.E. in order to establish whether the interaction patterns within the sites bore a similarity to those described as being typical of high or low E.E. families. Beyond this, however, the researcher aimed to gain an ethnographic understanding of the workings of the research organisations and the particular houses so as to look for the factors that created and/or maintained and legitimated the observed interaction patterns. The work of Becker (1958) as presented in his influential paper, 'The problem of inference and proof in participant observation', was found to be particularly useful and relevant as a guide to the on-going and systematic analysis of the data concerning the workings of the organisations.

As Becker notes the analysis processes in participant observation can be seen to contain three core elements. Firstly, the researcher reviews substantive field-notes looking for concepts and indicators, such as repeated interaction patterns or the systematic use of language, that give promise of yielding the greatest understanding of the organisation understudy. At this point the typical conclusion drawn is that a given phenomenon appears to exist, that certain events occurred, that language was used in a certain way and context, or that two phenomena or events appear to be related. The second stage involves the researcher in checking the frequency and distribution of phenomena or related events. The aim of this process is to ensure that the provisional concepts and phenomena that have been identified and which are becoming the major foci of the study are typical and wide spread. Finally, the researcher attempts to incorporate the individual elements and parts of the analysis into a generalized model of the

organisation or some part of the organisation (Becker in Bynner & Stribley 1978, pp. 314-321). As Becker writes;

> The typical conclusion of this stage of the research is a statement about a set of complicated interrelations among many variables (Becker 1958, reprinted in Bynner & Stribley 1978 p. 319).

Within this project the researcher produced lengthy provisional analysis papers during the latter parts of the observation periods. These papers were found to be extremely useful in bringing together previous analytic and substantive notes and alerting the researcher to areas that required further information or clarification.

The processes of analysis within this project were greatly aided by the use of computing facilities. As noted in the preceding section, all field-notes were word processed and this made the management of the large volumes of data somewhat easier. The computer files provided the researcher with both a chronological record of the events within the houses and an environment wherein the notes could be easily manipulated.

Procedures to safeguard the reliability and validity of the findings

Four basic strategies were employed within this project in order to ensure the validity of the findings from the periods of participant observation. Firstly, as noted above, during the periods of observation the researcher actively fed back the emergent parts of his understanding to the research participants in order to check that his understanding of their perspectives was accurate. At the end of each piece of field-work the researcher fed back his final understanding of the workings of the care setting and took account of any further information that participants volunteered.

Secondly, the design of the project meant that the researcher spent two periods of observation within different houses in the same organisation. This offered the researcher the opportunity to check his understanding of certain central organisational characteristics with people in the same organisation but who had not volunteered the original data. Further, this design meant that the researcher was able to gain data on how the same organisational imperatives were interpreted and operationalised by differing groups of workers and staff in the same organisation.

Thirdly, the use of regular supervision sessions with experienced academic researchers meant that the researcher was able to check his understanding of substantive field-notes with people who were not actively involved in their creation. Lengthy discussions of field-notes were carried out in supervision sessions and these discussions often led to the researcher following new and productive lines of enquiry and becoming aware of the gaps and inconsistencies in emergent hypotheses and theories.

Finally, the data gathered and the conclusions reached through participant observation were compared and evaluated against the findings from other data sources. Thus, organisational literature was closely reviewed and the results of the Sheltered Care Environment Scale (see below for description of this instrument) were set against the findings of the periods of participant observation.

The Sheltered Care Environment Scale

The second central research tool that was used during this study was the Sheltered Care Environment Scale (S.C.E.S.), which was developed by Moos and colleagues at the Social Ecology Laboratory in Stanford University (Moos and Lemke 1988). This standardised care environment measure represents the latest development in Moos's twenty year quest to develop a research tool capable of characterising and measuring collective care environments.

As was shown in the preceding chapter, Moos's approach rests on the belief that care settings have unique 'personalities' and that, through environmental press, they regulate the behaviours of the social actors therein. The S.C.E.S. attempts to gain insight into the characteristics of care environments by asking the participants their perception of certain aspects of the setting. The scale attempts to provide the user with a profile of care environments based upon three dimensions, Relationships, Personal Growth, and System Maintenance and Change, (definitions of these dimensions are presented in Chapter One). The S.C.E.S. questionnaire consists of sixty-three statements to which participants are asked to respond either 'yes' of 'no'. Each of the dimensions are made up of nine questions which are spread throughout the total questionnaire; the scoring directions are mixed with some questions being phrased positively and some negatively (see Chapter Five).

The central reasons behind the selection of the S.C.E.S instrument for this study were four fold. Firstly, the emphases within the S.C.E.S. upon gaining an understanding of the participant's views of their social setting fits well with the theoretical insights offered by Berger and Luckmann; thus within this study the use of this questionnaire was felt to offer the researcher a further means of gaining information on the care setting's collective common-sense knowledges.

Secondly, as was shown within the preceding chapter, the dimensions of the S.C.E.S. appear to bear a close relationship to the kind of environmental traits discussed in the previous literature on E.E. (see Chapter One). Thus, centrally, it was shown that there appears to be a significant relationship between what Moos describes as the Conflict and Self Exploration aspects of the Relationship and Personal Growth dimensions of collective care settings and the expression of Critical Comments and displays of Hostility noted in the literature on E.E. in family care settings.

Thirdly, the use of a standardised care environment measure appeared to offer the researcher a good form of triangulated data that could be used in comparison with the data obtained through participant observation; that is, both data sources could be used to check the validity and reliability of each other. The fact that the S.C.E.S. provides the researcher with a numerical profile of care environments, along certain standard dimensions, further aids the possibilities of inter-site comparisons.

Fourthly, the S.C.E.S. is relatively easy for the respondents to complete, requiring simple 'yes' or 'no' responses to the statements that are given. The ease of completion was felt to be important in a project which involved working with a group of people who often had difficulty engaging in intense concentration. Further, as central aspects of the E.E. theories are concerned with the impact of stress levels upon people within their 'home' environment, the researcher was particularly sensitive to the pressures that his presence and demands were having on the participants.

The completion of the S.C.E.S. scale

Participants within the four research houses were asked to complete the S.C.E.S. during the final week of the ten week field-work periods. The reason for completion at this point was that it was felt that the relationships and levels of trust between the participants and the researcher were likely to be at their height during the final days of the study period, and that this

would aid both completion rates and the validity of the results obtained. Respondents' names and/or staff grades were not recorded; the only biographical information noted was whether a respondent was a resident or member of staff. Thus during the coding and analysis of the results the researcher was unaware of which individual completed which questionnaire. The exception to this was for one resident who joined the first Alpha house during the latter stages of field-work and gave his consent for the form to be marked. It was felt that his late arrival meant that he was not in a position to offer informed answers to the S.C.E.S. questions, this belief was borne out by the divergence of his answers from those of other residents in the same house.

Respondents were informed prior to the completion of the questionnaire that the scale attempted to measure certain aspects of their 'home' environment in order to aid the researcher in comparing it with other establishments. It was made clear that the researcher would be the only person to see the completed form, that there were no right or wrong answers and that the researcher was genuinely interested in respondents' opinions. Staff were asked to complete the form alone and without discussing it with colleagues. Residents were offered a choice as to whether to complete the form alone or with the researcher's assistance. The reason that the researcher offered to aid residents in completion was related to his wish to avoid embarrassment for residents who lacked literacy skills. The majority of residents chose to complete the form with the researcher reading the statements while they circled their answers on a separate sheet. The researcher ensured that respondents had privacy during the completion of the form.

The time sampling technique

Within the original design of this study it was envisaged that the researcher would utilise a time sampling technique in order to acquire numerical data on the regular activities and locations of the participants within the four research houses. The mechanics of this technique were seen as involving the researcher in twenty minute sweeps of the houses, over specific periods, in order to record in a structured way where people were in the building and their type of activities. Numerical data of this type was seen as further aiding comparison across the sites. Further, it was felt that

this approach would potentially reveal patterns of activity that were not immediately apparent through participant observation; for example, the proportion of time that staff spent in direct contact with residents or the type of activities that staff engaged in most commonly with residents. Moreover, within the previous literature concerning E.E. it has been found that contact between a patient and a high E.E. relative that was over 35 hours per week significantly increased the risks of clinical deterioration (Leff and Vaughn 1985 p. 91). The quantification of the length of time that residents were in face-to-face interaction with either other residents or staff was thus seen to be of interest.

Unfortunately, during the negotiation of access to Alpha house One this data collection instrument had to be abandoned. Both residents and staff felt that this measurement technique would be too intrusive within what they saw as being essentially the residents' home. It was pointed out that if the technique was used it was likely that at least some residents would stay in their rooms, in order to avoid being overtly recorded in their daily living activities. Clearly the strong feelings that were engendered by this technique were potentially detrimental to both good will and the other aspects of the research design. Initially it was still intended to use the technique in the remaining three sites, however, on entering the first of the Beta houses it quickly became apparent that the use of a time sampling technique would adversely affect the behaviours of the nurses. At this point the decision was taken to abandon the technique for the entirety of the study. The researcher did however remain aware of the rationale behind his wish to use the time sampling technique and tried to gather participant observational data on the various levels and types of contact within the research sites.

THE NEGOTIATION OF ACCESS

Within both research organisations the negotiation of access is best seen as a process that took place at several organisational levels over a period of several months. Further, within the negotiation of access the researcher gained some useful insights into the workings of the organisations and therefore the negotiation of access and the gathering of data must be recognised as in some ways linked; this was particularly true in relation to Alpha organisation where the researcher began to learn what he was later to

know as the organisational ethos, (this concept, its components, implications and usages, are expanded upon at length in the data analysis sections).

Alpha organisation

Negotiation of access to Alpha organisation began with an initial meeting with the organisation's deputy director. During this initial approach the deputy director suggested that it might be beneficial, for both potential participants and the researcher, if the researcher attended a house as a volunteer for a few weeks. The formal reasons behind this request were two fold, firstly, it was felt that it would allow the potential participants to become familiar with the researcher, the proposed project and its implications for the life of the house. Secondly, it would provide the researcher with the opportunity to further assess the suitability of the organisation and house for the project. On an informal level, this period of volunteering also served as a time when the researcher was, so to speak, 'on trial'.

After approximately two months of weekly attendance at the house (Alpha site One), the researcher made a formal request to the deputy director to begin the study period. A formal research protocol was submitted and permission was given, by a meeting of senior care workers, for the researcher to address a formal house meeting and ask the tenants and workers for permission to commence the study. As noted above, during the negotiation process that took place at this house meeting one of the planned instruments, a time sampling technique, was abandoned. Access was granted between the hours of 8am and approximately 8pm.

Access to Alpha site Two was somewhat easier, due to a certain level of trust having been established between the researcher and gate-keeping personnel. The researcher was simply asked to telephone the second Alpha house and arrange with the tenants to visit and discuss the project. The fact that the researcher was requested to approach the tenants, rather than the workers, offered interesting insights into the workings of the organisation. The researcher was invited to attend a house meal and discuss his project. The research proposal was later discussed at a formal house meeting, that the researcher did not attend, and access was agreed.

Beta organisation

The negotiation of access to the Beta organisation was in some ways more clear cut. This reflected the fact the rehabilitation houses were Health Board resources and that recognised bureaucratic procedures existed to cope with requests to carry out research projects therein. The researcher was requested to make a formal application, including research protocol, to the hospital's research ethics committee. The committee approved the application in principle and allowed the researcher then to contact the nursing officer. The researcher met with the nursing officer and charge nurse, and then subsequently, separate meetings were arranged with the medical consultant, nursing staff and the residents that would be directly involved in the study. The ethics committee requested that both patients and staff received written information sheets concerning the project and signed official consent forms, (specimen copies of these forms appear in Appendix One). All staff and residents agreed to take part in the study.

CHAPTER THREE

An overview of the two research organisations: their stated goals, priorities and ways of working

INTRODUCTION

This chapter will present an overview of the two research organisations. Primarily this will be a context setting exercise aimed at providing the reader with background information to aid comprehension of the chapters to follow. The account will draw upon literature and policy documents produced within the organisations and will develop and explore their administrative and ideological differences.

ALPHA ORGANISATION

As noted within the preceding chapter, Alpha organisation was within the voluntary, 'not-for-profit', care sector. The organisation offered a variety of properties ranging in size from one to seven people. The central organisational aims were to provide clients with a home for life, where a tenancy could not be sustained independently; within a setting that was person centred and based on the needs of individuals. The following quotation is taken from an Alpha document and offers further insight into the aims and priorities of the organisation.

> Our work is firmly based on a number of principles. The first is that we endeavour to expand personal choice. Secondly, we strongly encourage personal dignity and privacy. Thirdly, our service actively promotes the mixing of staff and tenants. For example, meals are taken together. Fourthly, our service strives to promote participation of the tenants in (Alpha organisation) and developing its services.

Handy (1988) has offered a useful four fold ideal type model for studying voluntary organisations. He suggests that voluntary organisations are normally dominated by one of four organisational cultures; these he terms,

'the club culture', 'the role culture', 'the task culture' and 'the person culture'. Alpha organisation contained elements of both the club and role cultures but was dominated by the club culture. Handy outlines the features of the club culture through the metaphor of a spider's web, where the key to the whole organisation sits at the centre, surrounded by ever widening circles of intimates and influence (Handy 1988 p. 86). He argues that club cultures normally arise in situations where there is a strong leadership with clear goals and priorities. The organisation serves to achieve the aims of the leader often the founder or founders.

> That can sound like a dictatorship, and some club cultures are dictatorships of the owner or founder, but at their best they are based on trust and communicate by a sort of telepathy, with everyone knowing each other's mind. ...
> The key to success is having the right people, who blend with the core team and can act on their behalf. So a lot of time is spent on selecting the right people and assessing whether they will fit in or not (Handy 1988 p. 87).

Historically, Alpha organisation arose as a response by dissatisfied staff (primarily two social workers), to certain aspects of care which they witnessed within the hospital sector. At the time of the research project the two central founders of the organisation remained heavily involved and provided strong and forceful leadership. Underpinning Alpha organisation's stated aims, and sitting at the centre of the organisational web, was what the researcher came to know as the 'organisation's ethos'. The ethos consisted of a number of ideas and guiding concepts which combined to create an ideology that both integrated members of the organisation and provided a framework that steered staff and clients in their daily interactions. Within one organisational document this collection of ideas and principles was referred to as the 'guiding light'.

Staff supervision and support meetings were a prominent feature of Alpha organisation and staff regularly met with their immediate seniors and their organisational peers both within and across houses. The support sessions were designed as a forum where staff could express ideas, discuss difficult situations or experiences and offer one another support. The concepts of support, supervision and training were closely interlinked within the organisation and worker meetings were the major means by which new recruits learnt and internalised the organisational ethos. As was noted within

the preceding chapter, front-line house workers were not employed primarily on the basis of formal qualifications but rather on personal beliefs and attributes. Some workers did however possess formal qualifications relevant to the field of mental health work, such as, the Certificate of Qualification in Social Work or Registration as Mental Nurses. An organisation induction package did exist. However, the major form of initial training within the organisation consisted of the worker's learning and using the organisational ethos. Thus at the point of research one of the house-workers who took part in this project and who had been in post for eighteen months had still not completed the worker induction package. Alpha organisation did fund staff members to undertake training provided by outside agencies as and when there was felt to be a need.

The Alpha organisational ethos did not, however, consist of a coherent set of procedures or worker mandates but rather was a collection of desirable aims and goals. These aims and goals often stood in tension or even contradiction with one another, and as will be shown below, when the individual elements of the ethos were pushed to their logical conclusion it was impossible for participants to achieve all of the aims simultaneously. The organisation's ethos offered guidance and some control over the activities of clients and workers. However, the contradictions and tensions that existed also left the front-line social actors with significant freedoms to decide which aspects of the ethos to emphasize within specific situations.

In order to penetrate Alpha organisation's ethos, to identify its constituent parts and the contradictions that existed, it is therefore necessary to look more closely at the organisational positions of the front-line workers and clients. This discussion will be approached via an analysis of the worker's job descriptions and the client's tenancy agreements.

The concept of tenancy

One, if not the most central aspect of Alpha organisation's ethos was the notion of 'tenancy'. The organisation's clients were always referred to as tenants and had Assured Tenancy Agreements; the majority of Alpha's clients collected weekly Department of Social Security Board and Lodgings (D.S.S.) benefits and then went and paid rent at the organisation's central office, (there were some exceptions to this general rule and certain tenants had their rent paid directly from the D.S.S. to Alpha organisation). In return

tenants received their supported accommodation, a weekly personal allowance of £11.40p and a monthly clothing allowance of £26. The regulations concerning the way in which the clothing allowance could be spent were lax and tenants often chose to spend this income on non clothing items. Each Alpha house received a weekly budget from the organisation to cover the day-to-day running costs of the house, i.e. gas, electricity, food, cleaning materials, etc. Houses were expected to remain within budget and house workers were responsible for keeping house accounts and making monthly returns to the organisation's central office.

Alpha organisation claimed that the clients' tenancy agreements were legally binding contracts made directly between themselves and the client. However, in reality the exact wording of the agreement had taken the lawyers approximately two years to agree upon and at the time of research the legality of the contracts had not been tested within the court system. The organisation argued that the existence of the tenancy agreement and the paying of rent empowered their clients in two ways.

Firstly, on the practical level the notion of tenancy was seen to offer tenants rights and claims upon the organisation as well as bestowing certain responsibilities. Secondly, the notion of tenancy and the paying of rent was seen to aid a perceptual shift on the part of both staff and tenants. It was argued that the people who came to Alpha organisation had commonly spent many years in hospital environments and because of this had often lost, or never been encouraged to develop, the skills of personal choice and assertion. The notion of the clients being tenants was seen as beginning the process of redressing these problems by actively promoting client empowerment. In relation to worker attitudes, it was claimed that the usage of the term tenant, as opposed to the alternatives of 'resident' or 'patient', encouraged workers to relate to clients as 'whole people' who had the same rights and deserved the same respect as any other member of society. The term 'whole people' was itself part of Alpha's shared organisational language, and was seen to further aid the shift of staff and tenants' perceptions away from a person's diagnosis or medical label towards seeing the total person. The notion of tenancy was thus designed to try and stop professional carers relating to their clients in a paternalistic way, that disempowered clients and ultimately made them dependant upon the workers.

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At this point it is beneficial to look briefly at the dictionary definitions of tenant and the alternative phrases resident and patient. The aim here is to see whether the term tenant is inherently more empowering than the alternatives patient or resident.

The Oxford English Dictionary (Second Edition 1989) defines the terms tenant, resident and patient as follows;

> Tenant-
> 1) 'One who holds or possesses lands or tenements by any kind of title.'
> 2) 'One who holds a piece of land, a house etc., by lease for a term of years or a set time.'
> 3) 'One who or that which inhabits or occupies any place; a denizen, inhabitant, occupant, dweller.'
> Tenant rights- 'The right that a person has as a tenant (of any kind) with special applications varying in time and place.'
> Resident-
> 1) 'One who resides permanently in a place; sometimes *specifically* applied to inhabitants of the better class. Also a guest staying one or more nights in a hotel or boarding house'
> Patient -
> 1) a- 'a sufferer; one who suffers patiently.
>   b- One who suffers from bodily diseases; a sick person
> 2) One who is under medical treatment for the cure of some disease or wound; one of the sick persons whom the medical man attends; an inmate of an infirmary or hospital.
> 3) A person subjected to the supervision, care, treatment, or correction by someone.'

In looking at these definitions it becomes clear that the significant difference between being a tenant and resident lies in the actual conditions of the agreement rather than there being anything inherent in the definitions of the terms. Thus, in theory, it is possible that the terms of a tenancy agreement might actually lay down conditions and requirements that are more restrictive upon personal autonomy and choice than those that are experienced under residency. In the light of this observation it is necessary to look at the actual agreement that Alpha tenants signed, with a view to ascertaining which aspects of the agreement actually contributed or otherwise to clients' practical empowerment. (A copy of the Alpha tenancy agreement can be found in Appendix Two.)

In search of the practical advantages and security offered by the Alpha tenancy agreement

Firstly, the Alpha tenancy agreement was not a fixed term contract in the sense of many housing leases. The agreement did not entitle the tenant to the use of the room or property for a specified period of time: rather, the agreement continued from the date of signing until terminated by either the landlord or tenant (by giving one month's written notice). This type of tenancy agreement is itself unusual within the present climate of the housing market. Following the legislation laid down in the Housing (Scotland) Act 1988, most tenancy agreements now run for an initial period of six months with the option open to landlords and tenants to re-negotiate the conditions of the lease after this fixed period.

An example of a standard Short Assured Tenancy Agreement is given in Appendix Two. The agreement that is used here for comparative purposes is one that relates to a student flat share. In many ways this tenancy agreement is dealing with a situation that has fundamental similarities, as well as significant differences, to Alpha organisation's group living arrangements. That is to say, the Short Assured Tenancy Agreement relates to a situation where a group of people are living within the same property but are not living within what would normally be seen as a family set-up.

By not being a fixed term lease the Alpha tenancy agreement offered both the landlord and the tenant greater flexibility than the comparative Short Assured Tenancy Agreement; in that, the contract could be dissolved by either party at any time by giving one month's written notice. On the other hand, however, Alpha tenants were perpetually in the situation of knowing that their tenancy could be terminated at any time. This observation concerning the uncertainty that was inherent within the Alpha agreement seems particularly pertinent when one considers that many of the 'Alpha properties' were in fact not owned by the organisation but were leased from either housing associations or Health Boards, (Alpha organisation only owned approximately ten percent of the properties that their tenants inhabited). The security of the majority of Alpha tenants thus ultimately rested upon the integrity of the organisation and the continuation of the agreements between the housing associations/Health Boards and Alpha organisation, rather than on the client's individual tenancy agreements. Alpha organisation was aware of the potential threat to the security of 'their'

property and thus section nine of the agreement entitled, Alternative Accommodation stated;

> In the event of us, the landlord having to quit or give up the occupancy of this property, we reserve the right to remove and relocate the tenants to alternative accommodation.

Significantly there was nothing within this section regarding the tenants having the right to refuse the alternative accommodation offered or tenants' being entitled to apply for compensation because of any inconvenience caused.

The fact that the majority of Alpha properties were leased and not owned by the organisation clearly stemmed from the large capital expenditure involved in buying properties. The intention within the preceding section is not to suggest that the organisation was lacking in integrity but rather to point to the reality of the lack of security offered to tenants within their agreements.

The Alpha tenancy agreement also stated that;

> The room is for the exclusive use of the tenant. The common parts are for the shared use of all the tenants in the house.

Within this brief extract two things become apparent. Firstly, the tenants appeared to have no automatic right to invite friends to stay within their room. This was interpreted within the first Alpha house as an agreement between tenants that no individual would invite a friend to stay without first seeking the approval of the group. Here tenants seemingly lost some of the rights of adulthood (for example to engage in sexual relationships) because they had to seek the approval of others before inviting people to share their personal space. This appears somewhat paradoxical when one considers that a central reason behind the notion of tenancy was to promote personal autonomy and control.

Secondly, within the above extract, attention is drawn to the fact that the property was shared with other tenants and thus issues are raised concerning the rights of the individual vis-a-vis other tenants. In spelling out that tenants were not allowed to invite friends to stay within their private space the Alpha agreement again diverged from the more standard Short Assured

Tenancy conditions. Thus the equivalent section (5) of the Short Assured Tenancy (see Appendix Two) states;

> The house shall be used solely as a private dwelling-house and the Tenant will not have the right to assign this Lease or sub-let the house, in whole or in part.

Again, the Alpha agreement can be seen to have certain advantages, but also certain disadvantages, when compared to the standard agreement. On the one hand, all of the Alpha tenants had an individual agreement which they could draw upon or refer to; they were equal with regard to their rights and responsibilities. Thus an individual Alpha tenant had some protection against the possible situation of a fellow tenant repeatedly inviting people into the house that they found upsetting, annoying, or threatening. Further, one Alpha tenant was not in the position of being legally responsible for the conduct of those that he/she lived with.[1] On the negative side, however, in return for the formal guarantee of equality between the tenants each Alpha client relinquished a certain degree of their autonomy and freedom to the group.[2] Here a contradiction is found between the organisation's wish to promote the freedom and choice of individual tenants and the recognition that in a group living situation it is often necessary to curtail an individual's freedom in order to promote equality. This tension was on-going within the houses and something that the workers and tenants had to negotiate on a daily basis in their social construction of the care setting.

Section 2 of the Alpha tenancy agreement stated that;

> The tenancy is offered with the sole object of providing the tenant with accommodation and support to meet the tenant's needs.

This section of the agreement was clearly of a significantly different nature to a standard private tenancy agreement. Within this section it was explicitly recognised that the Alpha tenants had particular needs and required

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[1] Within the comparative Short Assured Tenancy the responsibility for the safe keeping of the property remains with the individual that has signed the tenancy agreement. Clearly this leaves *the tenant* in a fundamentally vulnerable position as they remain responsible for such items as, the deposit taken against damage, the gas and electricity accounts, the final months rent, etc..

[2] In reality within a student flat share the individual may also relinquish certain individual freedoms to the group, however, within Alpha organisation this situation was formalised through the medium of the tenancy agreement.

specific types of support. Here we are offered insight into another of the central contradictions that existed within the notion of the house occupants being 'tenants'. The notion of tenancy implies that the person is in a position to manage the tenancy, that they are able to make appropriate decisions, and are liable to be held legally accountable for their actions. The contradiction, however, was that the Alpha tenants were selected on the basis that they were not able to manage a normal tenancy independently and that they were in need of certain support services.

With the introduction of the notion of 'support to meet the tenant's needs' questions also arise concerning what are the individual tenant's needs and who is going to define and assess these needs? In any assessment of needs there is invariably a degree of negotiation between the assessor and the client concerning such issues as what is to count as a legitimate need, at what level the need is to be meet, what redress does the client have if the service offered is not satisfactory, etc. (Veit-Wilson 1981; Smith 1980). It is clear then that there exists here a potential clash or conflict between what the individual tenant sees as his or her needs and the needs that are ascribed to them by the organisation or individual workers. Within the tenancy agreement, by linking the assessment of needs to the conditions of tenancy, the organisation in some senses limited the negotiating rights and power from their clients in the social processes that surround the definition of needs. That is to say, because the client accepted within the tenancy agreement that 'the tenancy is offered with the sole object of providing ... support to meet the tenant's needs' they also appear to relinquish some of their power to resist the organisation's assessment of their needs.

Finally, it is necessary to look at the conditions under which tenants could potentially be deemed to be in breach of the agreement and thus asked to leave the accommodation. Nine clauses were included under the section of the agreement entitled 'The tenant also agrees not to' here, however, the first three of these clauses appear to be particularly significant, as they combined to create a situation whereby the tenant was essentially powerless to resist being asked to leave the property. These three clauses read as follows:

> The tenant agrees not to:
> i) endanger or cause nuisance to other tenants in the house or to neighbours. The landlord will be the sole judge of 'nuisance'.

> ii) allow any guest visiting the house to cause a nuisance to the other tenants in the house, neighbours or workers.
> iii) behave violently towards, or threaten violence towards other tenants of the house, neighbours or workers. The landlord will be the sole judge of 'violence'. The landlord will remove any tenant who behaves in a violent manner from the house immediately.

In the use of the term 'the landlord will be the sole judge of violence' and 'nuisance' the organisation legally removed the right of a tenant to resist the organisation's definition of a situation or behaviour. The wording in this section of the agreement left no room for the tenant to negotiate over the definition or attributions given to their actions; the organisation explicitly retained the right to be the ultimate judge and interpreter of any tenant behaviour or action and to remove the tenant from the property.

To summarise thus far, the intention within the preceding section has not been to question the integrity of Alpha organisation or to suggest that the organisation would in practice use the terms of the tenancy agreement maliciously or vindictively. Rather it has been to undertake a systematic analysis of the practical advantages offered to clients within their tenancy agreements. It appears from the foregoing that the Alpha tenancy agreement did not offer the 'tenants' any practical benefits that could not be afforded to 'residents' of a well run establishment. In fact the tenancy agreement served as a means whereby the organisation could potentially, via legal action, enforce the agreement at any point in time and demand that the tenant/s leave the house. Many organisations who have residents rather than tenants would have greater difficulty in removing a client than Alpha organisation. It is concluded that the security of the Alpha tenants rested ultimately with the integrity of the organisation. If, as has been suggested, the importance of the notion of 'tenancy' did not lie within the contractual terms of the agreement, then it appears necessary to look to the claimed perceptual shift in the workers' and clients' attitudes.

The stated ideological importance of the term tenancy

The notion of looking at the perceptual and ideological significance of a term/concept such as tenancy is clearly more difficult than looking at the wording and practical ramifications of the tenancy agreement. Ultimately, one can only ascertain whether the notion of tenancy works at the perceptual and ideological level, by recourse to the interaction patterns found within the

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care settings. The following chapter will offer data concerning the way these principles were operationalised within the two Alpha houses which were studied. At this point the priority is to provide insight into what the organisation aimed to achieve by the use of the term and concept of tenancy.

In May 1989 a member of Alpha organisation's governing council attempted to articulate the principles and aims of tenancy at the ideological and perceptual level. Due to the inconsistencies that emerged within that paper, and between the conditions of tenancy and the front-line workers' job descriptions, some members of the organisation have subsequently expressed dissatisfaction with his presentation, whilst still wishing to adhere to the central principles expressed therein. Despite the reservations of some staff concerning the May 1989 paper, the following diagram and the accompanying explanation remain analytically valuable, precisely because they draw attention to the extreme difficulty that is encountered when trying to coherently express the constituent parts of the organisational ethos. In turn this difficulty stems from the contradictions and tensions that existed between the guiding principles or individual elements of the organisational ethos.
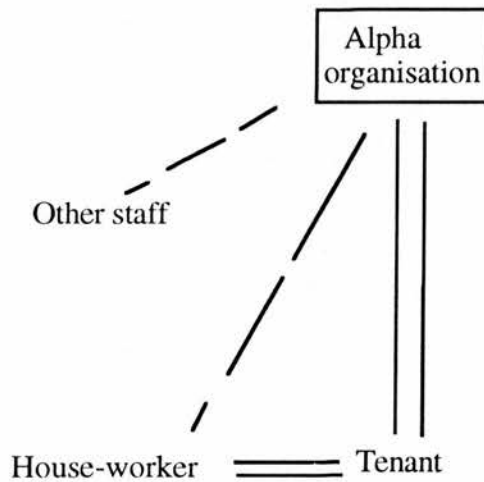
The tenant is in a direct relationship with the 'landlord' *Alpha* (central office; as it were). The 'house-worker' is in a separate relationship with the employer (and for residential staff, landlord), also *Alpha*. The 'house-worker's' role is beside the tenant (p.4; italics added).

Within the above diagram and explanation the author argues that at the perceptual level Alpha workers and tenants should perceive themselves as being essentially equal and at the same hierarchical level within the

organisation. The attempt within this model and within Alpha organisation more generally was to move away from the traditional hierarchical models of client/professional relationships and to point to an ideological belief that the carer and cared for person could have an equal and mutually reciprocal relationship. The desired practical ramifications of the above ideological belief were further spelled out in the following quotation from the same document. Here we are offered further insight into the way in which the individual houses were envisaged to operate on a daily basis. (As noted above Chapters Four, Five and Six will be concerned with the way in which front-line social actors actually operationalised these principles in the daily construction of house life.)

> *Alpha* is clearly set up in contrast to the usual residence of its tenants - long-term psychiatric institutions. Thus; its clients are called tenants, not patients. Extra care is taken to ensure that the tenant is responsible for his/her own decisions as far as is possible, from choosing to come, to taking part in the life of the house, to paying rent. Tenants are expected to 'do for' themselves as far as possible, though promoting this freedom is hard work for all when clearly it would be far easier for staff to do things for people. So, *Alpha* staff are not primarily employed for their psychiatric training or background. *Alpha* aims to remove institutionalisation and promote relatively more normal ways of living in the community (1989 p 2, italics added).

The position of front-line house-workers

In turning to look at the position of Alpha organisation's front-line workers it is firstly necessary to note that in the light of the preceding arguments it is likely that house-workers will be found to be an essentially contradictory or paradoxical position.[3] The Alpha organisational ethos suggested that the houses were the tenants' homes and that the tenants should be allowed to make their own decisions. At the same time the conditions of the tenancy agreement pointed to the fact that the tenants had certain 'special needs' and that the accommodation was provided with the explicit aim of

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[3] Within the May 1989 paper it was acknowledged that these 'contradictions' were real and experienced by the workers, however, the term *paradox* rather than contradiction was used. Paradox is defined by the Chambers (1989) as 'that which is contrary to received opinion: a statement that is apparently absurd or self contradictory, but is or may be really true.' Paradox is arguably a less threatening use of language than saying that contractions are evident within the organisational philosophy.

meeting these needs. No organisational system or procedures existed to facilitate the evaluation of needs and the organisation vehemently rejected the fact that they were in the business of assessing, changing or treating people. Indeed, Alpha organisation would also reject the generic term used within this thesis of being a collective care organisation. Within the ethos of Alpha organisation to care for someone was seen to involve disempowering them and to distract from viewing them as whole people. Beyond this, the ethos suggested that tenants and house-workers were ideally at the same hierarchical level within the organisation. That is to say, at the level of ideological rhetoric, it was claimed that there should not be a hierarchical distinction between the tenants and the workers.

A central contradiction or paradox seemingly lies in the fact that, if the workers were to engage in meeting tenant's needs, by providing support of various kinds, they must also at some level engage in the assessment of needs. A premise of an individual engaging in assessing need is that they must necessarily be deemed more capable, at least in the area they are to assess, than the recipient of the appraisal. To put essentially the same point from a slightly different perspective, as the workers were employed by the organisation they were presumably charged with the responsibility for performing certain tasks or functions, the question then arises as to whether the performance of staff tasks actually threatened or stood in contradiction to other elements of the organisational ethos, namely, the promotion of tenant autonomy and freedom of choice?

At this point it is necessary to look at exactly what the Alpha workers were charged with doing. Under section A of the house-workers' job description, entitled 'work with tenants', ten separate mandates were laid down. These were as follows;

> To: 1. establish a supportive relationship with each tenant, create a supportive environment and to be part of the shared life of the house.
> 2. maximise the tenants' individual responsibility and choice
> 3. ensure reasonable standards of domestic order and hygiene throughout the house (including tenants' own rooms) and assist tenants who have difficulties with basic living and social skills.
> 4. maximise tenants' involvement in the decision making and running of the house eg: shopping for food, cooking and cleaning.

5. i) be responsible for ensuring the provision of the communal evening meal

ii) be responsible for the planning, budgeting, accounting and shopping for all food and provisions required by the tenants.

6. assist tenants to participate in occupational and leisure activities and to encourage them to develop their own interests.

7. organise and attend the regular house meetings.

8. be aware of tenants' medication needs, but not to administer medication.

9. involve appropriate professionals when necessary.

10. involve volunteers in the life of the house.

Several interesting things become apparent from looking closely at this section of the house-workers' job description. Firstly, this section of the job description contained at least potential contradictions within itself. For example, section three laid a duty upon the house-workers to ensure 'reasonable standards of domestic order and hygiene throughout the house (including tenants' own room)', while section two dictated that the house-workers should 'maximise the tenants' individual responsibility and choice.' Here the contradiction within the house-workers' mandate lies in the fact that they could only encourage the tenants to exercise 'individual responsibility and choice' within certain limits. Should the tenant choose not to clean their room or take part in the other communal tasks the house-workers were obliged to 'ensure' that they did so. Similarly, the house-workers were charged in section four to 'maximise tenants involvement in the decision making and running of the house'. Again, however, the house-workers' mandates in sections three and five meant that there were very clear limits surrounding what the tenants could and could not take decisions over. Thus the tenants could not, for example, take the decision to abolish the communal meal because the house-workers had to 'be responsible for ensuring the provision of the communal evening meal'.

This is not to suggest, however, that the concepts of tenant choice and control were not real or of benefit. Tenants did have the right to take decisions over important areas of their lives, for example, whether or not to attend a day programme, seek employment, etc. Tenants also had real choice concerning daily menus, the household provisions that were bought, and were involved the choice of house furnishings and decor. Further, Alpha tenants also met all potential new house members and whilst they could not choose which candidate finally came to the house, they did have the right of

veto if they felt that they could not live with a particular individual. However, Alpha organisation argued that the eating of one communal meal a day, attendance at a fortnightly house meeting, and participation in cooking, cleaning and shopping, were all aspects of the type of accommodation that they offered. Clients were made aware of these conditions, both at the time of applying to the organisation and at the point of signing the tenancy agreement.

Several of the clauses in the house-worker's job description can also be seen to have worked directly against the notion of tenancy as portrayed in the May 1989 paper. Thus within that paper it was argued that the house-worker's position should ideally be alongside the tenants and that there should not be an inequality between the parties. However, in order to fulfil the mandates that were laid down in the job description the house-workers had necessarily to be in a position of authority and have some degree of power over tenants. Thus, on a practical level, in order to 'ensure reasonable standards of domestic order and hygiene throughout the house (including the tenants' own rooms)' the house-worker had firstly, to have access to the tenants personal space, and secondly, be able to instruct the tenant that their level of hygiene was unacceptable.

Further, as neither the tenancy agreement nor the house-workers' job descriptions defined 'reasonable standards of domestic order and hygiene' this was open to negotiation and interpretation; the house-workers were therefore implicitly asked to engage in evaluating and judging individual tenants' standards of domestic and personal hygiene.[4] The significant point here is that these implicit processes of tenant evaluation and judgement worked subtly to conflict with other central elements of the ethos and potentially encouraged workers into the position of evaluating and judging tenants. It is suggested then, that despite the organisational rhetoric, if workers were to perform certain of their mandates satisfactorily it was a prerequisite that they perceived themselves as being more competent than the tenants, at least in certain areas of social life.

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[4] Here it should be noted that the Alpha houses were in fact registered with the Social Work Department and that Alpha organisation received monies from that Department. One of the conditions of Social Work registration was that the properties were inspected by a Social Work Department representative/inspector The definition of acceptable domestic standards was not therefore entirely within the control of either Alpha organisation, the ground level workers, or the tenants.

The notions of 'permanence' and 'home' and the contradictions which were found with the concept of tenancy and the role of the workers

Within the preceding sections an analysis has been undertaken of the position of tenants and workers within Alpha organisation. The rights and responsibilities of both parties have been reviewed and it has been shown that internal contradictions existed both within the notion of tenancy and within the workers' job descriptions. Beyond this, it has been shown that tensions existed between statements at the level of the ethos or organisational ideology concerning 'tenancy' and those concerning the role and function of the house-workers. Within the following section it is intended to introduce two further aspects of the Alpha ethos, namely the emphases which was placed upon the 'permanency' of the accommodation and the attempt to achieve a 'home environment'. Again it will be suggested that there existed contradictions between the ideological uses of 'permanency' and 'home' and certain aspects of 'tenancy' and the house-workers' roles.

Alpha argued that it did not provide a rehabilitation programme or service but rather provided permanent supported accommodation. Thus the operational policy document stated;

> *Alpha* aims to provide people with a home for life where tenancy cannot be sustained independently (Alpha Operational policy, italics added).

The emphasis within the organisation on the permanency of the accommodation was seen to be particularly important due to the fact that many of the the people who came to Alpha had spent many years in psychiatric hospitals or attending rehabilitation programmes. Hospital accommodation was seen, by its very nature, to lack the emotional security of a normal home[5] environment.[6] Within the notion of the house being the tenant's long term home there existed a commitment, again at the level of the ethos, that people should not be assessed, evaluated, and/or have goals set for them. It was argued that people should be encouraged to make their own

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[5]Clearly questions exist surrounding what constitutes a normal home environment, this was not defined by Alpha organisation and within the research sites competing definitions or emphases were found (see chapter 5 and 6).

[6] 'Paradoxically', as has been shown, Alpha organisation itself did not in reality offer people guaranteed permanency, at least not through the conditions of the tenancy agreement. Rather permanency only existed at the level of ideology and the commitment and integrity of the organisation.

decisions and enabled to live within as normal a domestic environment as possible. It was stressed that most people who live within the community do not undergo assessments by professionals on an on-going basis and particularly not within their own homes. Home was seen for most people as being a place where they have control, particularly concerning such aspects as, who is invited into the environment, what they decide to do or not do within the home, what time they retire to bed and get up, etc.

The existence of paid employees within the 'home' and the conditions surrounding both becoming an Alpha tenant and living within the house (which I have discussed at some length above) can be seen to make the achievement of the above aspects of home impossible. That is, the aspects of 'home' and the view of 'normal domestic life' that were emphasised and seen as desirable, were something that was ultimately unachievable due to the conditions of tenancy, the role of the workers, and the individual difficulties/mental health needs of the tenants.

Further, as shown above, Alpha organisation aimed to promote tenant empowerment, in the sense of increasing individual choice and autonomy. Often the notions of enabling people to take individual responsibility and increasing personal assertiveness were cast in terms of enabling tenants to throw off the negative effects of institutionalisation. At the same time, however, there existed very clear boundaries surrounding exactly what the tenant could and could not take decisions over; the communal meal, existence of fortnightly house meetings and collective responsibility for household cleaning and shopping stood as examples of things that the tenants could not take decisions over (these aspects of life within Alpha organisation houses will be discussed at some length in Chapters Four and Six). Here again when this observation is related to the notion of the 'permanency of the accommodation' a clear tension can be highlighted with certain other elements of the ethos. Thus if the tenant used their new, or resurrected, powers of choice and assertiveness to decide to do something that was outside the boundaries that were placed around their autonomy, they ran the risk of endangering the security and permanency of their home. The permanency of the accommodation, which the organisation stressed as being so important, rested ultimately upon the tenants not achieving, or using, their choice/control to challenge other central elements of the ethos. The tenant was thus placed in the contradictory position of being asked to be assertive

and to make real choices, but if they genuinely achieved this goal, they potentially ran the risk of losing their home.

Alpha organisation and the therapeutic community movement

Alpha organisation denied that their houses were therapeutic communities. Paradoxically, however, many of their guiding principles and their rationale for working practices, find resonance within elements of the therapeutic community movement. As Lennard and Gralnick (1986) suggest a central characteristic of therapeutic communities is a belief that being within the organisational milieu is helpful, in that it offers residents and workers certain benefits pertaining to their quality of life and interpersonal relationships.

Kennard and Roberts (1983) point out that the term therapeutic community has been used to refer to a number of organisations with significantly different histories and evolutionary paths. Thus, the authors describe how the term has been used to refer to such seemingly diffuse care settings as: hospital wards trying to turn away from institutional practices towards more normal ways of living within stimulating social environments; organisations such as Charles Dederich's Synanon centres working in the field of addictions, offering an environment of 'no-holds-barred' honest confrontation pertaining to all aspects of life; small cohesive communities based on the pioneering work of Maxwell Jones, embracing egalitarian principles and the sharing of therapeutic decisions and functions; and certain organisations that have arisen in response to dissatisfaction with conventional psychiatry, organisations concerned primarily with the spiritual, moral and social aspects of emotional distress (ibid pp. 3-7). Alpha organisation bore closest resemblance to the anti-psychiatry types of therapeutic community. As Kennard and Roberts note anti-psychiatry communities often;

> ....include a strong commitment to a particular faith or philosophy of life, and an emphasis on the equal status of all members. There are usually no labels of 'staff' or 'patient'. It is also characteristic of those communities which arose from the anti-psychiatry movement of the 1960s that a member can experience breakdown without having it treated as an illness (Kennard & Roberts 1983 p. 7).

In reviewing the variety of organisations described as therapeutic communities Kennard and Roberts identify five elements that they suggest are common to all such environments. Again the majority of these attributes were found within Alpha organisation. Firstly, therapeutic communities are seen to be characterised by, an informal and communal atmosphere that is homely, casual, and possibly untidy rather than institutional. Secondly, within therapeutic communities group meetings are important and take place regularly. The aims of the meetings are normally seen as being to: maximise the sharing of information, build a sense of cohesion, make open and public the processes of decision-making, provide a forum for personal 'feedback' where people can both receive and give personal reactions to one another, and finally, provide an opportunity for community members to exert pressure on individuals whose attitudes or behaviours are disturbing or threatening.

The third common element identified by Kennard and Roberts is that therapeutic communities tend to involve a sharing of the work pertaining to maintaining and running the community, i.e. cooking, cleaning, decorating, laundry, shopping, etc. The rationale behind the sharing of communal tasks normally being to engender a feeling of participation in the community and provide the opportunity to practise or learn daily living skills. Participation in the running of the community is also often seen to contain a moral element, in that constructive work is seen to be beneficial.

The fourth common element of therapeutic communities is identified as being the recognition of patients or residents as auxiliary therapists. Kennard and Roberts argue that it is common within therapeutic communities that residents are encouraged to comment on and influence each others' attitudes and behaviours. These processes are more formalised in some organisations than others and can involve anything from residents assessing prospective new members to residents engaging in what Rapoport (1960) termed 'reality confrontation'. Reality confrontation in essence refers to residents being confronted with other members' views and interpretations of their behaviours/actions.

The fifth common element within therapeutic communities is a belief in egalitarianism. As Kennard points out the notion of equality between community members in turn often has two elements.

By human equality I am referring to the belief that we should treat others as we would like to be treated, that we should not exploit others or unduly restrict their rights or freedom. ...

The second equality is the recognition that all members, whatever their role, share many of the same psychological qualities. ... Neither side (residents or workers) has a monopoly of strengths or weaknesses. This contrasts with the view found in many traditional hospitals, where staff and patients usually find it comfortable to adopt the complementary roles of helper and helpless, ignoring those parts of themselves that do not fit with these roles (Kennard & Roberts 1983 p.13 brackets added).

Whilst Alpha organisation vigorously rejected allegations that they were engaged in therapy, they paradoxically stressed the importance of Kennard's central therapeutic community attributes, i.e. an informal atmosphere within the houses, regular house meetings and communal meals, tenant involvement in daily living activities, and egalitarian values. Further, the rationale offered by the organisation for insisting upon these ways of organising the house was remarkably close to therapeutic community ideals outlined above. Beyond this, whilst at the level of organisational rhetoric, Alpha did not accept that tenants were involved in each other's therapy, the ethos stressed that tenants should engage in 'honest and open communication' in order to let co-tenants know how their actions were perceived and affected other people.

BETA ORGANISATION

As noted in the preceding chapter, Beta organisation consisted of a chain of four rehabilitation houses attached to a National Health Service (N.H.S.) psychiatric hospital. The accommodation consisted of four large Victorian dwellings, all of which were situated within a one mile radius of one another and within a residential area. The four progressive rehabilitation houses catered for seventeen, nine, five and four residents respectively. Residents were initially admitted to the main seventeen bedded intake house and then, theoretically, moved on to one of the other houses. Although the chain of houses was progressive it was not necessary for the residents to pass through all of the houses before being discharged from the unit. The research houses were the two middle houses in this chain (i.e. the houses that catered for nine and five persons).

As noted within the preceding chapter, the official nursing complement for the rehabilitation houses was 10.33 nurses, however, during the period of the research project the team operated with only 8 nurses. The grades of the nursing team remained stable throughout the project (two charge nurses, five staff nurses and one nursing assistant). The personnel occupying these positions/roles did however undergo some changes between the first and second periods of field-work, with one charge nurse and two staff nurses moving from the organisation and being replaced. Three different student nurses were also on placement during the two periods of participant observation.

The nursing staff had two offices and a clinical treatment area within the seventeen bedded intake house but did not have a permanent base within any of the other houses; the nursing staff team were however responsible for all the 35 residents spread across the four sites. The second house in the chain was adjacent to the main intake house and the nursing staff were thus very close at hand. All main meals for residents within the first and second houses, apart from breakfast, were provided by the hospital caterers. The only exception to this was during periods when individual residents were involved in a care plan/treatment programme aimed at teaching cooking and/or shopping skills. Residents within the second house were responsible for the cleaning of their own rooms, their personal laundry and the changing of their bedding.

Within the third house, the five bedded unit, an Assistant Cook was employed Monday to Friday between the hours of 7.30 am and 1.30 pm. The Assistant Cook's official responsibilities were to provide a mid-day meal, clean the communal areas of the house and ensure that other provisions were ordered from the hospital suppliers. Residents within this house were responsible for cleaning their own rooms, cooking their evening meals and undertaking their own laundry. In reality the Assistant Cook had taken on a more substantial role in the life of the house than her job description required and this is something that will be discussed within Chapters Four and Six. Residents within the last rehabilitation house were relatively self-sufficient, with responsibility for the provision of all their own meals, the cleaning of the house, personal laundry, etc.

Within the original design of the rehabilitation houses it was a condition of residence that all clients attended a day programme of some kind,

however, at the time of research this requirement had been dropped. In 1981 the consultant responsible for the rehabilitation houses initiative wrote;

> The basic criteria for admission to the system include a degree of capacity for self care, a stable medication regime, a place of occupation whether within the hospital or outside, and some likelihood of progress or at least stability. The object is to give everyone with potential the chance of adequate rehabilitation and resettlement training...
>
> ... Rehabilitation methods are used, of course, in the hospital's short-stay and long-term wards and patients may be discharged independently of the support services, but the resettlement hostels offer a programme of increasing responsibility and independence which is needed by many 'new chronics', the institutionalised and some medium-term patients with serious disabilities. Admissions are also arranged for some continuing care patients whose struggles in the community are failing.
> (This quotation is taken from a published paper, the reference is not given in order to protect the anonymity of the site.)

Within the preceding overview and analysis of Alpha organisation it was suggested that the organisation most closely resembled Handy's ideal type of a 'club culture'. By contrast, while in the statutory rather than voluntary care sector, Beta organisation bore a significant similarity to the type of organisations typified by Handy as having a 'role culture'. As Handy explains, organisations that employ this 'organisational idea' see workers primarily as role occupants, rather than individuals with specific talents or personalities. The organisational emphasis is upon the role or 'job box' and these are joined together in a logical and orderly hierarchy in order to discharge the work of the organisation (Handy 1988 p. 89). In this type of organisation the attempt is to lay down job prescriptions that reduce the influence of personality and achieve uniformity in role completion. Within Beta organisation there were clear role demarcations between workers (i.e. the consultant psychiatrist attached to the organisation, the nursing staff, the domestics and the assistant cook), and between residents and workers, with each set of role occupants being aware of their hierarchical position and the obligations attached to that position. There also existed relatively long and separate managerial structures for the various classes of workers, i.e. nurses, domestics and catering staff.

The role of the consultant psychiatrist

A consultant psychiatrist was responsible for the medical care of residents within Beta organisation. He attended the organisation each Monday morning to conduct a ward round and took part in residents' three monthly reviews. The consultant also attended the houses at any other times as requested by the nursing team. The role of the psychiatrist during the residents' reviews and the way that the ward rounds were conducted will be discussed in Chapters Four and Six. At this point, however, it is worthy of note that the psychiatrist saw his role principally in medical terms, being primarily concerned with the medication requirements of patients and was prepared to leave the more social and behavioural interventions to the nursing team.

The role of the nursing team within the Beta organisation

Much has been written concerning the role and function of psychiatric nurses. Towell (1975) has argued that it is very difficult to identify a set of tasks or roles that are common to all the situations where psychiatric nurses are employed. Rather, he suggests that the role of the mental health nurse is dependant upon the context in which they work; within his empirical work he has shown that the role of psychiatric nurses in admission wards, geriatric wards and therapeutic community wards differs considerably.

Cormack (1983) in reviewing the literature on the role of psychiatric nurses has argued that a useful distinction can be made between writings that are 'prescriptive', offering thoughts on what the role of psychiatric nurses should be, and those that are 'descriptive' and provide accounts of what psychiatric nurses actually do in their day-to-day working lives. Cormack (1983 & 1976) suggests that historically there has been a discernible shift in the prescribed role of psychiatric nurses. He quotes Conolly as being representative of the early view of the role of psychiatric attendants, the predecessors of modern psychiatric nurses, arguing that from the early days until comparatively recently, nurses have been seen, and seen themselves, as the hand-maidens of the medical profession.

> ... all his (the physician's) plans, all his care, all his personal labour, must be counteracted, if he has attendants

(nurses) will not observe his rules, when he is not in the
ward, as consciously as when he is present
(Conolly 1856, p. 37, quoted in Cormack 1983 p. 11,
Brackets added by Cormack).

In recent years however, as Cormack notes, the nursing profession has
attempted to move away from being merely the servants of the medical
profession and increasingly strove to assert the uniqueness of their own
therapeutic interventions; establishing themselves as a group of people who
deserve a high degree of professional and therapeutic autonomy (see Altschul
1980a 1980b, Hessler 1980, Marks, Hallam, Connolly & Philpott 1977). In
reviewing the many prescriptions that have been presented concerning the
role of the modern psychiatric nurse Cormack concludes, in a similar vein to
Towell, that the role of nurses varies across situations and types of care
environment and that it is difficult to identify a unifying set of prescriptions
concerning what psychiatric nurses should do.

> The new role prescriptions, which supersede those of the
> nurse as a custodian and follower of 'doctor's orders' have
> undoubtedly confused, rather than clarified, the 'psychiatric
> nurses' role. In examining the prescriptive literature, it is
> difficult to identify a unifying thread, consensus of opinion or
> area of care which are exclusive to that group of people called
> 'nurses' (Cormack, 1983 p.18).

In view of the lack of clarity, that is evident within preceding literature
on the role of psychiatric nurses, it appears necessary, within the present
context, to look at what the nurses in Beta organisation saw themselves as
doing. Handy suggests that within organisations dominated by a 'role culture'
it is typical that there are many formalised procedures, rules and regulations
for staff to follow. This was true within Beta organisation where the nursing
team had produced several documents concerned specifically with their role
and the ways that good nursing care should be achieved. The emphasis within
these documents was on the role of the nurse; often the prescriptions were
very specific and aimed to standardise the procedures that the individual
nurse followed, whilst at the same time trying to allow flexibility in the
individual care offered to patients.

The organisational documents to be reviewed below reveal a
fundamentally different ideological model in Beta compared to Alpha
organisation. Within the Beta organisational literature the documents talked

of planned assessment and active interventions, with the specific intention of changing residents' behaviours. The strong ideological commitment within Alpha organisation to promoting overt tenant choice and control and the stress upon equality between tenants, and between staff and tenants, was not present within the Beta organisational literature. Rather, within Beta organisation a more linear rationality was present with the rhetoric talking of efficient or effective ways of treating or rehabilitating people and of professionals helping their charges.

The review of Beta organisation's policy documents presented below is analogous with what Cormack terms prescriptive literature, in that it advances Beta organisation's prescriptions of what the nursing team should do. Within the chapters to follow, data will be presented concerning what the nursing team actually did do during the social construction of Beta organisation's care environment; in Cormack's terminology the data presented in Chapters Four and Six will add to the descriptive literature on psychiatric nursing.

In Beta organisation the nursing team employed the system of care known as 'primary nursing'. Within an organisational document written primarily for teaching (or socialising) student nurses, the charge nurse laid out what he saw as the central advantages of primary nursing over more traditional task oriented approaches.

> 1. Used in conjunction with the nursing process it provides a goal directed and problem solving approach with an emphasis on a clearly unique therapeutic function of the nurse.
> 2. The adoption of this organisational framework moves firmly away from task centred to an individual approach to patient care. ...
> 3. Qualified staff become more involved in the therapeutic interaction of patients thus promoting a positive role model for other staff. ...
> 4. A member of staff is clearly identifiable by the patient, relatives and other members of the multi-disciplinary team to be the co-ordinator of a patient's care...
> 5. It assists the nurse to speak with confidence and authority at the multi-disciplinary team meetings...
> 6. Quiet and withdrawn patients who under traditional systems of care receive the minimal support have far greater therapeutic input, ...

7. Research shows that nursing staff experience greater job satisfaction, thus there is a higher level of commitment and morale.

The reasoning expressed within the above was not unique to the organisation, rather, it is representative of the consensus of opinion concerning good nursing care within the modern profession. Thus, Hunt and Marks-Maran (1987), in arguing for the adoption of primary nursing lay out broadly similar lines of argument. They suggest that primary nursing is more satisfying, expands the role of the nurse, helps learners, leads to the patient being seen as a person and improves communication (Hunt and Marks-Maran 1987 pp. 12-14).

As indicated, within Beta organisation 'primary nursing' was used in conjunction with the 'nursing process'. The nursing process in a similar way to primary nursing was not a unique practice within Beta organisation but is rather the dominant current organisational model within all spheres of the nursing profession, i.e. General nursing, Mental nursing, and Mental Handicap nursing. Many text books concerned with nurse education devote large sections to the nursing process or its constituent parts, (see Stockwell 1985, Hunt & Marks-Maran 1987). As Stockwell notes, at its basic level the nursing process;

> ... is a systematic way of consciously thinking about patients and clients, ensuring that what each patient needs in the way of nursing care is identified, organising and doing the nursing, checking and recording that the required nursing has been carried out, and evaluating the effectiveness of the nursing care given (Stockwell 1985 p. 4).

The nursing process consists of four essential elements; assessment of clients' needs, planning of care interventions, the intervention, and evaluation of intervention. Within Beta organisation, literature existed that spelled out the procedures that should be followed at each stage of the nursing process. Beta organisation's operational policy argued that the assessment process was;

> the most important part of the nursing process. If the assessment is incorrect, the nursing intervention developed within the Nursing Care Plan will be ineffective.

Residents within the rehabilitation houses underwent periodic (three monthly) assessments and reviews using material from the Kalamazoo (the nurses' daily recordings) and the completion of Rehabilitation Evaluation Hall and Baker, known as R.E.H.A.B., (Baker and Hall, 1988 & 1984). The assessment was said to be aimed at gauging;

> individual skills, assets and other positive features as well as handicaps, disabilities and other disfunctions (sic), (Beta operational policy).

Beta organisation's operational policy offered the following guide-lines to staff concerning how the assessment process should be undertaken.

> The resident's key worker co-ordinates the assessment. The assessment period takes one week, during this time nursing intervention is withdrawn, unless necessary, to allow for an accurate baseline of the resident's abilities. Direct and indirect observations are used to collect relevant information during the assessment period. ... Lastly the key worker liaises with other disciplines and significant others to gain as 'full a picture' as possible of the resident. All the above information is recorded in the Kalamazoo and on the 7th day of the assessment period, the resident's abilities are rated through the R.E.H.A.B. assessment tool.

Hall and Baker's rehabilitation assessment tool consists of twenty-three items. Seven of these items relate to offensive behaviours such as self mutilation, verbal and physical violence. The nurse is asked to indicate the frequency of these incidents. The remaining fifteen items on the scale relate to the categories of: self care, social activity, speech disturbance and community skills. In this second section the assessor is asked to mark on an anologue scale the point that they feel most resembles the resident's abilities. At a latter point the markings from the anolgue scale are translated into numerical scores, via a transparent coding sheet.

Care Planning

Following the assessment procedure the key worker was charged with designing a care plan aimed at meeting the assessed needs of the resident. In relation to the process of planning the intervention, the policy statement notes;

Behavioural terms should be used which describe what the patient is able or unable to do. This means writing what we see and not interpreting this and giving it meaning, e.g. if a patient is crying we should record this as we see it and not interpret it as a sign of depression, which could change the care required (Operational Policy Statement).

Similarly under a section entitled Nurse Care Planning the policy statement requested that staff should;

1.<u>Write concise, behavioural statements of patient's problems/needs.</u>
a)....
b) The written statement of the problems/needs should <u>describe</u> the <u>behaviours</u> involved.Ensure that the behaviours that are described are specific. General statements will not help.
2.<u>Write behavioural objectives of desired patient outcomes.</u>
What the patient will be able to do when the objectives are achieved.Each problem/need requires an appropriate objective.select objects which are achievable.
3.<u>Write a specific nursing care plan which shows how the objectives will be achieved.</u>
This is a programme showing how the objectives will be achieved. It states what patient and staff should do.
4.<u>Set appropriate review dates.</u>
Although evaluation is on-going, definite review dates will help ensure that time is taken to evaluate care.
5.
6.
(Nursing Care Planning. Operational Policy).

What is apparent from this operational policy statement is that there was a strong emphasis within the stated nursing procedures of Beta organisation upon the behaviour of residents. It was resident behaviours that were deemed to be the target of nursing interventions. The nursing stress upon behaviours was further reinforced by the heavy reliance, during the assessment process, upon the R.E.H.A.B. scale developed by the behaviourist psychologists Baker and Hall. It will be shown in Chapters Four and Six that in reality, the fact that the nurses knew that they had to fill in the Hall and Baker R.E.H.A.B. scale after the assessment week, led to their observations being skewed towards the categories of the scale. As noted above, the consultant psychiatrist within Beta organisation worked in a parallel and

complementary fashion to the nursing staff and focused his efforts primarily upon obtaining the optimum medication balance for individual residents. Within Beta organisation the organisational emphasis and rhetoric was therefore, upon attempting to treat or rehabilitate residents through the twin methods of medication and behavioural interventions.

The final part of the nursing process involves the evaluation of the nursing care plan interventions. Within Beta organisation the evaluation of care plans was said to be 'on-going', however, in reality the formalisation of three monthly reviews had led to a situation whereby resident assessments and the evaluation of the previous care plan had merged. Thus, within the organisation the three monthly assessment procedures, involving the withdrawing of nursing interventions for one week and the administration of the R.E.H.A.B. scale, were also the processes that were primarily used to evaluate the previous interventions, (i.e. the effectiveness of any changes in drug regime or nursing interventions). The processes of three monthly reviews, planed interventions, and assessment of interventions thus theoretically continued until the resident's level of functioning was deemed to be sufficient for them to leave the rehabilitation houses.

Community meetings

Community meetings took place on a weekly basis in two of the four Beta organisation houses (i.e. the seventeen bedded intake house and the adjacent nine bedded unit). Once again the nursing staff had produced documentation on the purpose of the meetings and procedures to be followed. Accordingly, staff were asked to meet prior to the meetings, in a preview session, to discuss the last meeting and prepare for the forthcoming event. Staff were also asked to take time after the meeting to review events and to discuss both the decisions taken and the personal contributions and behaviours of residents. Unlike Alpha organisation's house meetings the community meetings within Beta organisation were voluntary, although the literature did suggest that 'it is encouraged that everyone try and turn up'. The community meetings within Beta organisation were also described as being explicitly a 'therapeutic event'. This again differed from Alpha organisation's view of their house meetings. As noted above, within Alpha organisation any reference to therapy within the houses was rigorously rejected. Beta

organisation described the purpose of their community meetings in the following terms.

> It is a forum for discussion of ward issues, a platform for airing them, involving group decision making. It encourages the patient group to identify with each other and participate in responsibility taking as to the running of the ward.
> Issues of any kind can be raised and discussed however, staff must be sensitive to personal issues that may arise and deal with them appropriately so as to protect individuals from maybe being scape-goated...

SUMMARY AND CONCLUSION

Within this chapter an overview of the two research organisations has been presented. It has been argued that there were significant differences in the ideologies and administrative structures of the two organisations.

Alpha organisation has been shown to have been based upon a set of strong ideological beliefs, pertaining to the rights of members of society in general and their clients in particular. It has also been shown that Alpha organisation had developed a strong ethos which both integrated its members and bound them together. The ethos enjoyed strong commitment from all the social actors involved and there was a feeling of joint endeavour.

The Alpha ethos was not however a coherent set of principles, but rather a collection of desirable aims which often stood in tension or contradiction to one another. The various contradictions, or 'paradoxes' as the organisation preferred to call them, have been explored primarily through the analysis of the tenancy agreement and the front-line workers' job descriptions. The important point has been made that the ethos provided tenants and workers with a form of moral guidance concerning the ways that people should relate to each other and also a model within which to define and interpret potential difficulties or conflicts within the organisation's houses. At the same time, however, the ethos contained internal contradictions and lacked specificity and this created a situation whereby workers and tenants had considerable freedom to decide which elements to emphasize within concrete care situations. It will be shown in the chapters to follow that within the two Alpha research houses there were significant differences in the ways that the houses worked and the interaction patterns that took place therein. It will be

argued that, in large part, this resulted from the workers and tenants within the two houses emphasising different aspects of the organisational ethos.

Administratively Alpha organisation was relatively flat and this aided the effective transmission of the ethos and gaining of commitment to the central organisational principles. At the point of beginning field-work there was only one layer of management between front-line workers and the directorate. However, as the organisation has expanded a second tier has been introduced. Regular supervision and support meetings were a prominent feature of Alpha organisation. These meetings functioned both to socialise new members into the organisational ethos and to integrate members of the staff teams.

By contrast, Beta organisation's ideology offered a more linear rationale and formalised approach to the care of their residents. The processes that were in place within the organisation were in many ways more simple and logically easier to comprehend, as is reflected in the proportions of this chapter devoted to each organisation.

The stress within Beta organisation's literature was upon pharmaceutical and behavioural interventions and on professional carers working to help the people in their charge. The culture of Beta organisation has been characterised as a 'role culture', as opposed to the 'club culture' that dominated within Alpha organisation. The processes of care and treatment presented within the Beta organisational literature were ones that went from assessment, to planning the intervention, to treatment and finally evaluation of the effectiveness of the treatment/care. Alpha organisation explicitly rejected this model of care arguing that it often has the effect of depersonalising individuals and detracts from seeing clients as whole people with the same human rights as other members of society.

Administratively Beta organisation was more complex than Alpha organisation reflecting the fact that it was managerially part of a large psychiatric hospital. Tall management structures existed for the various categories of staff: i.e. the doctors, nursing staff, domestic staff and the catering personnel. The setting also abounded with procedures and rules concerning various aspects of daily living; thus seemingly simple matters such as keeping food in the fridge, taking food from the main intake hostel to the adjacent nine bedded unit and residents drawing their weekly benefits were all covered by specific rules and procedures.

Within the preceding chapter it was argued that the information available at the point of access suggested that Beta organisation was likely to have a higher overall level of E.E. than Alpha organisation. The review of the organisational literature undertaken in this chapter supports this hunch; thus the emphasis within Beta organisation's ideology upon planned treatment programmes and active interventions aimed at teaching or resurrecting social skills appears likely to lead to situations that the residents find difficult and potentially result in high levels of E.E. By contrast, the emphases within Alpha organisation's ideology upon the equality of relationships between tenants and staff, and the stress upon the houses being tenant homes where they should have choice and control, appears likely to lead to a care environment that is very low in E.E.

This chapter has been based primarily upon organisational literature and has sought to provide an overview of the two research organisations' aims, priorities and envisaged ways of working. The following three chapters will turn to look at the actuality of the four research houses and at the social construction of reality therein.

CHAPTER FOUR

The observed social reality of the research houses and the levels of Expressed Emotion

INTRODUCTION

In the preceding chapter a review and analysis of the two research organisations' ideologies and envisaged ways of working was undertaken, via close scrutiny of organisational documents. This chapter will present a comparative analytic description of the observed reality of the four research sites and the levels of Expressed Emotion (E.E.) therein, i.e. Critical Comments and displays of Hostility; no examples of Emotional Over-involvement were found.

This chapter commences with a statement on the definitions and usage of the terms 'Critical Comments' and 'displays of Hostility'. There then follows a description of a typical day within each of the four research houses. The descriptive days do not represent actual days but are rather composite, being made up from paraphrased field-notes covering the entire research period. The typical days are designed to provide the reader with a general overview of life routines within the houses and further context within which to understand the thematic presentation that follows.

Following the typical days the chapter turns to look specifically at the levels of E.E. within the four research houses. The analysis is presented thematically under the headings of; domestic daily living tasks, house meals and house meetings. These three themes have been selected for two central reasons. Firstly, E.E. is essentially concerned with interactions between social actors, the chosen themes therefore represent the main periods of resident/resident and staff/resident interactions, and thus best provide insight into the overall levels of E.E. within the houses. Secondly, the three themes represent activities that were common to the four sites and thus aid comparison across the houses, (with the exception that there was not a regular community meeting in Beta Two). It must be stressed at the outset that this chapter attempts to remain primarily descriptive. Qualitative data concerning the social actors' common-sense knowledges and the underlying

meanings behind their actions will be presented in Chapter Six.

THE DEFINITIONS OF CRITICAL COMMENTS AND DISPLAYS OF HOSTILITY

In undertaking this analysis and more generally throughout the research project it has been important to be consistent concerning definitions of Critical Comments and displays of Hostility. In this area the project has been guided by the published works of Leff and Vaughn and in particular the definitions they present in 'Expressed Emotion in Families' (1985). Both the content and vocal aspects of speech were taken into account when deciding whether a statement was to count as a Critical Comment or display of Hostility. Comments were regarded as critical when one or both of the following were present;

> 1) There is a *clear and unambiguous* statement that the
> (resident or worker) dislikes, disapproves of, or resents a
> behaviour or characteristic. ...
> 2) There is a rejecting remark. ... Rejecting remarks usually
> involve a pejorative comment about the person as a whole or
> a statement of frank dislike
> (Leff & Vaughn 1985 p. 39 Brackets added).

Displays of Hostility were deemed to exist where ordinary everyday matters were described in a critical or condescending way, implying that there were only a few things that the person could do satisfactorily. Or where there where direct generalised negative feelings involving a statement of frank dislike (Leff and Vaughn 1985 pp. 40-42).

The processes used herein in the rating of statements or interactional exchanges as either Critical Comments or displays of Hostility can be seen as having both positive and negative aspects when compared to the methods outlined by Leff and Vaughn. On the positive side, the researcher was able to see interactions at first hand in naturalistic settings and was therefore able to judge more sensitively whether statements involved criticism or hostility. On the negative side, however, the recording of field-notes and the decisions concerning whether criticism and/or hostility existed were inevitably linked. It was not possible to achieve a blind rating of the data due to the fact that the phrasing of field-notes and interpretation of interactions as involving Hostility or Critical Comments were near simultaneous processes. Whenever

possible, however, verbatim recordings of participants' comments were gathered. Further, as the Camberwell Family Interview was not used it was not possible to determine whether a care environment was high in E.E. by simply counting the number of Critical Comments, displays of Hostility or examples of Emotional Over-involvement. Rather, the researcher relied upon spending relatively long periods of time within the settings so as to make informed decisions concerning the normal persistent interaction patterns therein. As will be shown below this method proved very successful for this exploratory study, in that it allowed the researcher to gather information on the level, content and precipitating factors to high E.E. interactions in the four sites. The method also allowed the researcher to remain sensitive to aspects of the collective care environments that contributed to the emotional atmosphere and stress level, but could not be subsumed under the three major elements of Expressed Emotion, i.e. Critical Comments, displays of Hostility, and Emotional Over-involvement.

TYPICAL DAYS IN THE LIFE OF THE FOUR RESEARCH HOUSES

Alpha organisation

The worker complement for both Alpha houses was identical; two full-time workers (one male and one female) and one senior worker (who had responsibility for supervision of house-workers and taking part in the life of two houses), to cover seven days. Workers in both houses had some freedom in their shift patterns in order to facilitate their being in the houses when tenants were around. Worker times varied on a daily basis, with individual workers doing different times each day. However worker shifts followed a weekly pattern. Alpha staff were not normally in the house before 9am or after 7.30 pm unless accompanying a tenant/s to evening events such as, ballet, opera or theatre. For the purposes of these illustrative composite days the worker shift patterns have been taken to be the same in both houses, i.e. one worker in the house between 9.30am and 2.30pm, with another worker coming on shift between 12.30am to 6.30pm. Both Alpha sites had seven tenants living in the houses.

Alpha One

9am -12 noon: Alpha One is very quiet during the morning, Dianna and Simon (tenants) leave around 9.30 am to go to the day hospital (arriving back at 3pm), Louise and Jim (tenants) go to collect their D.S.S. benefits from the post office and then go to pay their rent at the Alpha head office. John (worker) and Christina (tenant) leave the house at 10.30am for coffee at one of their regular cafes in the city's shopping district; this will be paid for from the house budget. Kevin and Frances (the remaining two tenants) stay in their respective rooms throughout the morning, only occasionally coming out to make tea or coffee.

12 noon- 3pm: At 12.30am the second house-worker (Gill) arrives at the house, shortly afterward Christina (tenant) and John (worker) arrive back from their coffee trip. Over the next hour various tenants make lunch, some eat in the kitchen others take the food into their room. The two workers make a sandwich and sit at the kitchen table, they chat casually to each other and any tenants that come into the kitchen. At 1pm Frances (tenant) leaves her room and lies in her normal position on the settee in the hall. From here she can see both the kitchen and lounge, the main centres of activity during the afternoon. Frances chats casually to other tenants as they pass through on the way to the kitchen or their bedrooms. At 1.45pm Gill (worker) leaves with Jim (tenant) to go to the cinema for the afternoon. John (worker) tidies the kitchen, doing the breakfast washing up and wiping down the table, he leaves the house at 2.30pm. The house is very quiet until Gill (worker) and Jim (tenant) arrive back from the cinema at 3.30pm.

3.30 pm - 5.30pm: Dianna and Simon (tenants) arrive back from the day hospital at 3.30pm, Simon goes to his room for a lie down, Dianna makes a cup of tea and sits at the kitchen table. Dianna (tenant) talks about her day and the pottery class she attends. Just after 3.30pm Gill (worker) and Jim (tenant) start to prepare the evening meal. Two different meals are prepared because one tenant and the worker are vegetarian. The preparations for the meal take over an hour and a half. There is chick pea curry and a lamb casserole for the evening meal. Tenants come into the kitchen at various points to make drinks, they do not stay long because there is a no smoking policy while the cooking is undertaken.

At 4.45pm there are four tenants in the hall. On a couple of occasions tenants enter the kitchen and check the progress of the meal and comment

that the food smells nice. At exactly 5pm Gill (worker) and Jim (tenant) serve the meal. Christina (tenant) goes to call the two missing tenants and everyone assembles. All the tenants have their own places around the large kitchen table. The meal is eaten in almost total silence, apart from the worker who tries to make casual conversation. Two tenants eat extremely quickly and then leave the kitchen to return to their own rooms. The other tenants take slightly longer, but the whole meal is over in eight minutes.

Three tenants go into the lounge after the meal, three go to their rooms. Gill (worker) and Jim (tenant that cooked) start to clear up the kitchen, this is done immediately after the meal. Gill washes and Jim dries the plates. After the washing up coffee is made and taken into the lounge, where four tenants and Gill (worker) are present. At 6.30pm Simon (tenant) suggests that they go to the pub, Gill (worker) agrees and leaves with three tenants. Gill (worker) remains in the pub until the end of her shift. One tenant stays on after she leaves, the other two return to the house and start to watch television.

Alpha Two

9am -12noon: At 9.30am Bessy and Eddy (tenants) leave the house to go to the day-hospital. At 10am Kenny, (tenant) and Gerry (worker) leave to visit a small town outside the city (Kenny's home town). Bertha (tenant) is in bed and does not rise until 2pm. Danny (tenant) leaves the house to visit a friend who is still in a psychiatric hospital. The remaining two tenants spend the entire morning in the lounge, the curtains remain closed and the table lamps are left on. The television is on in the corner and the fire is at full blast. Both the tenants chain-smoke and the combination of the smoke and heat makes the atmosphere feel oppressive. Jane (tenant) complains that again nobody has gone to collect the milk and bread and so they have to drink black coffee. She is not prepared to go herself. There is very little conversation and both tenants doze occasionally.

12 noon - 4pm: Gerry (worker) and Kenny (tenants) arrive back at the house at 12.30pm. They have brought some cream cakes and the tenants that are around have one each. Three cakes are put to one side for the house members that are out or still in bed. Between 12.30pm and 2.30pm four tenants and the worker sit in the lounge. The worker reads various magazines and papers, there is little conversation and there is a feeling of lethargy. The worker suggests that the curtains are opened and the fire

turned down a little. Occasionally people comment on the programmes that come on the television. Bertha (tenant) comes into the lounge with a cup of tea and a cigarette at 2.15pm: she is just out of bed. The second house-worker comes into the house at 2.30pm and joins everyone in the lounge.

Danny (tenant) complains that he is bored and that it drives him mad just sitting around all day; two other tenants agree, one adding that she misses her O.T. placement, (this has been cut back recently from four to two days per week due to the closure of part of the local psychiatric hospital). The worker asks what people would like to do this afternoon; no one has any ideas.

Bertha and Jane (tenants) do not go out of the house unless they really have to; in reality this means that they only go out for the communal shopping approximately every seven weeks and to the bank every two weeks or so. Bertha and Jane (tenants) describe themselves as being agoraphobic. Sue (worker) suggests various things that the tenants could do, various sports activities, a walk in the park and a trip to a pub. The money for these activities is to come from the house budget. Danny and Bob (tenants) say that they would like to go to the pub. Sue (worker) agrees and leaves with the two tenants. The remaining tenants return to watching the television. Later Kenny (tenant) announces that he is going to see a friend at another Alpha house and leaves.

4.00pm -7pm: At 4pm Sue (worker), Danny and Bob (tenants) arrive back at the house and come into the lounge, at this point there are four other tenants present. After the initial conversation concerning which pub they visited the conversation again dies. Everyone sits smoking, the air is thick. At 4.30pm Bertha (tenant) asks whose turn it is to cook. There is silence for several seconds and then Bessy (tenant) replies that it is Eddy's turn, he is not in and the conversation is dropped. Eddy (tenant) arrives back at the house at 4.45pm and comes into the lounge. Bessy (tenant) comments that it is his turn to cook: he replies that he can't tonight and that his hernia is causing him trouble. Sue (worker) tells him that she will help him and after some jollying along he agrees. They go into the kitchen.

The meal is served at 5.30pm and consists of oven chips and sausages, with ice cream and tinned fruit for pudding. All but one of the tenants are at the meal, none have specific places and people just sit anywhere. Sue (worker) tries to make conversation, Bertha (tenant) joins in by talking about something she saw on the news today. The meal takes around 15

minutes, as people finish their meal they scrape their plates into the bin and then stack the dishes into the dishwasher (the dishwasher is a luxury that Alpha One did not have).

After the meal four tenants return to the lounge, where they all smoke and watch television. Kenny (tenant) leaves the house to visit a friend and Joan's (tenant) boyfriend arrives at the house, and they go into her room. Sue (worker) sits with the tenants in the lounge until the end of her shift at 7pm. At one point Sue (worker) suggests that they have a tidy up as the ash-trays are full and there are coffee cups everywhere. No one is prepared to help and so it is left for another day.

Beta organisation

Nursing cover during the day in Beta organisation was organised around two shifts, 7am to 3pm and 1.30pm to 9.30pm. (Night shifts are not covered by this study.) On the average day shift there was one staff nurse and one or two student nurses or a nursing assistant to cover the four rehabilitation houses. For the purposes of this illustrative composite day the staffing complement is assumed to be one staff nurse and a nursing assistant for each shift. Beta One contained nine residents (five male and four female), Beta Two five male residents. An Assistant Cook was employed within Beta Two between the hours of 7am and 1.30pm.

Beta One

7am - 9am: Hand-over between the night nurse and early shift is completed by 7.05am. While most of the residents are just said to be 'OK', three residents are thought worthy of comment due to their being awake during the night. The night nurse leaves. Jimmy and Ian (staff nurse and nursing assistant) make a cup of coffee and sit in the office. At 7.35am two of the residents from Beta One come into the hall of the intake house and start to pace back and forth, (they are waiting for their 8am tablets). At 7.40am Jimmy (nurse) writes on the office black board the names of the residents who have care plans and the numbers of the nursing interventions to be completed during the day. The board is designed to be a visual reminder to staff of the care interventions to be completed

At 7.45am the nursing assistant leaves the intake house, walks down the garden path and into Beta One. He knocks on each of the bedroom doors,

enters without necessarily being invited, and asks the residents that are still in bed to get up. The nursing assistant then returns to the intake house.

The residents of Beta One eat breakfast in their own house, with the exception of Jane (resident) who is still in bed and two residents who insist on eating in the intake house. At 8am the staff nurse opens the drug trolley and over the next 20 minutes all the residents that have tablets during the morning drug-round file into the office. Between 8.15am and 9am the residents that are still in bed are called twice more. At 9am the staff lock the main office and go to the back room for their break, this lasting until 9.45am.

9am- 12 noon: In Beta One five residents are in during the day. Four do not have day placements and one has decided not to go today because it is raining. Kate (resident) paces the hall until 10.15am and then leaves for her daily trip to the charity shops in the high street, arriving back at 11.30am. Jane (resident) stays in bed until she is given her third call by the nurses at 10.30am, when the nurse runs a bath for her, (the care plan dictates that today is one of her days to bath). Of the remaining residents two sit in the kitchen and one goes to the intake house to watch television. The hospital domestic comes into the house at 10am and cleans until 11.30am.

The nursing staff remain in the office between 10am and 12 noon.. Some of this time is spent doing the daily recordings, some updating care plans and some reading the morning papers. A depot injection is also given. Four residents come in to see the nurses during the morning, two to ask for bus tokens and two for their weekly money. None stay longer than five minutes.

At 11.15am some residents start to gather in the hall of the intake house ready for lunch. Lunch is not actually due until 12 noon and is delivered by van from a hospital in another part of the city. By 12 noon the hall is full: ten residents have congregated, some sit on the stairs others pace back and forth. Several other residents sit in the staff office waiting for the meals.

12 noon-3pm: The meals arrive at 12.15pm and a resident rings a large gong in the hall to let everyone know. The two nurses unpack the food, residents queue for their meals and then carry them along the passage into the dining room. As residents finish their meals they file into the office and are given their mid day tablets. The residents then disperse either to their rooms or the lounge.

At 12.30pm the nurses lock the office and go through to the back room for their second break. They remain there until 1.45pm. The late shift starts

at 1.30pm and hand-over is between 1.45pm and 2pm. Hand-over takes place in the office, the door is locked throughout. All of the residents of the rehabilitation houses are named in turn. The vast majority are merely said to be O.K., only seven (from thirty three) being commented on. Most of these reports refer to such matters as residents that are going home for the weekend, forthcoming review dates and PRN's[1] or depot injections that have been given. The four staff (early and late shift members) stay in the office until 3pm chatting amongst themselves. Two of the nurses clean out one of the office cupboards. The early shift leave at 3pm.

3pm - 5pm: The nurses spend the majority of this time in the office, again working on the care plans and the daily recording and chatting casually to one another. Two residents from the main intake house come into the office and ask for bus tokens and then leave. The residents of Beta One that have been to day placements arrive back between 3pm and 4pm, tell the nurses that they are back and then go over to Beta One. All the residents of Beta One sit drinking tea or coffee and smoking. At 4.30pm three leave for the main intake hostel to start queueing for the evening meal. By 4.50pm the hall of the intake house is once again full. The meal arrives at 5.10pm and again there is a procession of residents going from the kitchen to the dining room with meals. Residents finish their meals and then go into the office to receive their evening medication.

5.00pm - 7.30pm: At 5.30pm the nurses lock the office and go through to the back room for their break. They remain there until nearly 7pm, being disturbed twice by residents that require bus tokens, and once by a telephone call from a resident's relative. At 6.30pm two of the residents from Beta One wash the dishes from the evening meal

7.30pm - 9.30pm: The majority of the residents in Beta One spend the evening watching the television, two residents go to the local pub and one has a friend visiting (a Jehovah's Witness) to talk about the Bible. After the staff finish their break, Wil (staff nurse) comes into Beta One and joins the group watching television. Two of the residents make conversation asking about the nurse's new baby. The nurse stays for thirty minutes and then returns to the office of the intake hostel. The two nurses remain in the office until the end of their shift at 9.30pm.

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[1] PRN's were medicines given at the nurses' discretion as and when required .

Beta Two

7am - 9.30am: Jeanie (Assistant Cook) arrives at the house at 7am and immediately starts to clean the living-room. All the residents are in bed, one (resident) is sleeping in a tent in the back garden. At 8am Jeanie gives the residents a call and then starts to make Gerry's breakfast (resident). He is the first one up as he has to leave for his day placement by 9am. He comes into the kitchen with an armful of washing, puts it into the machine and asks Jeanie (cook) to check that he has it on the right setting. Gerry (resident) takes his breakfast and goes into the lounge. Over the next forty-five minutes all the residents get up. Jeanie (cook) makes all their breakfasts in turn. Each resident has an individual breakfast requirement, two always have cheese on toast, one a roll with jam and two residents have cereal. Jeanie (cook) takes Joey's (resident) breakfast out to the tent. By 9.30am the two residents that have day placements have left. Between 9.15am and 9.30am Jeanie has a cup of coffee and cigarette in the dining room.

9.30am - 12noon: Two residents spend the morning in the lounge only occasionally going through to the kitchen to make tea. One resident sits in the corner and reads the paper, while the other watches an old black and white film. There is little communication between the two residents. Between 9.30am and 10.30am Jeanie cleans the downstairs and upstairs halls, the two bathrooms, and also hangs out the finished washing. At 10.30am she starts to cook lunch and then lays the dining room table. While she is cooking one of the residents comes through and chats to her for half an hour about the film that he has been watching. They reminisce about the old film stars.

At 11.45am Jeanie (cook) makes herself coffee and goes into the lounge to join the two residents. She sits and reads the paper commenting on several news items. At 11.55am the two residents that have been out during the morning arrive back. They join the others in the lounge. Jeanie serves lunch to the men at 12am, and clears the plates between courses. As the residents finish their puddings they put their plates in the kitchen. Jeanie puts the scraps out for the birds and then washes up. One resident helps her dry the plates and chats to her casually. Jeanie then makes sandwiches for the men's evening meal and leaves them wrapped in cling-film on the table.

1pm - 4.45pm: Joey (resident) again returns to his tent for the rest of the afternoon, the others go into the lounge with cups of coffee. At 1.15pm Gerry (resident) returns to his day placement, Jeanie (cook) joins the other men in the lounge and chats until 1.30pm when she leaves. During the

afternoon three residents sit watching television, one goes to the local shop and brings in two cans of beer, then sits and drinks. There is some conversation about the film. At 2.30pm a friend of Jock's (resident) arrives, he makes her coffee and they go to his room. She stays for about forty-five minutes then leaves, Jock returns to the lounge and the television. Gerry (resident) arrives back at the house at 3.45pm and joins the others in the lounge.

4.45pm-7pm: At 4.45pm Jock (resident) goes into the kitchen and lays the dining room table for the evening meal. He makes a pot of tea and at exactly 5pm tells the others that the meal is ready. All the residents attend and sit in their normal places. The meal takes about fifteen minutes, four residents then return to the living room with cups of tea. Joey (resident) again returns to his tent in the garden. At 5.45pm two residents wash-up the evening meal plates and tidy the kitchen. At 6.45pm they leave the house to go to the pub. The remaining two residents sit in the lounge for the rest of the evening watching television.

THEMATIC COMPARISON OF THE FOUR RESEARCH SITES AND THE LEVELS OF E.E.

Domestic Daily Living Tasks

Alpha houses

Within the Alpha houses, in addition to their cooking duties, tenants had responsibility for all of the household cleaning and shopping. Alpha organisation did not employ the services of any domestic staff. In both of the houses the responsibility for the large weekly shopping trip was divided on a rota basis with one tenant going, with a house worker, each week. Within the first Alpha house this system worked well. Tenants were clear whose turn it was and shopping took place on a specific day and time each week. Shopping did not appear to cause any of the tenants in the first Alpha house difficulty and no examples of high E.E. interactions were recorded. Within the second Alpha house things were more complex. Tenants arranged amongst themselves whose turn it was to go shopping and workers occasionally appeared unsure who should be going. At times within the second Alpha house the confusion concerning who was responsible for the shopping, combined with the reluctance of certain house members to take a turn, caused difficulties. In the following field-note extract a tenant expresses

concern that there is no food left in the house. In spite of her concern, however, she refrains from engaging in direct confrontation or a high E.E. interaction with her co-tenant.

> Gerry (worker) comes through after about ten minutes and starts to read a magazine. ... Bessy (tenant) asks if he is going to get the shopping today. (It is normally collected on a Wednesday, today is Thursday.) Gerry comments that he doesn't know and that it is up to Bob (tenant) when they go, he adds that he thinks it is Bob's turn. Bessy (tenant) replies that they don't have any food left and that someone will need to go. Gerry comments that she had 'better get Bob telt then'. Later Bob comes into the room but Bessy doesn't raise the issue with him, Gerry also doesn't mention it and the shopping isn't collected. The meal consists of mince and sausages the only food left in the freezer (A2 3/30).

It is interesting to note here that the Alpha Two worker did not intervene directly in order to ensure that the shopping was collected. Rather he attempted to get one tenant directly to approach/confront the other. It will be shown in Chapter Six that this was a constant ploy of workers in Alpha organisation and that it represented an attempt by workers to encourage tenants to take greater control in the running of the house. Within the second Alpha house it was unusual for tenants openly to confront each other. By contrast, within the first Alpha house tenants were more prepared publicly to raise issues concerning communal responsibilities.

The cleaning of the communal areas of the houses was an on-going and difficult issue within both Alpha sites. Workers in both houses argued that in theory they did not want to become involved in directing tenants to clean; both teams arguing that it was far better for tenants to raise issues concerning the standard and distribution of domestic cleaning directly with each other.

> John (Alpha One worker) then goes on to explain how he would deal with a situation where someone was not taking their share of the house hold tasks. He explains that if it was cleaning he would probably leave the task undone and wait until one of the other tenants mentioned it. When this happened he would encourage the concerned tenant to address the other tenant directly and/or to raise it at a house meeting (A1 8/4).

In reality issues surrounding household cleaning were not often spontaneously raised by tenants in either house and workers were forced into direct action. Within the first Alpha house workers were seen occasionally to spend odd moments cleaning (particularly the kitchen area), these actions corresponding with periods of worker boredom when tenants were either in their rooms or out of the house. In the second house workers never cleaned unless a tenant was directly involved, and this resulted in the house on occasions becoming very dirty and untidy.

Within both Alpha houses workers eventually decided to raise the issue of household cleaning in the forum of a house meeting. The methods employed by the two teams of workers and the responses of the two groups of tenants were however significantly different. Within the first Alpha house workers managed to encourage a tenant to raise the issue at a house meeting. Once raised the workers then supported her and managed to negotiate a redistribution of tasks.

> He (worker) continues by saying that it was Dianna (tenant) that brought up the fact that she had been doing more than her fair share of cleaning for a reasonably long period of time. I tell him (worker) that Betty (worker) has told me that Dianna's decision to raise the issue came out of a long conversation that they had and that I feel that it was the workers who weren't happy about the distribution of tasks within the house. John acknowledges that this was in fact the case, but adds that he believes that Dianna would not have raised the issue if she hadn't agreed (A1 8/26).

In the second Alpha house a senior worker directly raised the issue of household cleaning during a house meeting. (At this point six tenants were living within the house: however only five were present at the meeting.) Tenants were asked individually how they felt about their cleaning duties. Three tenants claimed that they were unable to do more because of their illness, the other two tenants merely commenting that they thought that the present situation was satisfactory. The result was that no new agreement was achieved and the cleaning of the house remained a source of difficulty.

The differing responses by the two teams of workers in the Alpha houses to the ongoing problem of household cleaning are illustrative of some central differences between the two houses. These differences will be discussed in detail in Chapter Six. At this point however it is worthy of note that workers

in Alpha One encouraged a tenant to raise the issue at a house meeting whilst workers in Alpha Two chose to raise the matter directly themselves. In Alpha One a re-negotiation of task distribution took place, with tenants taking on new responsibilities, in Alpha Two tenants resorted to an illness model in order to justify their non-motivation. In the second Alpha house, cleaning remained an ongoing and unresolved issue. Workers within the second Alpha house claimed to work with a 'willed action' model of tenant behaviour but there was some evidence to suggest that they also had sympathy with tenant's views of ill-health causing difficulty with motivation.

Beta houses

In the first Beta house residents did not have any communal shopping responsibilities and very few responsibilities for communal cleaning. House provisions were ordered from the hospital stores by the nursing staff. There was a hospital domestic who cleaned all communal areas, i.e. everywhere apart from residents' bedrooms. Some attempt had been made historically to encourage residents to take part in tidying the kitchen and wiping down the table. A rota was pinned to the kitchen wall with the days that each resident should clean. In reality none of the residents adhered to this rota and the domestic had resumed the responsibility. Neither residents nor staff ever raised the matter of people not taking their turn at tidying the kitchen and there were no repercussions.

Residents in the first Beta house did have responsibility for changing their bedding once a week, laundering their own clothes, keeping their rooms tidy and washing up the meal plates once a week. The majority of tenants shared twin rooms and so there were normally two residents responsible for cleaning each bedroom. It was noted in the preceding chapter that Beta organisation relied heavily upon the behavioural assessment scale developed by the behaviourists Hall and Baker. It might therefore be expected that residents' domestic duties would be an area where high E.E. interactions between staff and residents might occur, particularly if care plans involved behaviour modification techniques. In reality, the cleaning of the rooms, laundering of clothes and washing up, were carried out in a very low-key way and no examples of high E.E. interactions were observed. Residents were allowed a great deal of freedom concerning the level of cleanliness in their rooms, the timing of cleaning activities and personal laundry, staff only intervening in extreme circumstances. The majority of residents' care plans

involved reference to interventions concerning either personal or domestic hygiene. However, the prescribed nursing action normally consisted of merely reminding residents that they should tidy up or wash their clothes (with nurse assistance if need be). The following extract from a resident's care plan offers a typical example of how a resident's room cleaning and personal hygiene were to be dealt with.

Need
It has been identified through assessment that Eddy rarely launders his clothes and frequently his clothes are strewn around his room.
Goal/objective.
Short term. to assist Eddy to launder his clothes- minimum of once fortnightly and assist him to maintain his room at a mutually acceptable level.
Nursing intervention 1. In discussion with Eddy he has agreed to the following
a) Each morning put his dirty clothes in a bag. (Staff should verbally prompt to do this.)
b) Eddy has decided to launder his clothes on a weekly basis, (Monday evenings). Staff should supervise Eddy to do this, give assistance when necessary to work the washing machine.
c) On Monday and Wednesday evenings Eddy has agreed with staff assistance to tidy his room. Eddy has expressed a wish that when staff give him assistance it should be in an informal way giving him the opportunity to 'socially' chat to them.
Nursing intervention 2.
1. In discussion Eddy has agreed to bath twice a week, Tuesday and Saturday afternoons.
2. Eddy has requested that staff should remind him to bath on Saturday afternoon and Tuesday evening.
3. If by 2pm on Saturday and 8pm on Tuesday Eddy has not bathed staff should remind him to do so.

It is interesting to note that within the above care plan, part of the resident and staff agreement was that the resident would tidy his room if the staff spent some social time with him. It was a noticeable aspect of the first Beta house that the staff had very little contact with the residents and the vast majority of the contact that was observed tended to be very instrumental; staff/resident interactions concentrated on the task in hand, whether this involved the dispensing of medicines or the implementation of care plans.

In the social context of low contact with nursing staff, residents in the

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first Beta house had to resolve inter-personal conflicts within the resident group. Several examples of inter-personal conflicts between residents were observed, these conflicts being primarily related to individuals' personal behaviours and thus primarily 'personality clashes' as opposed to conflicts over communal responsibilities. Although a significant number of Critical Comments were witnessed in connection with anti-social personal behaviours, it should be noted that it took quite severe provocation to initiate such interactions. Here, for the purposes of illustration, the example is taken of one resident who displayed certain repetitive questioning behaviours.

> I go through to the sitting room, Jean, Eddy, Paul, Kate (residents) are there. They say hello and I join them. ... Paul (resident) asks questions constantly. I count that he asks Jean four times, Eddy four times and myself five times, if we know that he is going home for the weekend and that he is going home for two weeks at Christmas. It is not only the fact that he asks the questions but his insistent manner that is wearing. It is not possible to just nod and agree. When people do this he becomes more and more insistent. He uses phrases like, 'isn't it ?, isn't it?, or 'do you know that X, do you know that?'. I can feel that I am becoming quite annoyed by the pressure that he is putting on me. ...During one of Paul's (resident) persistent barrages of questions Jean (resident) gets up and turns her chair so that he can only see her back. Paul doesn't take the hint and simply tells her that he can't see the T.V.. She ignores him and so he moves to sit next to me. He then starts again ... (B1 12/1).

Two central resident responses were seen to have emerged in relation to behaviours such as those described above. Firstly, some residents choose to try and avoid residents with whom they were having interpersonal difficulties. This involved some residents spending relatively long periods, particularly in the evening, alone in their bedrooms. The second major strategy employed by residents to deal with personality clashes and difficult behaviours involved residents engaging in direct confrontation. Often these interactions were pitched at a very personal level with Critical Comments or Hostility being directed at the perpetrator.

> In an attempt to avoid this constant questioning I try to engage Jane (resident) in conversation. ...We sit and chat for several minutes. This appears to have the effect of drawing Paul's (resident) attention to Jane. He asks her how she is and

then what she has been doing today. Again his tone is insistent. At first Jane's replies are civil. However, as Paul begins to repeat the same questions she becomes increasingly annoyed. He asks her if she was at the station today and she tells him to mind his own business. Paul asks her again and she shouts at him that she wasn't there. Paul then starts to ask her about his medication and whether she knows that he is going home for two weeks over Christmas. She starts to deal with this by talking across him saying, 'yes, OK, yes son, yes OK, yes' and continues with this loudly until he stops. She then turns to me and says, 'can't you come up with a cure for him? he is driving me mad.' I smile but don't reply.
(Several minutes later)

    Paul (resident) again turns his attention to Jane (resident). She looks at me and says 'here we go again'. She answers Paul's first two questions civilly and then starts to get annoyed. She tries again with the 'OK. yes son, OK yes, yes' which cuts across the questions. Paul is not put off and as soon as she stops he starts again. Jane then starts to shout at Paul, 'God you're driving me to my f... grave and I don't want to go there yet.' She repeats this sentence at shouting pitch three times. She is shaking with anger. Paul apologises and then starts on me. Jane cuts in and tells him to shut up (B1 12/15).

Residents in the second Beta house theoretically had responsibility for personal laundry, keeping their own rooms clean and changing their bedding. Three of the five residents in Beta Two had single rooms and two shared a twin bedded room. Within the second Beta house no examples of high E.E. interactions were observed in connection with daily living tasks either between residents or between residents and the Assistant Cook. In reality the Assistant Cook had become involved in these areas of domestic responsibility and reduced the burden upon residents. In relation to the cleaning of bedrooms she had taken it upon herself occasionally to check the rooms and then clean them when she felt that it was necessary. Similarly in relation to personal laundry the Assistant Cook helped the residents use the machine and often hung the clothes on the line when clean. Although residents clearly knew about these Assistant Cook interventions they were unspoken agreements.

    I return to talking to Jeanie (cook) as she prepares lunch. I tell her that I have been invited into several of the residents' rooms and that they are always clean and tidy but I have never seen residents cleaning them. Jeanie replies that she has

to admit that she keeps an eye the rooms and when she feels that they are getting too bad she has a quick polish round. She continues by saying that she doesn't tell the residents this so that they try to keep them clean (B1 6/15).

In return for the Assistant Cook's 'extra help' with domestic responsibilities residents in the second Beta house made a significant effort to keep the communal parts of the house clean and tidy; of all the four research sites Beta Two was by far the cleanest and best kept. Residents were seen to prompt each other concerning household cleanliness via the use of the Assistant Cook's name and the threat of what she might do if the house was untidy. It was common to hear the residents say such things as, 'you'd better tidy that or Jeanie will go mad'. In reality there was no evidence to suggest that the Assistant Cook would have actually 'gone mad' at the residents. She herself claimed to have only spoken to the residents on one occasion concerning the condition of the house. Importantly however the use of the cook's name appeared to provide the men with a way to remind each other to keep the house tidy without having to engage in direct confrontation and thus had the secondary effect of keeping down the overall level of E.E.

The House Meals

Alpha houses

As noted in the preceding chapter, it was in theory one of the Alpha conditions of tenancy that tenants attended one communal meal a day, this meal being prepared by tenants with the assistance of house-workers. Within both of the Alpha houses the communal meal was the evening meal and each of the tenants had responsibility for preparation of the meal one day per week. In reality there were important differences between the ways that the meals were organised within the two houses and in turn the level of E.E. associated with these communal events.

In the first Alpha house tenants were genuinely expected to attend the evening meal and an absence from no more than one, or possibly two, meals per week was all that was acceptable. By contrast, in the second Alpha house workers had relaxed the expectations surrounding attendance at the meal. The result of this relaxing of expectations was that tenants could choose not to attend if they did not feel up to it or if they wished to avoid one of the other tenants. In comparison with the meal in Alpha One, meals in the

second Alpha house were less stressful and very few Critical Comments or displays of Hostility were observed. Those that were observed took the form of quick 'sniper' attacks, which were primarily personal insults rather than serious attempts to change the target's behaviour. Attendance at the communal meals in the second Alpha house varied and it was difficult to predict which tenants would attend which nights. Generally, however, attendance was good with five or six tenants normally present.

As indicated, attendance at meals in the first Alpha house was quite often difficult for certain tenants. The timing of the meal was 5pm sharp and it was important to tenants that this time was adhered to. The strict adherence to the timing of the meal had been accepted by workers and examples of workers becoming panicked if they were late in preparation were observed. Three of the seven tenants in the first Alpha house tended to eat their meals very quickly and then retired to their rooms.

> I then say that the meal often feels like an anti-climax in that people eat it very quickly and then scrape their plates and leave. The worker laughs at this description and says, 'if you think that they eat quickly now you should have been here last year'. She (worker) explains how the meal was then eaten in total silence in less than two minutes, she comments that she thinks it is wonderful that 'folks' now take slightly longer and speak sometimes (A1 8/18).

During part of the research period in the first Alpha house a tenant had to be admitted to a psychiatric hospital. Although a hospital in-patient for several weeks, this tenant on occasions returned to the house for the evening meal. This situation created a significant amount of high E.E. interactions. Critical Comments were observed both from the returning tenant and towards her from co-tenants and one worker. The following field-note extracts offer examples of the type of interactions that were common during this period.

> Christina (tenant) then shouts very aggressively, 'yes and you were aggressive to me and Frances (tenant) as well'. Jim (tenant) replies, quite timidly, that she didn't answer the phone. Again she shouts, 'I didn't hear it OK, I'm that dumb OK, I'm that stupid, I didn't hear it.' There is no response from either John or Gill (workers), ... After a short silence Christina continues shouting, 'you were aggressive to me and Frances (tenant) there was no need for that, you have made

yourself a favourite, well you're not going to be' Jim (tenant) doesn't respond he just sits quietly smoking (A1 7/14).

I sit in the kitchen. Christina (tenant) enters from the sitting room, she is home for the evening meal. Christina (tenant) sits in her usual place, I say hello but get no response. Gill (worker) turns and looks sternly at Christina but says nothing. Christina (tenant) sits watching me, she has a very penetrating stare and I feel uneasy. After a few minutes Kevin (tenant) enters the kitchen. He comments, very pleasantly, 'Hello Christina (tenant) how are you.' She seems to be struggling for a reply, after several seconds she answers, 'Not very well really.' Kevin (tenant) remarks that he is sure she will be better soon. Christina (tenant) then turns to look directly at him and says, 'You're su su.' The conversation continues; 'Sorry Christina?' Christina (tenant), You're 'su su.' Kevin (tenant), 'I'm sorry Christina (tenant) I don't know what that means.' Christina (tenant) now getting quite angry, 'It means bloody, you're an optimist, it's all of your faults, and I'm the one that is being punished.' Gill (worker) intervenes in quite a stern manner, ... 'Stop it Christina (tenant), or you'll.' She stops the sentence, it appears that she was going to say 'or you'll go back to hospital.' Christina (tenant) gets up and goes to leave the kitchen, she hovers for about 30 seconds, clearly not sure whether to leave the room or not. She decides to go back to her seat, as she does Kevin (tenant) turns and leaves (A1 7/21).

During a conversation later the same day the worker involved in the above interaction offered further insight into her perspective.

On the way back I comment to the house-worker that, 'I think that Christina (tenant) feels that folks are trying to get rid of her.' Gill (worker) replies, 'I'm afraid I'm giving her a bit of a hard time. ... If she's going to come down here for tea she can damn well be civil to folks. If she is not going to be she might as well be in hospital. The reason she is in hospital is because she was being so unpleasant (A1 7/21).

As shown above in the typical house days, significant differences were also apparent between the two Alpha houses with regard to the preparation of communal meals. In the first Alpha house the preparation of the meal was normally a focal point of the afternoon and workers used the meal preparation as a time when they could be in one to one contact with tenants. Meals were normally more elaborate than in the second Alpha house and

involved the cooking of fresh foods rather than the heating up of frozen items. Workers made it very clear that there was an expectation that tenants fulfilled this communal aspect of house life. Whilst some of the tenants within the first Alpha house clearly found the preparation of the evening meal enjoyable, and appreciated the one to one contact with the house workers, other tenants found the task very difficult.

> Kevin (tenant) serves up the casserole, and politely gives everyone their plates. He serves one too many and asks if anyone wants it. The extra food is split between Jim and Frances (tenants). Kevin (tenant) then covers his own plate and leaves for his bedroom. It appears that the exertion/stress of cooking has been too much. When I leave at 6pm he has still not reappeared. Nobody comments on him leaving, he is very polite and makes sure that everyone is O.K. first (A1 7/21).

By contrast, in the second Alpha house meal preparations were looked upon by both tenants and workers as a chore to be completed as quickly as possible and with minimal effort. It was also noticeable that tenants in Alpha Two used the flexibility offered to them by the variation of the timing of the meal to reduce the pressures and stresses associated with having responsibility for the preparation of the evening meal. One tenant regularly started to prepare the meal at 12 noon and always cooked a casserole dish, others started to cook after 5pm and always heated frozen pies and oven-chips. In spite of the greater control and flexibility that tenants in the second Alpha house had over the time of the meal and the lowering of the work load brought about by the greater simplicity of the meals, several examples were observed of one tenant not being in the house when it was his turn to cook. This remained an on-going and unresolved issue within the house.

Beta houses

Although the first of the houses in Beta organisation was a geographically separate entity, residents ate their main meals in the communal dining area of the adjacent seventeen bedded intake hostel. This meant that there could be up to twenty-six residents having their meals at the same time. Residents were theoretically supposed to choose their meals, via a menu system, one week in advance, but staff had found this to be impractical and begun to order a selection of meals allowing residents to choose what they would like

to eat when the food arrived.

Unfortunately there was not sufficient seating in the dining area of the intake house for the residents of both houses to eat simultaneously, and thus on occasions, residents were witnessed either eating standing-up or waiting with meals for a seat to become vacant. Personality differences also meant that certain residents were very particular whom they would and would not sit next to. The result of these factors was that meals became a source of considerable stress. Displays of Critical Comments and Hostility were routinely observed during the meal periods. One resident had taken to eating his meals in a staff office due to the difficulties that he had experienced in the dining area, whilst other residents arrived up to one hour before the meals were due so as to ensure that they were first in the queue. All research participants ate quickly and returned to their own house. The following field-note extracts provide valuable insight into residents' perspectives on communal meals within the first Beta house.

> By this time it is 11.50 and John (resident) says that we had better go through to the other house for lunch. He comments that they (the residents) are trying to get the meals brought through to their own house. He says that he finds it very difficult to be in the large dining room next door. He continues by telling me that he tries to eat his meal between collecting it from the kitchen and getting to the table. He says that this is so that he doesn't have to spend too much time in the large group. I ask him how he feels afterwards and he tells me that he goes straight back to his own house and that it takes him a while to calm down (B1 10/20).

> Jean (resident) tells me that she hates the meal times ... I ask her why and she tells me that she finds the rush really difficult. I ask gentle probing questions to try to understand exactly what it is that is the problem. She tells me that she likes to be at the front of the queue because otherwise she has to stand for too long and her legs get very sore. She then adds that when she is at the front of the queue the people behind get impatient and start to push. She continues by telling me that she also feels that they are all watching her and that it makes her really 'anxious' and 'up-tight' (her words). She says that she realises afterwards that the people are only waiting for their own meals and are interested to know what is for the meal but that this doesn't help with her feelings at the time. She says that she was so worked up today that she felt that she was going to pass out. She adds that she

sometimes also experiences feelings of aggression but that she manages to control these (B1 12/1).

In comparison with all the other research houses the second Beta house provided the site with the lowest level of E.E. related to communal meals. In theory residents of Beta Two should have been responsible for the preparation of their own breakfasts, the serving up of lunch, the cooking of the evening meal and the washing-up after lunch and the evening meal. In theory the Assistant Cook was only responsible for the cooking of lunch and the ordering of provisions. In reality, however, the Assistant Cook had become involved in making breakfast (occasionally serving it to residents in their beds), serving the lunches and greatly aiding the preparation for the evening meal. It was normal, in relation to the evening meal, for the Assistant Cook to leave sandwiches or food prepared in saucepans that only needed to be heated. The following field-note quotation provides insight into a typical lunch time within the second Beta house.

> Jeanie (Assistant Cook) shouts through that she is serving up and the men come through and take their places. Everyone has their own places and their own mugs. Jeanie brings through the soup and they all start to eat. As the residents chat, Jeanie asks Gerry (resident) what he has done this morning, he tells her that they (O.T. group) went to play snooker but that he didn't quite get round to it and had a pint in the bar. There are several jokes about that being the life. The atmosphere at the table is very relaxed with everyone chatting... Jeanie serves them all with their food, and collects the dishes between courses (B2 6/1).

Despite the Assistant Cook's interventions into the preparation of the evening meal this remained the only area of life within Beta Two that occasionally generated inter-resident Critical Comments. These exchanges were however spasmodic and not a regular feature of house life. The Critical Comments that were observed referred either to the timing of the meal (one resident was insistent that the meal was always at exactly 5pm), or the distribution of cooking and washing-up duties. On most occasions residents were able to resolve these issues amongst themselves, but where this did not prove possible the group resorted to the creation of house-myths to excuse and justify residents' non-participation. (The use of house-myths within the second Beta house will be explored further in Chapter Six.)

House and community meetings

<u>Alpha houses</u>

House meetings took place fortnightly within both the Alpha research sites. Whilst there were significant similarities between meetings in the two Alpha houses there were also important differences. Critical Comments were found within both sets of house meetings; in Alpha Two Critical Comments were exclusively between tenants, in Alpha One Critical Comments existed both between tenants and between one worker and tenants. The two field-notes presented below offer examples of Critical Comments within house meetings in the Alpha houses, (One and Two respectively). The exchanges are characteristic of the interaction patterns associated with high E.E. families as described by Leff and Vaughn (1985). In both cases the comments are pitched at the personal level even though the first interaction refers to a person suffering from a bronchial complaint for which he was receiving medication.

> At this point Gill (worker) asks if anyone else wants to raise anything. She looks at Kevin (tenant), who doesn't say anything. All through the meeting he has been looking quite uncomfortable. ... Gill (worker) continues after a short silence, 'I might be stepping on someone's toes here, but, Kevin (tenant) and Frances (tenants) have mentioned Simon's (tenant) coughing at the dinner table.' Kevin (tenant) takes the prompt and says 'ouu I can't handle it, it's disgusting, it puts me off.' Gill (worker) addresses Simon in an authoritarian tone, 'I know that we spoke about this a couple of days ago and you have tried to stop doing it, but will you please continue to do so, it is very off-putting.' Simon, looking at the floor, comments, 'I have made an effort.' (A1 7/12).

> Eddy (tenant) returns at 4.45pm and joins the meeting. He sits silently. Colin (worker) asks if anyone else has anything to raise, Eddy (tenant) comments that he needs new glasses. There then follows a discussion as to the price of the eye test, the exemptions and the price of glasses. Bessy (tenant) says that she brought two pairs and that they cost her £8.40. Eddy looks at her and says, 'yes they look like they only cost that as well.' This is said quite viciously but he quickly follows it up with, 'I'm only joking Bessy.' Bessy looks both annoyed and upset, but does not respond. The meeting continues. (A2 3/6).

Important differences were found in the patterns and content of the Critical Comments associated with the house meetings in the two Alpha houses; the above quotations serve as representative illustrations. In the second Alpha house Critical Comments tended to take the form of 'sniper attacks' from one tenant to another with workers never involved. The majority of these comments were not aimed at effecting a change in the target's behaviours but were rather merely personal insults or slights. As the field-work progressed it became apparent that these Critical Comments related to underlying disagreements that tenants were not openly prepared to discuss and attempt to resolve. Centrally these disagreements related to the distribution and completion of communal tasks, and more specifically, the collection of shopping and cleaning of the house. (The reasons behind the tenants' wishes to avoid open discussion of these issues related to the history of the house and will be discussed in Chapter Six). By contrast the Critical Comments that were observed in the first Alpha house were normally designed to effect some change in the other's behaviour; there was thus more to these exchanges than mere personal insults.

It was noted within the preceding chapter that theoretically it was an Alpha condition of tenancy that all house members attended the fortnightly house meeting. Workers in the first Alpha house were rigorous in their insistence that tenants attend house meetings. By contrast, workers in the second Alpha house had reduced the expectation and compulsion to attend house meeting had been removed. Within the second Alpha house attendance at the house meetings fluctuated. One or two tenants were however missing from all meetings and one meeting was cancelled due to the small number of tenants present. The removal of compulsion to attend the house meetings also created a situation where Alpha Two tenants could further avoid difficult house issues, or certain individuals, and thus refrain from addressing the causes of tension within the house.

> Colin (worker) continues by saying that within the house there are times when there are only three or four tenants at the house meeting. I ask what happens in these situations and he tells me that it is difficult because the group cannot really take any decisions with so many people missing. ... Colin then tells me that the real problem is when someone doesn't attend the house meeting because they are trying to avoid someone or a particular issue (A2 3/16).

Whilst workers in both Alpha houses agreed that it was preferable that tenants spoke directly to one another when there was a dispute, the workers in the first Alpha house were more rigorous in their attempts to initiate such interactions. Alpha One workers also genuinely expected tenants to take an active part in discussions concerning the way that the house was run. Within the first Alpha house there were occasions when workers expressed feelings of frustration and/or annoyance with tenants who were reluctant to take part in discussions that affected the running of the house. This was not something that was observed in the second Alpha house. The following quotation provides an example of an Alpha One worker becoming frustrated with the tenant group's refusal to discuss a proposed change in household budgeting.

> There is silence for about 15 seconds, then Gill (worker) begins to speak. She says that it must be really frustrating for people to get up in the morning and then find that there is no bread or eggs. She says that instead of having to wait until the worker comes in and then ask us if they have remembered, it would be better if folks could get their own daily provisions. Again there is silence for several seconds and then Christina (tenant) says that nobody would go and get the shopping. Gill (worker) looks annoyed and says, 'well in that case perhaps I should stop getting it as well, I'm not mummy who brings in the shopping for you.' Again there is an awkward silence and then Betty (worker) speaks, asking if anyone minds if they give the new budgeting method a try. Again nobody speaks, the tenants just sit smoking and looking straight ahead. Gill (worker) again quite irately says, 'well does the silence mean that everyone does mind or that everyone doesn't mind'. Again there is no reply, Gill (worker) looks across at me and then looks up in the air to signify her frustration. John (worker) again reiterates that he thinks that it would give folks more control over their money. Betty (worker) then says that they will give it a try unless anyone objects and that if it doesn't work they can always discuss it at another meeting. (A1 8/18).

In the first Alpha house tenants were held accountable to the house group, through the forum of the house meeting, even when displaying quite clear signs of mental ill-health. The clearest example of these processes related to a tenant who was eventually asked, by other tenants, to leave the house due to her behaviour.

John (worker) tells me that there have always been problems ever since Sarah (tenant) moved into the house, about a year ago. ... He explains how she left of her own free will just before Christmas ... then decided that she would come back. John (worker) continues, 'Folks said no at that time and she went into hospital as a respite patient. Eventually it was agreed that she could come back under certain conditions and she made an agreement with tenants to stop drinking, attend the house meetings, and generally take part in house life.' He explains that since she came back things haven't really changed, although he notes that she did improve for a short while. He continues by telling me that 'folks' started saying to workers that Sarah was causing problems, being very difficult, shouting at them, etc. John continues, 'We (house-workers) tried to get folks to say these things to Sarah herself in an attempt to make her join in more. For a long time they couldn't do that, either because of themselves or because she (Sarah) didn't attend house meetings. Eventually they did. As is the way at Alpha it was the tenants' decision that she should leave not ours' (A1 7/14).

At the time that this particular tenant was held accountable to the tenant group she was displaying quite clear signs of mental ill-health. The field-note extract below refers to a return visit that she made days after being asked to leave the house. The extract offers examples of her responding to auditory and possibly visual hallucinations and expressing feelings of paranoia.

Sarah (ex-tenant) enters the kitchen and asks John (worker) if it is all right if she has a cup of tea. He (worker) uses one of his most common phrases 'you'd better ask the others, it's not my house'. She asks Jim (tenant) who says, 'yes sure'. Sarah sits down but before doing so goes through a strange process of lifting her skirt then pulling it down again. I observe this process three time before I leave, every time she stands up she repeats the process before sitting down again. Nobody comments.

...she (ex-tenant) then turns to John (worker) and shouts 'John my things are being stolen in that place (the hostel where she is staying at present). John my dressing gown has gone, so have some of my clothes'. John is in the larder, I am not sure if he replies. As he comes out she repeats the statement in a raised voice. This time she adds, 'They follow me everywhere, watching me. They followed me to the post office today, you can't watch everyone can you? (7/14).

In addition to actual displays of inter-tenant or tenant/worker Critical Comments and/or displays of Hostility, the meetings within both Alpha houses were often characterised by tenants displaying behaviours characteristic of feelings of tension and stress. The following examples are illustrative of the extreme difficulty that the fortnightly house meeting created for some tenants.

> Danny (tenant) does not take a seat and wanders around the room (three times). He is smoking and looking very anxious. He does not speak at first. Colin (worker) recaps on the beginning of the meeting and says that he would like to know what Danny (tenant) feels about Bob (prospective new tenant) moving in. Danny (tenant) replies speaking quickly, saying that he doesn't know and he isn't sure. He then comments that he can't speak for all the tenants. Colin (worker) explains that he is not asking him to do that and that he just wants to know what he feels about Bob coming to live with them. Colin (worker) states that he doesn't know Bob at all. Danny (tenant) moves around the room and takes a seat next to Colin. He says, 'well all I know is that he keeps coming to me with all his problems and that I cannae handle that.' At this point Danny (tenant) looks directly at me and says, 'I didn't know that Steve was going to be at the meeting, I don't want that, I don't want that.' Colin says that this was something that they spoke about at the last meeting (Danny wasn't present), and that I had asked then if anyone minded. ... I join in at this point saying that if Danny (tenant) would prefer it I will leave. Danny (tenant) is clearly tense, he looks at the floor and says, 'ahy, please Steve, if you don't mind' I stand up to leave (A2 3/30).

> Christina (tenant) makes the tea and we all assemble in the sitting-room. Dianna (tenant) is late as she is getting ready to go out, but she isn't last. Kevin (tenant) comes up last and the meeting is held up until he appears. ... When Kevin (tenant) does make his entrance he looks very anxious and has clearly been running his hands through his hair. Betty (worker) offers him a seat but he declines saying that he wants to stand. His answer is quite emphatic and leaves no room for Betty (worker) to continue the conversation. Frances (tenant) again sits in the corner on a bean bag, this time she is half hidden by Gill (worker) who sits in front on a small stool ...
> (At the end of the meeting) Gill (worker) asks whether anyone else has anything to raise. As Gill (worker) begins to say this last sentence Kevin (tenant) turns for the door, when he is half way towards it he says, 'is that it then?' He is at the

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door when the reply returns and leaves. He did not sit throughout the meeting and looked very uncomfortable. Frances follows after him and Jim also leaves (tenants) (A1 8/18).

Beta houses

In contrast to the house meetings observed within Alpha organisation the weekly community meetings of Beta One were low key affairs with very low levels of stress and tension. This finding is somewhat surprising in light of the view of community meetings presented within Beta organisation's internal literature. As will be recalled, Beta organisation's literature suggested that community meetings should be regarded as therapeutic events, which provided a forum for discussing ward issues and group decision making. Beta's organisational literature anticipated that inter-resident tensions were likely to be raised within community meetings and suggested that staff be very careful how they dealt with such disputes.

> Issues of any kind can be raised and discussed. However, staff must be sensitive to personal issues that may arise and deal with them appropriately so as to protect individuals from maybe being scape-goated (Beta organisational document).

The reality of the observed community meetings in Beta organisation was quite different to that envisaged in the organisation's literature. Firstly, only one member of staff attended the meetings and the proposed briefing and debriefing before and after the meetings did not happen. No examples of Critical Comments or displays of Hostility were observed within these meetings, either between residents or staff and residents. Attendance at the meetings was not compulsory and it was not uncommon for two or three of the nine residents not to attend; one resident never attended a community meeting during the entire observation period. Whilst staff informed residents that the meetings were about to commence they did not put any pressure upon residents to attend; on average community meetings only lasted between ten and fifteen minutes. In reality the meetings had become merely a forum for staff and residents to exchange practical information, with the same safe issues being raised week after week. The first field-note quotation below offers an example of one such meeting, whilst the second field-note gives insight into one staff nurse's perception of the Beta community meetings.

We all go into the lounge. Ken, Jean and Paul (residents) are already there, Eddy (resident) joins about three minutes into the meeting. Sarah (nurse) turns off the T.V. opens the minutes book and says that she doesn't really have much to discuss tonight, in fact only one thing. She then says that that concerns tying up the laundry tonight for the collection tomorrow. She suggests that Eddy (resident) do it and he agrees. She then asks if anyone has anything to say. John (resident) says that he doesn't like the bread that they are getting. Sarah (nurse) writes it in the book. He then asks if there is any milk for them next door. Sarah tells him that there is none left. John (resident) asks what they are going to do for tea tonight. Sarah replies that there is nothing that she can do. ...

John (resident) then asks if it would be possible to get more biscuits and milk on the weekly allowance. Sarah (nurse) tells him that it is not and that there is someone high up in the Health Board who decides on the individual allowances of such things. She comments that she thinks that it is four fifths of a pint of milk per day per person. Ken (resident) remarks that that is pathetic. ... John (resident) also asks when they are to receive the money to buy some pictures for the house. Sarah (nurse) tells him that the charge nurse is dealing with that and she thinks that he is waiting to hear from a charity. The meetings is longer than most and lasts 20 minutes (B1 12/1).

At this point Sarah (staff nurse) says that we had better go through to the community meeting. Jeremy (a new student) asks what this is about. Sarah looks at me and says, 'you have been to some, there is nothing very scintillating is there? She then continues by reciting the questions that she thinks will come up, 'they (the residents) will say that there isn't enough milk, the light bulb has gone out on the upstairs landing, when can the meals be delivered directly to the house, things like that'(B1 12/1).

SUMMARY AND CONCLUSION

To summarise, this chapter commenced with a presentation of typical days in the life of the four research houses. These days were based upon paraphrased composite field-notes taken from the entire research period. Following this a comparative analytic description of the four research houses was undertaken along the themes of domestic daily living tasks, communal

meals, and community and house meetings. The analysis reveals that significant Critical Comments and occasional displays of Hostility were present in three of the four research houses (i.e. Alpha One and Two, and Beta One). The Critical Comments that were observed were not however uniform across sites and differed in the important respects of overall volumes of Critical Comments, the content of the Critical Comments and/or the social situations that precipitated such exchanges. The second Beta house provided the only house with negligible levels of Critical Comments and no displays of Hostility.

Within the methodology sections (Chapter Two) of this thesis it was argued that the information available at the point of access suggested that Beta organisation was likely to have a higher level of E.E. than Alpha organisation. This view was reinforced by the review of the organisations' literature conducted in Chapter Three. It appeared that the role of Beta organisation in rehabilitating residents and preparing them for life in less supported accommodation was likely to lead to high E.E. interactions, as staff attempted to teach residents new or forgotten social skills and residents struggled to meet new challenges. This view was further supported by the fact that Beta organisation claimed to use an assessment scale developed by the behaviourists Hall and Baker, indicating that staff care plans and interventions were likely to be behaviourist, utilising positive and negative reinforcement. By contrast, Alpha organisation was seen as likely to be low in E.E., due to the organisation's ideological stress that workers should not engage in treatment or attempts to change people's behaviours but rather help to create a secure and permanent home for people who cannot maintain a tenancy independently.

The data presented in this chapter offers a radically different picture from the provisional thoughts and hunches outlined in Chapters Two and Three. The qualitative data reveals that the first Alpha house had the highest level of Critical Comments and displays of Hostility and these were found both between tenants and between one staff member and tenants. The Critical Comments that were observed were pitched at a personal level and people were held accountable for their actions to the house group, even when the behaviour in question appeared quite clearly to stem from mental ill-health. Both staff and tenants used attributions concerning the causes of each others actions to willed and controlled behaviour rather then to mental ill-health. The Critical Comments observed within the first Alpha house were nearly

always related to attempts to change another person's behaviour and related most often to the communal domestic tasks within the house.

By contrast, a lower overall level of E.E. was observed within the second Alpha house and Critical Comments were solely between tenants. No examples were observed between workers and tenants. The observed patterns of Critical Comments within the second Alpha house also differed from those in Alpha One in that such interactions took the form of quick 'sniper attacks' between tenants. Observed Critical Comments in Alpha One were not primarily concerned with effecting change in the target's behaviour but rather were intended primarily as personal slights or insults. The data reveals that within the second Alpha house there were certain issues, particularly related to communal daily living tasks, that were not openly discussed. Grievances that were not discussed appeared to result in pent up feelings of annoyance which then spilled over into interpersonal Critical Comments, the observed 'sniper attacks'.

Beta organisation was characterised by low levels of staff/resident contact. Within the second of the Beta houses this was as low as one nurse visiting for one hour twice a week. Nursing care plans in the first Beta house were not based on behaviourist principles and nursing interventions tended to focus on the practical tasks of daily living, such as personal hygiene, the tidying of residents' bedrooms, waking and retiring to bed. Staff interventions were carried out in a very low key way, normally consisting simply of verbal prompts to remind residents to carry out an activity. Both of the Beta houses were characterised by quite clear routines and residents fulfilled the minimal requirements made upon them without significant staff intervention; hardly any high E.E. interactions were observed in relation to the implementation of resident care plans. In reality both of the Beta houses had moved considerably from the original organisational goal of providing a rehabilitation service aimed at resettlement. The houses were looked upon by staff and residents as 'home', at least for the majority of residents, for the medium term.

The minimal level of nurse contact with residents of Beta One led to a situation whereby residents had to resolve any interpersonal difficulties or personality clashes within the group. Residents were on the whole quite tolerant of one another and primarily used illness attributions when seeking to explain unwanted or difficult behaviours. However, notable levels of high E.E. interactions were observed in relation to personality clashes and anti-

social behaviours. Some residents attempted to avoid confrontation and retired to their rooms but other residents were prepared to confront one another when there were personality clashes or behaviours that they found difficult.

The second Beta house provided the research site with the lowest level of E.E.: very few Critical Comments were recorded between residents and none between the main carer, the Assistant Cook, and residents. The Assistant Cook had become involved in many areas of house life over and above the mandates laid upon her by her official job description. On a practical level the cook's interventions removed some of the demands and pressures associated with daily living from the men, i.e. the preparation of meals, the cleaning of the kitchen and their bedrooms. She provided the men with a listening ear and historically had helped residents to resolve disputes within the house. The Assistant Cook was also genuinely able to accept the residents as they were and did not become involved in attempts to change their behaviours. She appeared to be aided in her acceptance of the residents' levels of social and psychological functioning by her role as cook.

In addition to the observed levels of E.E. within the research houses the qualitative data reveals that certain tenants and residents found significant difficulty in certain communal situations and displayed behaviours characteristic of anxiety and stress. The communal activities and social situations that created difficulty were not however the same across the sites. Thus whilst the house meetings were seen to cause difficulty for some tenants in both Alpha houses this was not true of the community meetings in Beta One. Within the house meetings in both Alpha sites examples were seen of some tenants becoming very anxious and tense both prior to and during the meetings and leaving immediately the opportunity arose.

The communal meals were seen to be very difficult for residents of Beta One and Alpha One, marginally less difficult for tenants in the second Alpha house and were actually enjoyed by residents in Beta Two. As noted above, in the first Beta house some residents arrived up to an hour before the meal and paced back and forth in anticipation. Another resident had taken to eating his meals in the staff office, whilst a third attempted to eat his meal between collecting it from the kitchen and arriving at the table (a walk of approximately fifteen metres).

The fact that the levels and displays of anxiety and stress associated with the meals and community meetings differed across the sites is suggestive that

there was more to the causes of these stresses than merely being in close geographical contact with co-residents or co-tenants. Rather it appears that the levels of stress and anxiety associated with communal activities were related to the meanings that the events had for the social actors. Thus for example, the removal of compulsion to attend the communal meal in the second Alpha house appeared to have reduced the associated pressures for most tenants. The role of the meaning of communal events for residents/tenants and workers and its relationship to the level of stress or anxiety is something that will be discussed in detail in Chapters Six and Seven.

As has been noted previously, this thesis is primarily concerned with observation and analysis of care processes and the organisational features which lead to high E.E. care environments. The research project was not designed to be a reliable outcome study, which could measure resident/tenant improvement or deterioration over a specific time period. Any attempt to use the data gathered by this project to reach conclusions concerning client outcome is, in particular, hindered by the lack of independent resident/tenant diagnoses at the commencement and termination of the study. Having noted these problems however it does appear beneficial at this point to offer evidence concerning tenant/resident turnover for the four research houses; that is to report the number of tenants leaving the houses during the ten week observation periods and the reasons for these moves. The conclusions reached from this data must be treated with caution but are suggestive of a link between the emotional levels within the houses (levels of E.E.) and resident/tenant mental health prognosis.

During the research period within the first Alpha site, two of the tenants' mental health was seen to deteriorate to the point whereby they had to leave the house. One resident was asked to leave the house permanently due to her 'behaviour', whilst a second tenant was admitted to a psychiatric hospital for a period of several weeks. (The resident asked to leave the house due to her 'behaviour' was admitted to a psychiatric hospital within a month of leaving the organisation.) In the second Alpha site one tenant left of his own accord to live in a different geographical location in another Alpha organisation house. This particular tenant regarded the move as positive and as his returning to his home area.

In the first Beta house one resident took the decision to refer himself to an acute admissions ward of the hospital. This decision was supported by the

charge nurse and he remained in the acute care ward for nearly two months, he then returned to the rehabilitation houses. The resident group in the second Beta house remained stable throughout the entire research period.

CHAPTER FIVE

The profile of the four research houses provided by the Sheltered Care Environment Scale

INTRODUCTION

In Chapters One and Two it was argued that within this thesis, the use of the Sheltered Care Environment Scale (S.C.E.S.) would serve two central purposes (Moos and Lemke, 1988). Firstly, the S.C.E.S. was seen to provide a means of triangulation with the data gathered through participant observation and the review of the research organisations' internal literatures. Secondly, the Conflict and Self Exploration sub-scales of the S.C.E.S. were thought to bear a theoretical relationship to E.E. It was felt that the S.C.E.S. might provide a shorthand method of measuring E.E. that overcame some of the problems inherent in the use of the Camberwell Family Interview (C.F.I.). As was argued in Chapter One, the C.F.I. suffers from being capable of only measuring one relationship at a time, normally that between the key worker and client; accordingly it does not measure the complex overall level of emotional expressions that the resident is subjected to within a collective care environment.

This chapter presents the house profiles provided by the S.C.E.S. In general the S.C.E.S. results provide support for the qualitative data findings; however, during the use of the questionnaire certain theoretical problems were encountered which mean that the S.C.E.S. results must be treated with a significant degree of caution. Firstly, certain of the S.C.E.S. questions for the sub-scales of Self Exploration, Independence, and Organisation, were found to carry different normative connotations within the two research organisations. Secondly, many of the questions used within the S.C.E.S. implicitly involve the respondent comparing his/her present situation to past experiences. Respondents within this study, staff and residents/tenants, did not all share identical previous care backgrounds. Taken together these theoretical difficulties cast doubts over the reliability and validity of undertaking inter-site and inter-organisational comparisons using the S.C.E.S. data. In the light of the problems encountered, this

chapter is presented in a way that allows for both the display of the house S.C.E.S. profiles, and elaboration and discussion of the central theoretical difficulties.

The chapter begins with a brief re-statement and discussion of the S.C.E.S. dimensions; information on staff and resident/tenant questionnaire completion rates is provided. There then follows a comparison of the staff and residents'/tenants' S.C.E.S. scores for the sub-scales of Conflict and Self Exploration. The Conflict and Self Exploration scores are discussed in relation to the observed levels of E.E. in the four research houses. In the final section of the chapter a more general analysis of the S.C.E.S. data is undertaken along the three dimensions advocated by Moos and his colleagues (i.e. Relationships, Personal Growth, and System Maintenance and Change). Information on the completion procedures used in relation to the S.C.E.S. can be found in Chapter Two and will accordingly not be repeated here.

At the outset of this chapter, it should be noted that the term 'staff', when used in relation to Beta Two, refers solely to the Assistant Cook. The nursing staff were not asked to complete S.C.E.S. questionnaires for the second Beta house, due to their very low levels of contact with residents.

THE SHELTERED CARE ENVIRONMENT SCALE

Over the past twenty years, Moos et al. have developed several structured questionnaires that attempt to characterise certain types of care environments along various empirically derived dimensions, (see for example, the Ward Atmosphere Scale and Community Oriented Programme Evaluation Scale, Moos 1974). Moos and colleagues' social ecological approach rests upon the assumption that care environments have unique 'personalities' that regulate the behaviours of the social actors therein, through a process of 'environmental press'. Moos suggests that it is possible to arrive at a profile of care environments that can be used for comparative purposes, through asking participants their perceptions of the care setting. As Moos recognises,

> ...these individual perceptions result from the interplay of actual events and qualities of the setting, the individual's role within the system, and the individual's personal values and beliefs (Lemke & Moos 1990 p. 569).

The S.C.E.S., as part of the wider Multiphasic Environmental Assessment Process (MEAP, Moos and Lemke, 1988), represents the latest development in Moos and his colleagues' work.[1] The 63-item forced-choice S.C.E.S. questionnaire attempts to characterise sheltered care environments along three central dimensions. These dimensions are; *Relationships* made up of the sub-scales of Cohesion and Conflict; *Personal Growth* consisting of Independence and Self Exploration; and *System Maintenance and Change* made up of Organisation, Resident Influence and Physical Comfort. Moos defines the sub-scales of the S.C.E.S. as follows.

Relationship Dimensions.
1. Cohesion -measures how helpful and supportive staff members are toward residents and how involved and supportive residents are with each other.
(Do residents get a lot of individual attention?)
2. Conflict -Measures the extent to which residents express their anger and are critical of the facility.
(Do residents ever start arguments?)

Personal Growth Dimensions.
3. Independence -assesses how self-sufficient residents are encouraged to be in their personal affairs and how much responsibility and self direction they are encouraged to exercise.
(Are personal problems openly talked about?)
4. Self- Exploration -measures the extent to which the residents are encouraged to openly express their feelings and concerns.
(Are personal problems openly talked about?)

System Maintenance and Change Dimensions.
5. Organisation -assesses how important order and organisation are in the facility, the extent to which the residents know what to expect in their day-to-day routine, and the clarity of the rules and procedures.
(Are activities for the residents carefully planned?)

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[1]The complete MEAP consists of four research tools; the Physical and Architectural Features Check-list (PAF), the Policy and Program Information Form (POLIF), the Resident and Staff Information Form (RESIF) and the Sheltered Care Environment Scale (SCES). Moos suggests that these tools can be used either in combination or independently. Originally the MEAP was developed in relation to sheltered care environments for the elderly. However, Moos argues that the scales are also applicable to other client groups including those involved within this study (see Moos 1988 p.68 and Forrest 1992).

6. Resident Influence -measures the extent to which the residents can influence the rules and policies of the facility and the degree to which the staff directs the resident through regulations.
(Are suggestions made by the residents acted upon?)
7. Physical Comfort -taps the extent to which comfort, privacy and pleasant decor, and sensory satisfaction are provided by the physical environment.
(Can residents have privacy whenever they want?)
(Reproduced from Moos & Lemke 1988 p.48.)

Drawing upon his normative data (N= 1911, 1085 residents and 826 staff from across many care facilities), Moos argues that the seven sub-scales of the S.C.E.S are relatively independent of one another. As he writes;

The sub-scales' intercorrelations are moderate for residents (three of the correlations are between .50 and .60) and roughly similar for staff (four of the intercorrelations are above .50). In general, Cohesion, Independence, Organization, and Physical Comfort are positively interrrelated, whereas Conflict shows negative correlations with these dimensions. The average sub-scale correlations (r=.28 for residents and r=.26 for staff) are moderate and indicate that the SCES dimensions tap somewhat separate but interrelated aspects of the social climate of a facility (Moos & Lemke 1988 p 55).

Three parallel versions of the S.C.E.S. questionnaire are provided and Moos suggests that these forms can be used either separately or in conjunction with one another. The first version of the S.C.E.S. is the Real Form and asks residents and staff to rate how they see the current care environment; the second is the Ideal Form, which asks people how they conceive of an ideal care environment; the third is the Expectations Form, which asks prospective clients or staff what they think the care environment will be like. In this study only the Real Form was used, primarily due to concern that too high a set of demands upon participants (the completion of two or three 63 item questionnaires) would lead to unacceptable stresses upon respondents and ultimately low completion rates. The fact that two residents within Beta One were not able to complete one form tends to support this view. On a theoretical level the use of the Real Form on its own caused some problems; it is believed that some respondents were unable to

keep a clear distinction between the way their house was and the way they thought it should be.

STAFF AND TENANTS'/RESIDENTS' S.C.E.S. COMPLETION RATES

The S.C.E.S. completion rates are presented in Table 5.1 (below); a generally high response rate was achieved (Alpha One, staff 66%, tenants 85.7%; Alpha Two, staff 100%, tenants 100%; Beta One, staff 66%, residents 83.3%; Beta Two, staff 100%, residents 80%). In the first Alpha house, one tenant and one worker joined the house during the latter part of the study. The worker entered the house in the sixth week of the ten week field-work period and declined the opportunity to complete the S.C.E.S. questionnaire. The tenant joined the house during the final two weeks of field-work; his questionnaire was marked with his permission and later excluded from the data presented due to the shortness of his stay in the house. In the first Beta house the resident completion rate of 66% results from three of the nine residents not completing the questionnaire, (one resident was transferred to the acute admissions ward of the hospital just prior to the completion of the scale, two other residents began completion of the questionnaire but asked to stop before the form was half finished: these requests were obviously respected). One staff member in Beta One declined to complete the questionnaire. In the second Beta house one resident answered 'yes' to all questions, this questionnaire was considered 'spoiled' and thus also eliminated from the results.

AN OVERVIEW OF THE S.C.E.S. RESULTS

Table 5.1 also presents the house profiles provided by the S.C.E.S. The S.C.E.S. seven sub-scales are each made up of nine separate questions; there is no overlap between the questions. Individual questions are varied with regard to the scoring direction; thus some questions are scored when answered 'yes' others when answered 'no'. Individuals' scores for the nine point scales are converted to percentage scores and a mean score obtained for the group of respondents, (i.e. staff or residents/tenants).

The mean scores in Table 5.1 refer to the means for each group of participants; that is, they are calculated by combining the percentage scores for participants in a particular group (staff, residents or tenants), and then

dividing by the number of respondents. The mean scores are therefore the means for the staff, or tenant/resident groups within a particular site. The standard deviation figures relate to the dispersion of scores within the staff, tenant/resident groups. Standard deviation figures for Beta Two are not provided as there was in effect only one member of staff (the Assistant Cook). As is apparent, the standard deviations are on the whole quite large; this factor combined with the small number of sites and participants means that the differences across sites, and between tenants'/residents' and staff scores, are not statistically significant.

Within the S.C.E.S. manual Moos et al. provide normative data relating to staff and residents' scores for 323 care settings catering for elderly clients in North America (127 Nursing Homes, 55 Residential Care Facilities, 62 Apartments, 36 Nursing Home units, 21 Long-term Care Wards and 22 Domicilaries). Mean scores for staff and residents are provided by the type of facility and the standard deviations between care settings of the same type are given. Thus for example, Moos's normative data reveals that the mean staff score for the Cohesion dimension in Nursing Home Units (n=36) is 60% with a standard deviation of 10. The standard deviations that are provided refer to the distribution of aggregate mean scores for staff or residents groups by the type of care facility. What Moos and his colleagues do not provide is normative data pertaining to the standard deviations for the staff and resident groups within particular sites; that is, the distribution of staff and resident scores within specific homes for each of the seven sub-scales. However, in response to criticisms made by Smith and Whitbourne (1990), concerning the validity of the S.C.E.S., Lemke and Moos point firstly to the various methodological compromises that are involved in the development of any research instrument, and then state;

> we tried to minimize such individual differences and to maximise the consensus among individuals in how they appraise a common environment. In other words, if a facility's social climate exerts some common influence on various participants, then these participants should be able to agree to some extent on how they report it (Lemke & Moos 1990 p 569).

It would appear from Lemke and Moos's comments, that this study's intra-group standard deviations are abnormally high. However as stated, Moos and his colleagues provide no normative data pertaining to the

distribution of scores for the staff or resident groups within specific care settings.

Table 5.1   The Sheltered Care Environment Scale Data.

| | Completion rates | | Relationship Dimension | | | | Personal Growth Dimension | | | | System Maintenance and Change Dimension | | | | | |
| | | | Cohesion | | Conflict | | Independence | | Self Exploration | | Organisation | | Resident Influence | | Physical Comfort | |
	Number	Response	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.	Mean	S.D.
Alpha 1 tenants	6	85.7%	56.8	22.4	49.5	16.6	51.8	25.4	62.3	21.6	62.3	23.7	44.0	12.0	64.2	17.6
Alpha 1 staff	2	66%	66.0	0	77.0	15.5	66.0	0	82.5	7.7	66.0	0	66.5	46.6	44.0	15.5
Alpha 2 tenants	6	100%	66.0	27.8	49.5	15.1	47.6	17.9	53.1	23.5	60.5	24.8	62.3	15.0	64.1	16.1
Alpha 2 staff	3	100%	77.0	19.0	73.3	6.3	62.3	12.7	91.6	6.3	44.0	11.0	66.0	11.0	58.6	12.7
Beta 1 residents	6	66%	47.6	13.3	66.0	18.4	38.5	9.2	42.1	12.8	58.6	17.9	40.3	23.7	58.6	21.6
Beta 1 staff	5	83.3%	48.4	18.4	66.0	15.5	72.6	9.8	85.8	9.2	57.2	21.1	59.4	29.7	33.0	11.0
Beta 2 residents	4	80%	66.0	10.5	24.2	14.2	55.0	10.5	59.4	11.0	79.2	12.7	26.4	10.5	83.6	11.0
Beta 2 staff	1	100%	33.0	-	55.0	-	44.0	-	77.0	-	66.0	-	77.0	-	44.0	-

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STAFF AND TENANTS'/RESIDENTS' SCORES FOR THE S.C.E.S. SUB-SCALES OF 'CONFLICT' AND 'SELF EXPLORATION' AND THE RELATIONSHIP WITH THE OBSERVED LEVELS OF E.E. IN THE FOUR RESEARCH HOUSES

As was noted in Chapter Two, it appears that theoretically the combination of the Conflict and Self Exploration Sub-scales of the S.C.E.S. may provide a short hand measure of the level of E.E. in a collective care environment. Moos argues that the Conflict sub-scale measures the extent to which residents express their anger and are critical of one another, whilst the Self Exploration sub-scale assesses the extent to which residents are encouraged openly to express their anger. Taken together these two sub-scales thus appear potentially to predict the levels of Critical Comments and displays of Hostility in a specific site. This section aims to verify or refute this possibility in relation to the research houses. Histograms 5.1 and 5.2 (below) present a comparison of the staff and tenants'/residents' scores for the two relevant sub-scales. The bracketed ratings of high, moderate or low E.E. refer to the general levels of E.E. in the research houses. These broad categorisations clearly lose certain of the more subtle insights offered by the qualitative data (concerning the differences in the causes and content of high E.E. interactions), and are given solely to facilitate easy comparison between the qualitative assessments of E.E. and the Conflict and Self Exploration sub-scales scores.

Histogram 5.1

Conflict sub-scale: Staff and tenants'/residents' scores compared by site
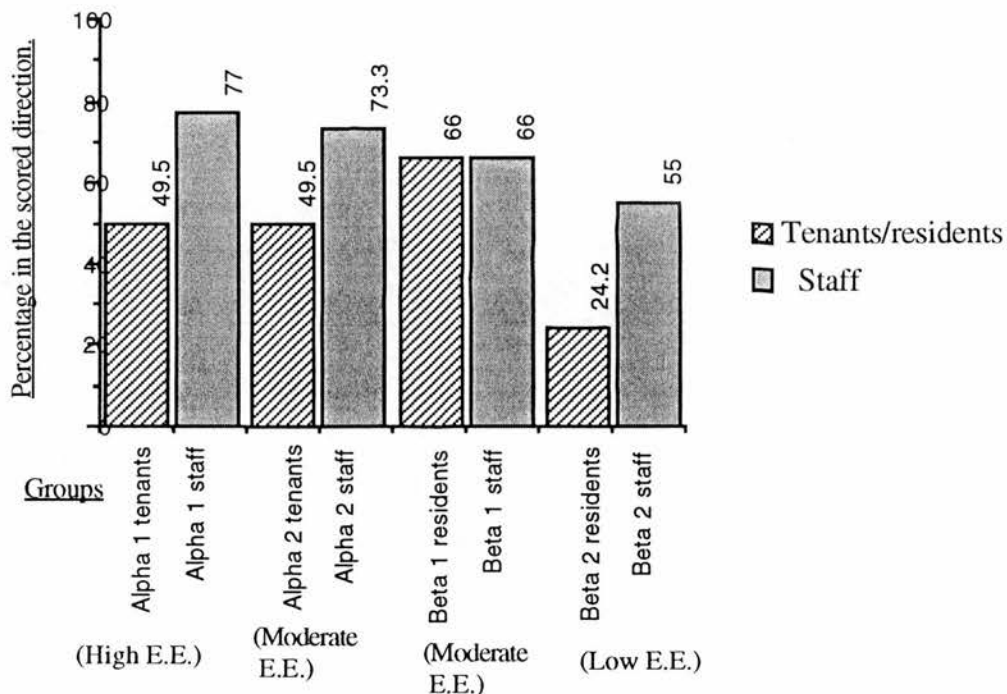
As is apparent from the above histograms, the staff scores for the Conflict sub-scale are broadly in line with the qualitative assessment of E.E., (presented in the preceding chapter). Thus, the Alpha One staff score shows the highest level of Conflict (77%), followed by Alpha Two staff (73.3%), then Beta One staff (66%) and finally Beta Two staff (55%). The residents' and tenants' scores for Conflict do not however relate to the observed overall levels of E.E. Residents of Beta One rated their house as being highest in Conflict at 66%, followed by the two Alpha houses which tenants scored identically at 49.5%, with Beta Two scored lowest at only 24.2%. It is also noticeable that, with the exception of Beta One, there is considerable divergence between the staff and tenants'/residents' scores. The staff in Alpha One, Alpha Two and Beta Two rated the houses as considerably higher in Conflict than did the tenants or residents. As Moos notes it is not uncommon for staff S.C.E.S. scores to differ considerably from those of residents.

> Comparisons of average resident and staff perceptions
> show that staff see considerably more emphasis on Conflict,
> Self-exploration, and Resident Influence and somewhat more

Cohesion and Independence than do residents. Average staff and resident perceptions of Organisation and Physical Comfort are relatively similar. In hospital-based psychiatric programs, staff tend to see the social environment somewhat more positively than do residents, suggesting that those with more authority and responsibility in a setting tend to perceive that setting more positively (Moos & Lemke 1988 p. 51).

When interpreting the relatively high Beta One residents' rating for the Conflict sub-scale there are two important factors which must be borne in mind. Firstly, the Beta One residents' score is based upon a 66% response rate, the lowest for all sites, and has the highest standard deviation for this sub-scale at 18.4. Secondly, the administration of the S.C.E.S. within Beta One took place very shortly after one resident was moved to the acute admissions ward of the hospital. During the build up to this admission, Conflict within the house was higher than at other times during the ten weeks of research. It appears likely that this factor affected the residents' overall rating for the Conflict sub-scale.

On the theoretical level the Beta One residents' score for the Conflict sub-scale points to the important theoretical point that the S.C.E.S. gathers information pertaining to a single point in time. Moos and colleagues acknowledge that of all the research tools contained within the MEAP the S.C.E.S. is the most sensitive to changes in the social environment over time, (see, Moos and Lemke 1988 p. 55). With regard to the measurement of E.E. through the S.C.E.S.'s sub-scales, the sensitivity of the instrument to relatively short lived changes is problematic. The level of Expressed Emotion within a care setting is seen theoretically as an on-going factor which possibly acts as a source of chronic stress upon the patient or resident/tenant. If the scores of the S.C.E.S. are altered by relatively short lived factors then the instrument would not appear to be a reliable measure of the on-going level of E.E. in a collective care setting.

The S.C.E.S. Conflict sub-scale's questions read as follows:

> 2, Do residents ever start arguments?
> 9, Is it unusual for residents to openly express their anger?
> 16, Do residents sometimes criticise or make fun of this place?
> 23, Do residents usually keep their disagreements to themselves?

30, Is it unusual for residents to complain about each other?
37, Is it always peaceful and quiet here?
44, Do residents often get impatient with each other?
51, Do residents complain a lot?
58, Do residents criticise each other a lot?
(Moos & Lemke 1988).

In looking at the questions that make up the Conflict sub-scale it is apparent that the majority of the questions do not provide information on the direction of expressed conflicts; thus questions 16, 23, 30, 44, 51 and 58, do not offer insight into whether residents voiced their anger and criticisms to each other or solely to staff. In Alpha Two it was noticeable that tenants tended to voice their concerns and criticism to staff but not to each other. With regard to the levels of E.E. in the houses the direction of expressed conflicts appears important. Thus, if residents express their anger and criticism solely to staff this would not appear to raise the overall level of E.E. to the same degree as expressions directly between residents.

Moreover, the questions contained in the Conflict sub-scale fail to provide insight into the content and causes of the conflicts. The qualitative data presented in Chapters Four and Six reveals that a central difference between the two Alpha houses was that Critical Comments in Alpha One normally pertained to a tenant's or worker's attempt to change an individual's behaviour, while Critical Comments in Alpha Two were normally merely personal insults which arose because tenants were deliberately avoiding certain difficult issues. The Conflict sub-scale's inability to determine the direction and cause of conflicts appears likely to account for the identical tenants' scores for Alpha One and Two. This theoretical problem significantly limits the usefulness of the Conflict sub-scale as a short-hand measure of E.E.

Histogram 5.2

Self Exploration: staff and tenants'/residents' scores compared by site.
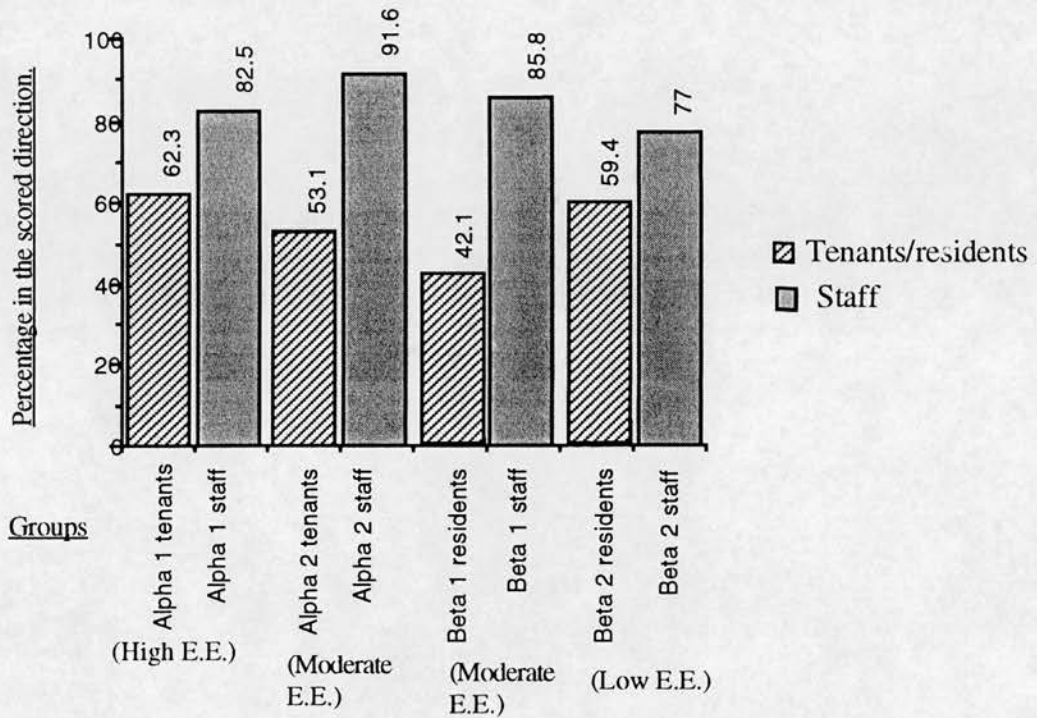
The staff scores for the sub-scale of Self Exploration do not bear a positive relationship to the qualitative evaluation of the levels of E.E. in the research houses. The staff of Alpha Two rated their house as highest in Self Exploration (91.6%), followed by Beta Two at 85.6%, Alpha One at 82.5% and finally Beta Two at 77%. By contrast, the tenants' and residents' scores for Self Exploration are more closely related to the observed levels of E.E. in the four houses (Alpha One-62.3%, Alpha Two-53.1%, Beta One-42.1%, Beta Two-59.4%). The anomaly within the residents'/tenants' profiles is the score for Beta Two; here the residents' rating of 53.1% is higher than both Alpha Two and Beta One. Once again it is striking that the staff in all sites scored the houses considerably higher than residents or tenants. These differences are particularly striking for Alpha Two and Beta Two (Alpha Two staff 91.6, Alpha Two tenants 53.1; Beta One staff 85.8, Beta One residents 42.1).

In attempting to understand these results it is again necessary to look closely at the questions asked on the Self Exploration sub-scale.; the nine questions read as follows.

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6. Are staff strict about the rules?
13. Are new and different ideas often tried out?
20. If two residents fight with each other will they get into trouble?
27. Do staff allow the residents to break the minor rules?
34. Are suggestions made by the residents acted upon?
41. Do residents have any say in the making of the rules?
48. Are the rules and regulations rather strictly enforced?
55. Would a resident ever be asked to leave if he/she broke a rule?
62. Can residents change things here if they really try?
(Moos & Lemke 1988).

What becomes apparent when looking closely at the questions on the Self Exploration sub-scale is the high degree of relativity involved in certain of the items. Thus the answer that a respondent gives to questions 6 and 48, and to a lesser extent 13, 27 and 34, appears largely to depend upon his/her previous care experiences. A similar relativity is also found in questions 44, 51 and 58 on the Conflict sub-scale. Within the research houses both residents and staff had previous care experiences that differed significantly. Thus for example, some residents had spent periods in The State Mental Hospital whilst others had not, and two of the Alpha staff had previously worked in psychiatric hospitals whilst none of the Beta staff had worked in community oriented care settings such as Alpha. It is believed that the differing background experiences of respondents affected certain of the answers given and that this creates difficulty when undertaking inter-site comparisons.

Staff in Alpha organisation found the completion of the Self Exploration sub-scale of the S.C.E.S. difficult. Alpha staff argued, in line with the organisational ethos, that there were no 'rules' or 'regulations' in the houses and pointed to the fact that the houses were the tenants' homes. Within the context of Alpha organisation's ethos, the terms 'rules' and 'regulations' carried very negative normative connotations. Such terms were seen to relate to more institutional types of care than that offered by Alpha organisation. One Alpha One worker described some of the Self Exploration questions as being the sociological equivalent of: Have you stopped beating your wife? Here either a positive or negative answer equally results in incrimination. Interestingly, tenants in the Alpha sites and staff and residents in Beta organisation did not voice such concerns in relation to the Self Exploration questions.

Further, when studying the items that make up the Self Exploration sub-scale it again becomes apparent that the majority of the questions asked do not provide information on the direction of expressed concerns; that is, they do not provide insight into whether residents express their feeling and concerns solely to staff or also to co-tenants or co-residents. In the preceding chapter it was shown that in reality important differences existed in the expression of anger and concerns within the research houses.

Summary

To summarise, the scores for the Conflict and Self Exploration sub-scales of the S.C.E.S. do not provide a satisfactory shorthand guide to the levels of E.E. in the four research houses. Although a positive relationship was found between the observed levels of E.E. and the staff scores for Conflict, there are important theoretical reasons for treating this result with caution.

Firstly, the Conflict and Self Exploration questions do not provide information on the direction of expressed conflicts; that is, whether tenants or residents express their concerns directly to each other or solely to staff. Thus for example, the sub-scales did not reveal the fact that tenants within Alpha One were more prepared to confront each other when there was a problem than were Alpha Two tenants. Alpha Two tenants attempted to avoid direct confrontation and tended to voice their concerns and criticisms of co-tenants solely to staff.

Secondly, certain of the questions that make up the Self Exploration sub-scale were found to carry different normative connotations within the two research organisations. Alpha workers found terms such as 'rules' and 'regulations' difficult and pointed to the way that such language contradicted the organisational ethos, which stressed that the houses were the tenants' homes. The differing meanings of the questions within the two research organisations cast doubts over the validity of inter-organisation comparative analysis. Moreover, certain of the S.C.E.S. questions for the Conflict and Self Exploration sub-scales were found to contain a considerable degree of relativity to the respondent's past care experiences. Within this study neither staff nor residents/tenants had identical past care backgrounds.

Finally, the Conflict and Self Exploration sub-scales were found to provide a snapshot of an organisation at a particular point in time. This point was illustrated by the Beta One residents' score for the Conflict sub-scale. As

E.E. is seen theoretically as detrimental to people who suffer from certain types of mental illness, because it acts as a chronic stressor, it is crucial that any measure is capable of capturing enduring patterns of interactions and relationships.

A COMPRISION OF THE HOUSE S.C.E.S. PROFILES BY THE DIMENSION OF 'RELATIOSHIPS', 'PERSONAL GROWTH' AND 'SYSTEM MAINTENACE AND CHANGE'

Relationships dimension

Histogram 5.3

Cohesion sub-scale: staff and tenants'/residents' scores compared by sites.
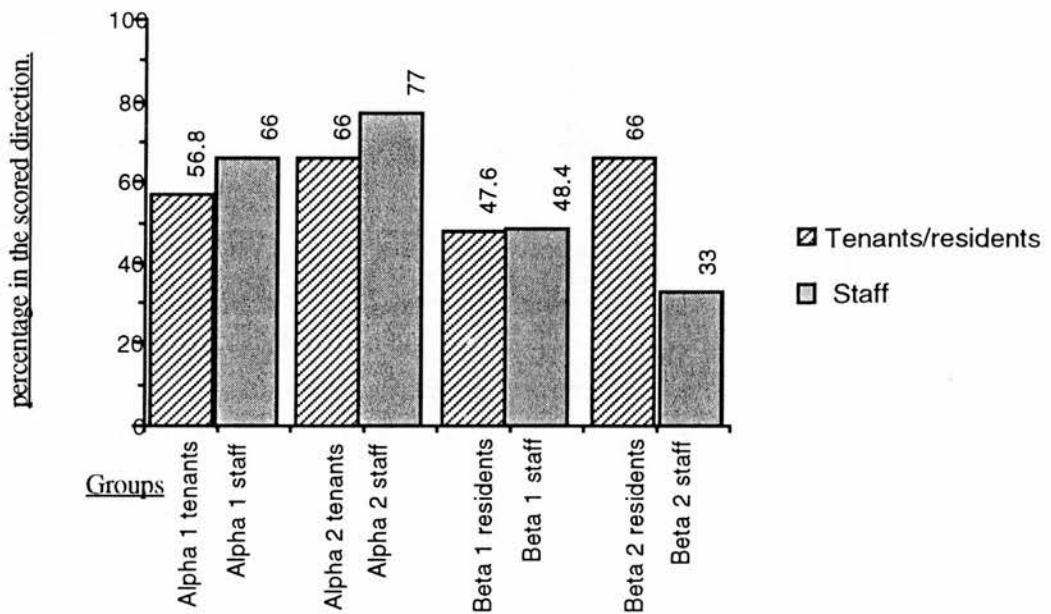
Histogram 5.4

Conflict sub-scale: staff and tenants'/residents' scores compared by sites.
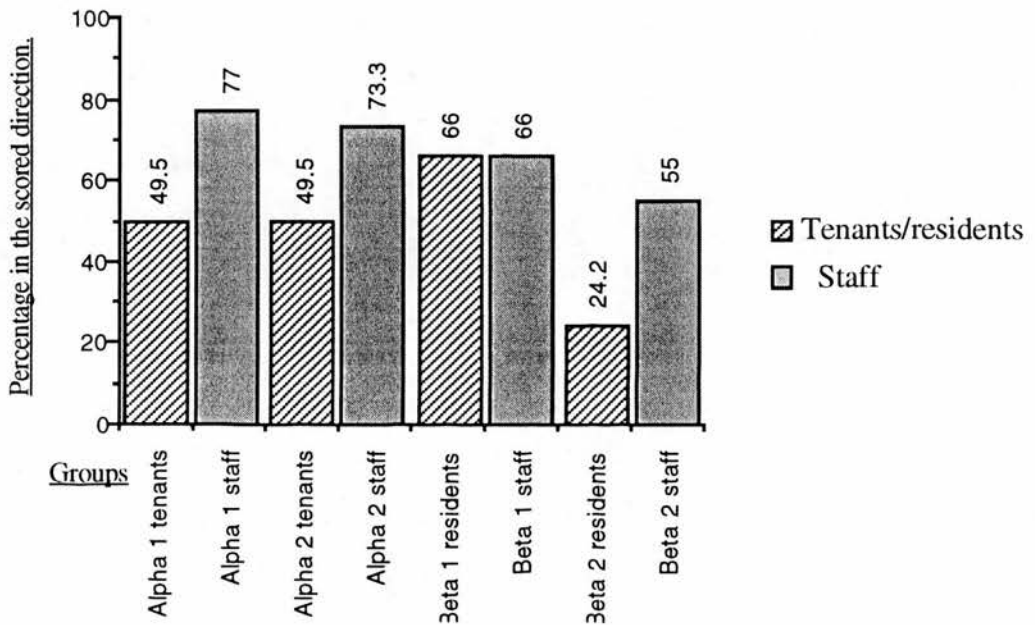
Histograms 5.3 and 5.4 present the S.C.E.S. house profiles for the Relationships dimension; consisting of the sub-scales Cohesion and Conflict. As is apparent, staff in the two Alpha sites scored their houses as higher on both relationship sub-scales than the Beta Staff, (Alpha One staff, Cohesion 66.0%, Conflict 77.%; Alpha Two staff, Cohesion 77.%, Conflict 73.3%; Beta One staff, Cohesion 48.4%, Conflict 66.%; Beta Two staff, Cohesion 33%, Conflict 55%). Alpha tenants scored their houses as higher than Beta One on the Cohesion sub-scale, however, the Beta Two residents' score of 66.% is equal to the higher of the two Alpha houses, (Alpha One tenants 56.8%; Alpha Two tenants 66%; Beta One residents 47.6%; Beta Two residents 66%). On the Conflict sub-scale the Alpha tenants rated their house as higher than Beta Two but lower than Beta One (Alpha One tenants 49.5%; Alpha Two tenants 49.5%; Beta One residents 66%; Beta Two residents 24.2 %).

The scores for the S.C.E.S. Relationships dimension provide general support for the qualitative assessment of the relationship patterns within the research houses. As was shown within Chapter Four, when compared to Beta residents, Alpha tenants were required to undertake greater communal responsibility and become more involved in the practical tasks involved in

communal living. Alpha tenants were also encouraged by workers, and the wider organisational ethos, to hold co-tenants accountable when tasks that contributed to communal living were not completed. The result was that inter-personal relationships within Alpha organisation were generally more intense than those in Beta organisation. Relationships within Alpha were marked by higher levels of social cohesion than Beta organisation but also higher levels of conflict.

Although the S.C.E.S. Relationship dimension results provide general support for the findings of the qualitative analysis there are certain theoretical considerations which mean that these results must be treated with a degree of caution. Within the previous section, certain problems pertaining to the Conflict sub-scale were highlighted. Thus it was argued that certain of the questions that make up the Conflict and Self Exploration sub-scales contain a considerable degree of relativity to respondents' previous care experiences. The Cohesion sub-scale also involves relativity to the respondents' prior care experiences, particularly with regard to questions, 1, 8, 22 and 50. This factor should thus be borne in mind when interpreting the Relationships dimension results. The questions that make up the Cohesion sub-scale read as follows.

1. Do residents get a lot of individual attention?
8. Do staff members spend a lot of time with residents?
15. Do staff members sometimes talk down to residents?
22. Are there a lot of social activities?
29. Do residents just seem to be passing time?
36. Are requests made by residents usually taken care of right away?
43. Do staff sometimes criticise residents over minor things?
50. Do residents tend to keep to themselves here?
57. Are the discussions interesting here?
(Moos & Lemke 1988).

Moreover, Smith and Whitbourne (1990) have argued that the Cohesion sub-scale contains a bias towards the measurement of staff-resident cohesion as opposed to resident-resident cohesion. Thus, none of the Cohesion sub-scale's nine questions focus explicitly on resident-resident interactions, five

focus on staff-resident interaction (questions 1,8, 15, 36 and 43), while the other four are ambiguous in their direction (questions 22, 29, 50 and 57).[2]

Certain of the results obtained within this study provide support for Smith and Whitbourne's observation. Thus, the high Beta Two residents' Cohesion score seems to reflect the fact that residents appreciated the work of the Assistant Cook and wished to register their satisfaction, (see Chapter Six). Similarly the high Alpha Two staff and tenants' ratings for Cohesion appears to reflect the fact that, staff in Alpha Two placed greater emphasis upon tenant choice and control than their counterparts in Alpha One. The Alpha Two workers' operationalisation of the organisational ethos led to higher levels of staff/tenant Cohesion than was the case in Alpha One. (In Chapter Six it will be shown that the staff in Alpha One were more prepared to intervene directly in order to facilitate inter-tenant accountability.)

Personal Growth Dimension

Histogram 5.5
Independence sub-scale: staff and tenants'/residents' scores compared by site.

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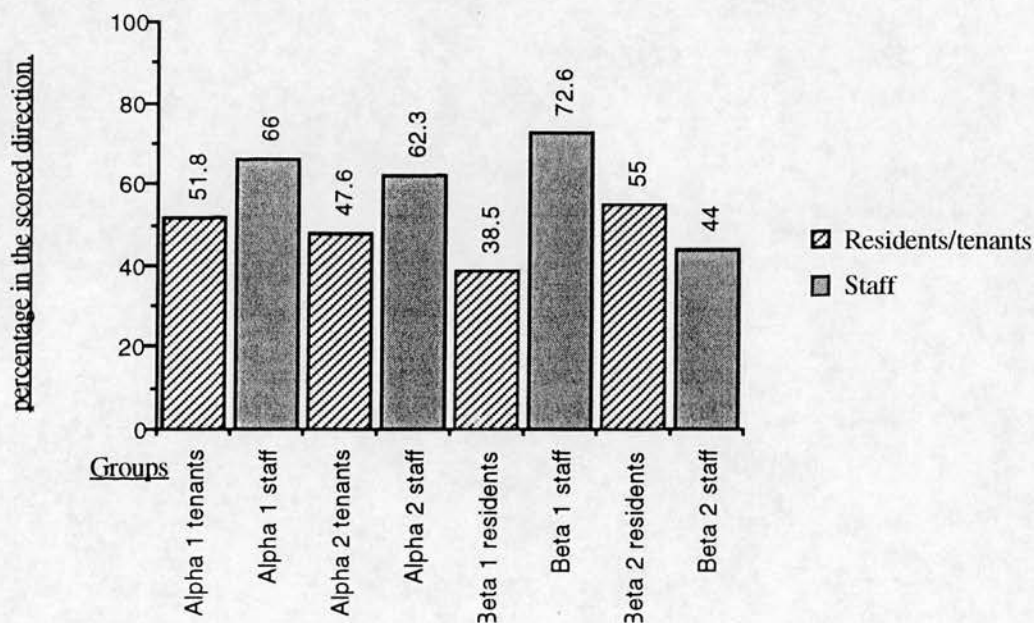
[2] Lemke and Moos (1990) accept Smith and Whitbourne's (1990) criticism of the Cohesion dimension of the S.C.E.S., but point to the fact that in their previous Ward Atmosphere Scale and Community Orientated Programmes Evaluation Scale (1974) they found a positive correlation of .60 between patient-patient support and staff-patient support. Lemke and Moos argue that this positive correlation was too high to justify separate sub-scales for resident-resident Cohesion and staff-resident Cohesion.

Self Exploration sub-scale: staff and residents'/tenants' scores compared by sites.
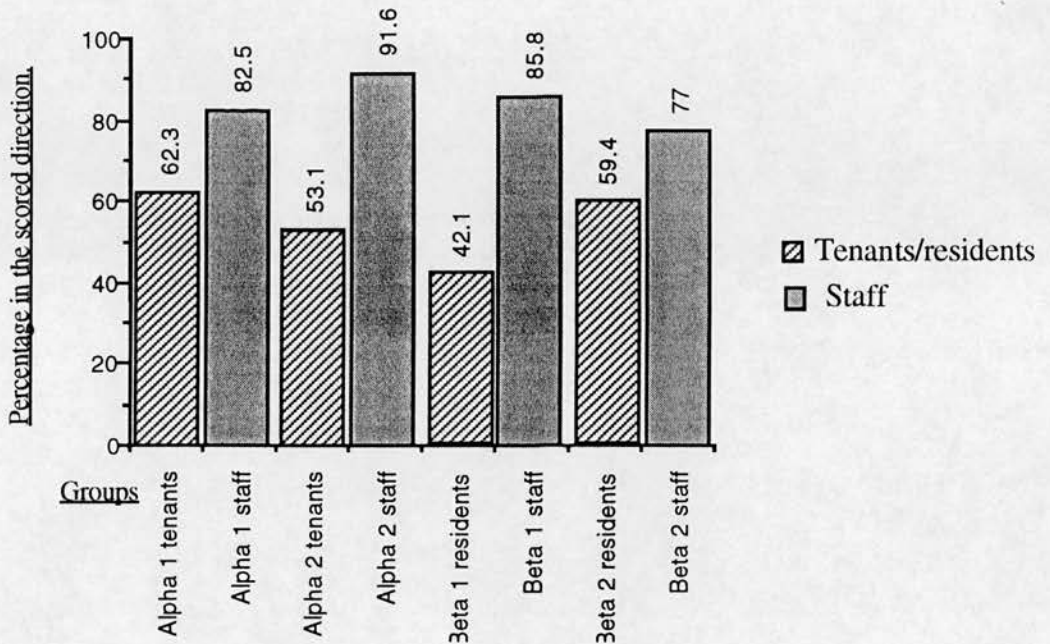
Histograms 5.5 and 5.6 present the S.C.E.S. profiles for the Personal Growth dimension. In looking at the profiles provided by the Independence and Self Exploration sub-scales it is not immediately apparent which of the houses provided the care environment with the best opportunities for resident/tenant Personal Growth, (as defined by Moos et al.). Thus for example, whilst Staff in Beta One scored their house as being the highest on the Independence sub-scale (77.6%), Beta One residents rated the house as lowest at only 38.5%. Similarly, Beta Two residents rated their house as highest for Independence (55%), whilst the Assistant Cook rated Beta Two as the lowest of the four sites (44.%).

Before attempting to interpret the Personal Growth dimension results, it is again necessary to note that staff within the Alpha houses expressed difficulty in completing certain items on the Independence sub-scale. The problems expressed by Alpha staff were similar to those described in relation to the Conflict sub-scale. Centrally, the problems again pertained to the normative connotations of certain Independence sub-scale questions within the social context of Alpha organisation. Alpha staff argued that they

were not attempting to treat or cure people, nor provide a rehabilitation unit, and pointed to the fact that the houses were first and foremost the tenants' homes. Specifically, Alpha staff took issue with questions that referred to planned activities or to tenants being taught new skills (questions, 3, 17, 24, 31, 45, 59). Staff argued that they attempted to build their relationships with tenants upon equality and not a teacher/pupil basis. The problems experienced by Alpha staff were not voiced by the Alpha tenants or Beta staff and residents; however, the large standard deviations for both sets of Alpha tenants may point to the fact that they also had difficulty in interpreting the Independence questions, (Independence sub-scale tenants' standard deviations, Alpha One 25.4, Alpha Two 17.9). As the problems expressed by Alpha staff referred to a large proportion of the Independence sub-scale staff inter-organisational comparisons for this sub-scale are difficult and the results must be treated with caution. The questions that make up the Independence sub-scale read as follows;

> 3. Do residents usually depend on the staff to set up activities for them?
> 10. Do residents usually wait for staff to suggest an idea or activity?
> 17. Are residents taught how to deal with practical problems?
> 24. Are many new skills taught here?
> 31. Are residents learning to do more things on their own.?
> 38. Are the residents strongly encouraged to make their own decisions?
> 45. Do residents sometimes take charge of activities?
> 52. Do residents care more about the past than the future?
> 59. Are some of the residents' activities really challenging?
> (Moos & Lemke 1988).

The most striking features of the Personal Growth dimension profiles are the large divergences between certain staff scores and those of tenants or residents. The divergence of staff scores from the residents'/tenants' scores are particularly striking in the case of the Beta One Independence scores (staff 72.6%, residents' 38.5%), the Beta One Self Exploration scores (staff 85.8%, residents 42.1%), and the Alpha Two Self Exploration scores (staff 91.6%, tenants 53.1%).

With regard to the considerable disagreement between the Beta One staff and residents' scores for the Independence and Self Exploration sub-scales,

the qualitative data offers some interesting insights. As was shown in the preceding chapter, a dominant feature of Beta One was the low levels of staff/resident contact and the instrumental nature of the staff/resident interaction that did take place. Staff in Beta One explained these interaction patterns in terms of a desire to promote resident independence as part of the rehabilitation process. The high Beta One staff scores for the Independence and Self Exploration sub-scales therefore appear to reflect an important aspect of the staff's common-sense knowledge; namely that rehabilitation is aided by promoting independence through low staff/resident contact. The divergence of the Beta One residents' scores for Independence and Self Exploration points however to the fact that residents did not share these staff beliefs. Within Chapter Six it will be shown that Beta One residents commonly held the belief that greater staff/resident contact would have aided their rehabilitation.

System Maintenance and Change Dimension

Histogram 5.7

Organisation sub-scale: staff and residents'/tenants' scores compared by site
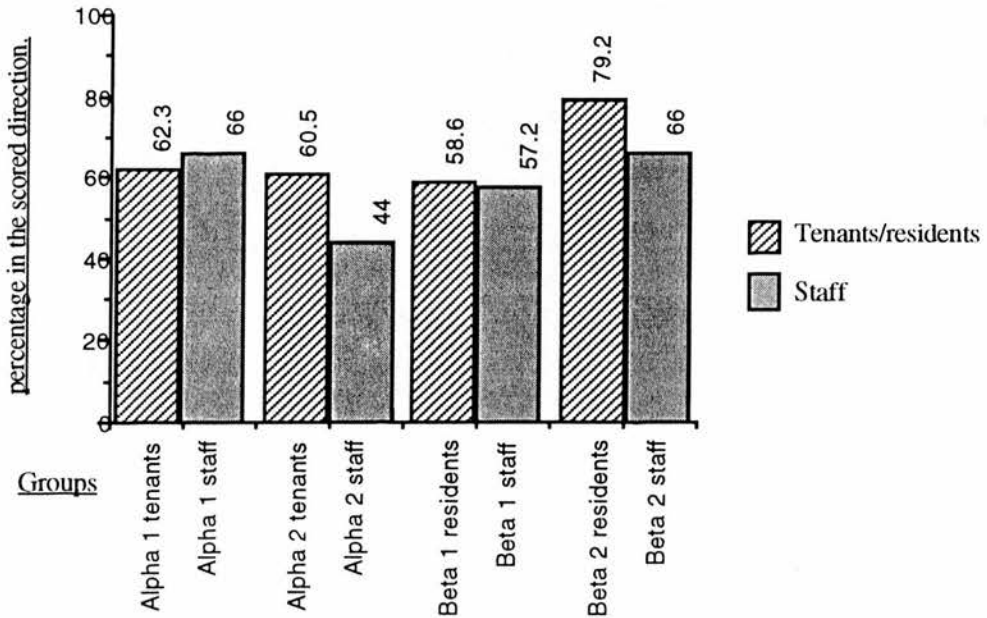
Histogram 5.8

Resident Influence sub-scale: staff and residents'/tenants' scores compared by sites.
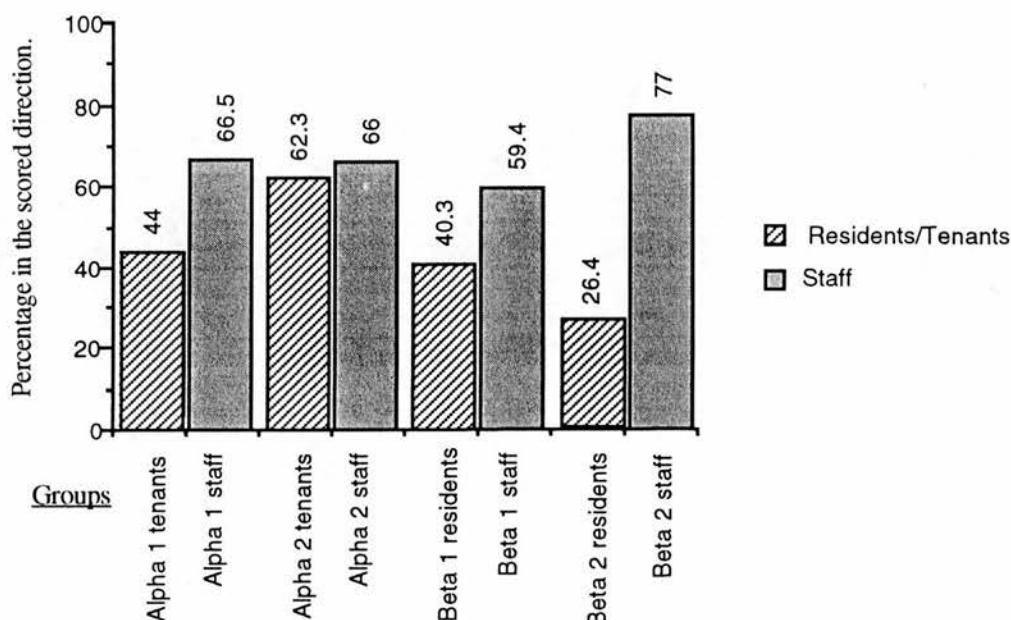
Histograms 5.7, 5.8, and 5.9 (below) present the house profiles for the System Maintenance and Change dimension. The Organisation sub-scale reveals that the staff and residents of Beta Two rated their house as being highest on this sub-scale (residents 79.2%, staff 66%), followed by the two Alpha houses (Alpha One, tenants 62.3%, staff 66.%; Alpha Two, tenants 60.5% staff 44.%), and finally Beta One (residents 58.6%, staff 57.2%). The staff house profiles for the Resident Influence sub-scale reveal that Beta Two was again rated highest (77.%) followed by the two Alpha houses (Alpha One 66.5%; Alpha Two 66.%) and finally Beta One (59.4%). The residents'/tenants' scores for Resident Influence show that Alpha Two tenants rated their house highest (62.3%), followed by Alpha One (44.%), Beta One (40.3%) and finally Beta Two (26.4%). One of the most striking aspects of the Resident Influence house profiles is again the large divergence between the staff and residents'/tenants' scores for Alpha One, Beta One and Beta Two.

Before providing further interpretation of the System Maintenance and Change dimension profiles it is again necessary to note the theoretical difficulties that were encountered. Alpha staff expressed difficulty with the

wording of two of the questions contained in the Organisation sub-scale (questions 12 and 33). These questions again referred to 'rules' and planned 'activities'; concepts which the Alpha staff argued stood in opposition to the organisation's aims of creating a permanent home for tenants, where relationships were based, as far as possible, upon equality and mutual respect. Moreover, one worker in the second Alpha house commented that he did not feel that it was any of his concern if tenants looked 'messy' (question 19), and argued that this would only become a problem if a person's personal hygiene was raised as an issue by another tenant. The high Alpha tenant standard deviations for the Organisation sub-scale (Alpha One tenants 23.7, Alpha Two tenants 24.8) may again point to Alpha tenants' encountering similar problems in interpreting certain of the Organisation sub-scale's questions. These factors should be borne in mind when interpreting the Alpha scores. Neither staff nor tenants/residents raised objections to the questions that make up the Resident Influence sub-scale. The questions for the Organisation and Resident Influence sub-scales read as follows:

Organisation sub-scale
 5. Do residents always know when the staff will be around?
12. Are activities for residents carefully planned?
19. Do some residents look messy?
26. Do things always seem to be changing around here?
33. Do residents know what will happen to them if they break a rule?
40. Is there a lot of confusion here at times?
47. Is this place very well organised?
54. Are things sometimes unclear around here?
61. Are people always changing their minds around here?

Resident Influence sub-scale
 4. Are residents careful about what they say to each other?
11. Are personal problems openly talked about?
18. Do residents tend to hide their feelings from one another?
25. Do residents talk a lot about their fears?
32. Is it hard to tell how the residents are feeling?
39. Do residents talk a lot about their past dreams and ambitions?
46. Do residents ever talk about illness and death?
53. Do residents talk about their money problems?

60. Do residents keep their personal problems to themselves?

The profiles for the Organisation and Resident Influence sub-scales provide partial support for the qualitative data. Within Beta One the low residents' and staff ratings for the Resident Influence sub-scale appear to point to the predictable and routinised patterns of daily living within the house; the Beta One Organisation scores are not however as high as might have been expected. The high Beta Two Organisation scores similarly appear to reflect the routinised patterns of life within this house. Within the following chapter it will be shown that, in Beta Two, although nursing staff/resident contact was extremely low, the residents still followed very habitual and predictable patterns of daily living. The high staff Beta Two Resident Influence sub-scale score suggests that the Assistant Cook felt that the low amount of contact between the nursing staff and residents afforded them a high degree of control over the running of the house. Beta Two residents clearly did not share this view and scored the house very low on Resident Influence (26.4%). Three of the Beta Two residents did not have day activities and spent the vast majority of their days sitting watching the television. In the following chapter to follow it will be shown that several Beta Two residents expressed dissatisfaction and frustration at what they perceived as a low quality of life.

Although the Alpha scores must be treated with some caution the low Alpha Two staff Organisation score (44%), together with the relatively high Alpha Two Resident Influence scores (staff 66%, tenants 62.3), does appear of importance. It will be shown in the following chapter that staff in Alpha Two stressed the importance of individual tenant choice and control as their primary care aims. The Alpha Two workers' care emphases contrasted considerably with those of Alpha One workers, who placed greater emphases upon the communal aspects and responsibilities of group living. The higher rating by Alpha Two tenants on the Resident Influence sub-scale (62.3%) when compared to the Alpha One Tenants' score (44%) appears to offer further support for the assertion that tenants in Alpha Two had greater control over the running of the house than their counterparts in Alpha One.

<u>Histogram 5.9</u>

<u>Physical comfort sub-scale: staff and tenants'/residents' scores compared by sites.</u>
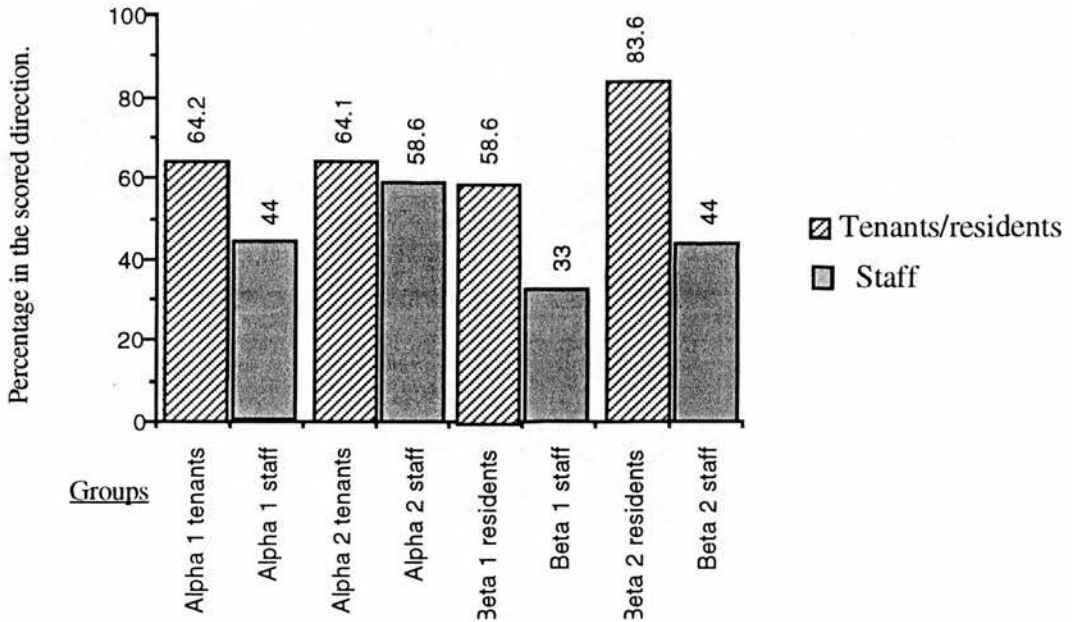
The questions that make up the Physical Comfort sub-scale are printed below. Almost inevitably, the Physical Comfort sub-scale contains a considerable degree of relativity to the respondents' previous care experiences and general cultural norms concerning a physically acceptable home. As was noted in relation to the Self Exploration sub-scale, within this study respondents, both staff and tenants/residents, had notable differences in their previous care backgrounds. The respondents' differing backgrounds again mean that the Physical Comfort sub-scale results must be treated with caution.

7. Is the furniture comfortable and homely?
14. Is it ever cold and drafty here?
21. Can residents have privacy whenever they want?
28. Does this place seem crowded?
35. Is it sometimes very noisy here?
42. Does it ever smell bad here?
49. Is it ever hot and stuffy here?
56. Is the lighting very good here?
63. Do the colours and decoration make this a warm and cheerful place?

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The tenants' and residents' ratings for the Physical Comfort dimension are broadly in line with the qualitative assessment of the houses' comfort and cleanliness levels. Beta Two, under the influence of the assistant cook, provided the site with the highest levels of Physical Comfort, followed by the two Alpha houses and finally Beta One (Alpha One- 64.2%, Alpha Two 64.1%, Beta One- 58.6%, Beta Two- 83.6%). Although Beta Two was kept clean by a hospital domestic it was very bare and badly in need of decoration. The staff Physical Comfort scores do not reflect the qualitative impressions of the researcher concerning the relative standards of comfort and cleanliness within the houses.

SUMMARY AND CONCLUSION

Within the design of this study the use of the Sheltered Care Environment Scale was seen to fulfil two central functions. Firstly, the S.C.E.S. was to be used to provide a method of triangulation with the data gathered through participant observation and the review of the research organisations' internal literatures. Secondly, there appeared to be a theoretical relationship between the Conflict and Self Exploration sub-scales and E.E.; this relationship appeared to be worthy of empirical investigation.

The findings from this study do not support the use of the Conflict and Self Exploration S.C.E.S. sub-scales as a short hand measure of E.E. within collective care settings. Firstly, the sub-scales were found not to be capable of determining the direction of the expressions of anger or criticism; that is, of providing information on whether residents expressed their anger, criticisms, feelings and concerns to one another or solely to staff. The direction of residents' expressed anger and criticism has considerable implications for the level of E.E. within a care facility. Secondly, the sub-scales appear to provide a snap shot of a care environment at a particular point in time. The high Beta One Conflict scores suggest that the instrument may be over-sensitive to relatively short lived events within the environment. As high E.E. is seen, at the theoretical level, to be detrimental to patients because it acts as a chronic stressor, it is important that any measure is capable of capturing on-going and enduring patterns of interaction.

With regard to the use of the S.C.E.S. data as a form of methodological check on the validity and reliability of data gathered through other methods, certain theoretical problems were encountered. Firstly, it was found that certain of the questions that make up the S.C.E.S. carried different normative connotations within the two research organisations. This was particularly apparent for the sub-scales of Self Exploration, Independence, and Organisation. Staff in Alpha organisation argued that the organisation was trying to move away from institutional models of care and pointed to the fact that the houses were first and foremost the tenants' long term homes. Alpha Staff argued that concepts such as 'regulations', 'rules' and organised 'activities', were not applicable to settings that were primarily people's homes; where inter-personal relationships were based, as far as possible, upon equality.

On the positive side, the difficulties encountered in relation to the language used in the S.C.E.S. provides further insight into the importance of terminology with Alpha organisation. The process of S.C.E.S. completion also highlights the commitment of Alpha staff to the organisational ethos and its associated care aims. Alpha tenants did not voice the same concerns over the wording of the S.C.E.S. questions and this suggests that tenants were not as acutely aware of the importance of language within the organisation. On the negative side, the differing meanings and normative connotations of certain S.C.E.S. questions, within this study's two research organisations, raises some doubt over the validity of inter-organisation comparative analysis.

Secondly, during the use of the S.C.E.S. it became apparent that there is a significant degree of relativity inherent within the questionnaire. Thus questions such as: Do residents often get impatient with one another?, Are staff strict about the rules?, Are rules and regulations rather strictly enforced?, Do residents get a lot of individual attention?, etc., implicitly invite the respondent to make comparisons with past care experiences. Within this study respondents had not all come from identical care backgrounds. Thus, four residents/tenants (one Alpha tenant and three Beta residents) had previously spent time in The State Mental Hospital, the remainder had not had this experience. The Alpha tenants all had prior experience of psychiatric hospital care however very few Beta residents had lived in community care organisations such as Alpha. The length of time that respondents had lived in their present setting also differed considerably.

Some residents/tenants had moved from hospital acute admissions wards within the last year, while other residents had been in their present homes for a number of years. Similarly, staff backgrounds and experiences also differed. Thus whilst three of the six staff in Alpha organisation had previously worked in psychiatric hospitals none of the nursing staff had worked in community care organisations. The differing previous care experiences of both staff and residents/tenants, together with the small number of respondents in this study, again means that the S.C.E.S. results must be treated with caution.

However, whilst bearing the theoretical difficulties in mind, the S.C.E.S. house profiles do offer some general support for the findings of the qualitative data. Thus, the Relationships dimension scores point to the fact that relationships within Alpha organisation were marked by relatively high levels of social cohesion but also high levels of conflict. The Personal Growth dimension scores present a confusing picture with large divergences between staff and residents'/tenants' scores. The divergence between staff and resident scores within Beta One for the sub-scales of Independence and Self Exploration are particularly large; these scores appear to point to a strong disagreement between staff and residents concerning the benefits or otherwise of low levels of staff/resident contact. The very high Alpha Two staff rating for the Self Exploration sub-scale support the qualitative data's findings that staff within Alpha Two placed a very strong emphasis upon promoting individual tenant choice and control.

General support for the findings of the qualitative data is also provided by the System Maintenance and Change dimension scores. Thus the scores for Beta organisation point to the routinised and predictable patterns of life within these houses; whilst comparison of the Resident Influence and Organisation sub-scales for the two Alpha houses indicate that tenants within Alpha Two felt that they had more control and influence over the running of their house than their counterparts in Alpha One. These themes will be explored further in the following chapter.

CHAPTER SIX

The social construction of house life in the four research sites

INTRODUCTION

In Chapter Three an overview of the two research organisations was presented. It was noted that the research organisations' internal literatures suggested Beta organisation was likely to have a higher level of Expressed Emotion (E.E.) than Alpha organisation. This appeared likely because of Beta organisation's ideological stress upon rehabilitation and resettlement and the associated emphases upon the teaching or resurrecting of residents' personal and social skills. Chapters Four and Five have presented qualitative and quantitative data pertaining to the observed reality of life in the four research houses. The data reveals that the observed levels of E.E. were highest in Alpha One, followed by Alpha Two and Beta One, with Beta Two showing the lowest levels of Critical Comments and displays of Hostility. The qualitative data also reveals that the content of and precipitating factors for high E.E. interactions varied across the four settings. Moreover, it was found that the communal meals and house meetings invoked differing levels of stress and anxiety in residents/tenants in the various settings.

This chapter aims to look behind the observed levels of E.E. in the four houses in order to ascertain the key factors that contributed and combined to create the empirical realities. The focus here is primarily upon the meanings that participants attached to their social interactions and the workers' operationalisations of the organisations' ideologies. This chapter draws upon the theoretical work of Berger and Luckmann (1979) and in particular their insights concerning the social construction of daily life. As was noted in Chapter Two, Berger and Luckmann's work is of methodological significance within organisational studies because it points to the importance of the social actors' shared common-sense-knowledge in the creation of daily life. Berger and Luckmann's work on secondary organisational socialisation also offers a partial resolution to the methodological problems surrounding

the researcher's not having direct access to the inner consciousness and subjective meanings of the social participants that he/she studies. Within this Chapter these theoretical insights will be utilised in order to explore the relationships between the shared-common-sense-knowledges of workers, tenants and residents, and the observed levels of E.E.

In order to facilitate the analysis, this chapter is organised around the following central themes: the role and ideological commitment of the workers; the effect of attributions to willed and controlled behaviour or to a state of mental illness; the social characteristics and cohesion levels of the tenant and resident groups; and the impact of the recent history of the houses. In the interests of clarity these themes are presented as independent factors. In reality however they remain essentially interconnected; and this should be borne in mind during the reading of this chapter.

THE ROLE AND IDEOLOGICAL COMMITMENT OF THE WORKERS

As Otto and Orford (1978 p. 33) note, staff within halfway houses and hostels make a disproportionate contribution to the functioning of such settings because they fulfil a 'specialised social role and have greater social power than other members'. As Apte notes staff are in a position to:

> give or withhold privileges which are intensely important to the resident, such as allowing or withholding privacy, lengthening or curtailing a resident's stay, taking a flexible attitude in the interpretation of rules and regulations, and seeing that an unemployed resident is cared for (Apte 1968 p. 53).

This section reviews the role of the front-line staff in the social construction of house life in the four research sites. The weighting given to this section as a proportion of the chapter reflects the crucial importance of the role of staff and in particular their interpretations and operationalisations of the organisations' care ideologies.

Alpha organisation.

As has been shown in the preceding chapters, at the heart of Alpha organisation lay a strong and relatively well defined ethos; at times the organisation's internal literature referred to this ethos as the 'guiding light'.

Essentially, Alpha's ethos consisted of a number of key ideological principles that provided both workers and tenants with a set of moral prescriptions concerning the ways that people within the organisation should relate to one another. The ethos functioned as an alternative to the bureaucratic structure found in many organisations (including Beta organisation) and provided guidance, support and a degree of control over the workers and tenants. An in depth discussion and analysis of the components of the Alpha ethos is provided within Chapter Three. However to reiterate, the key elements can be summarised thus: a belief in the rights of people with mental health problems to live in the community with dignity and respect together with a down playing of the individual's mental illness; a commitment to provide people with a home for life where a tenancy can not be maintained independently; a commitment to expanding individual tenants' choice and control; a belief in the possibility and desirability of equality between tenants, and between tenants and workers; and a belief in the importance of creating a cohesive tenant group capable of offering support to one another.

Workers within both Alpha houses expressed and displayed a strong commitment to the aims of the organisation. At times this bore parallels to a religious fervour. There was a sense throughout the organisation of a crusade being waged, with traditional and often stereo-typed versions of institutional care being cast as the antithesis of Alpha organisation. Regular staff supervision and support sessions, both across and within houses, aided the effective transmission and pervasiveness of the ethos.

The Alpha ethos was not however totally coherent or without internal tensions and contradictions. Moreover, as with all organisational policy, the ethos had to be interpreted and operationalised by social actors in concrete historical contexts. Chapter Three identified and discussed several key internal contradictions within the organisation's ethos (or 'paradoxes' as the organisation preferred to call them). These central tensions and contradictions can be summarised as follows:

1) The notion of tenancy and the signing of a tenancy agreement suggests legal accountability, but tenants were selected on the basis that their mental health difficulties made the achievement and maintenance of a normal tenancy impossible. The importance of the individual's mental illness was largely denied and the secondary disabilities resulting from institutionalisation, prejudice and stigma, were emphasised. At the same time

however, the criteria for gaining a tenancy within the organisation rested essentially on having, or having had, a diagnosable mental health problem.

2) The ethos stressed that relationships between tenants and workers should be based upon equality, but workers were employed to support and help tenants; staff were thus implicitly deemed more capable, at least in certain important areas of life.

3) The ethos stressed the promotion of individual tenant choice and control, but the accommodation was collective and communal responsibilities were part of the conditions of residence. The workers were simultaneously asked to promote individual choice and control, together with tenant group decision making, whilst also ensuring that tenants discharged their communal responsibilities; namely, the preparation and consumption of one communal meal a day, attendance at a fortnightly house meeting, and taking part in the communal cleaning of the house and the collection of weekly house shopping.

The tensions and contradictions in the organisation's ethos were on-going matters of negotiation within both Alpha houses. Importantly, however, workers within the two houses were found to emphasise different individual elements of the ethos; staff also attempted to resolve the ethos's internal contradictions in subtly different ways. In turn these differences in emphasis contributed significantly to the differing levels of E.E. in the two Alpha houses.

Within the first Alpha house the workers argued that the houses should be seen first and foremost as the tenants' home. In reality, however, the workers found the deceptively simple notion of creating 'home' very difficult to operationalise. The qualitative analysis reveals that the two front-line Alpha One workers held subtly different versions of 'home', derived primarily from their respective personal experiences. For one worker, an unmarried man in his early thirties, the notion of 'home' had at its core the concept of personal control and autonomy. This worker explained his view of 'home' through the expression, 'it's your own front door'. He argued that control over one's life begins within the home, with the home providing a secure base from which to expand control into other areas of life. This house-worker argued that in attempting to aid the tenants' creation of home he essentially sought to promote their involvement and participation in the running of the house. He argued that such participation was particularly important for people who had spent long periods in

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institutional care. As the following field-note quotation illustrates, this worker was aware that the conditions of tenancy placed limits upon the areas of house life over which the tenants could take decisions, but he did not view this as a serious obstacle.

> I comment that there seems to be a contradiction in that, on the one hand he wants people to be in control in their own home, whilst on the other he is a worker and is charged with ensuring that people take part in the communal life of the house. I point out that if people choose not to take part in communal life they are technically in breach of their tenancy agreement but may also be simultaneously developing and exercising personal choice. John (worker) agrees that this is a constant tension, and then comments that a senior worker once told him that this is one of the many contradictions in the job that he is asked to do (A1 8/4).

The second Alpha One worker, a married woman with three young children, offered a significantly different view of home. She stressed that for her, home was primarily somewhere where the individual should feel safe, secure and enjoy being. She placed primary importance upon how individuals felt emotionally towards the home. She also stressed personal control, but here the term denoted individuals controlling their personal actions and behaviours in order to contribute to harmonious interpersonal relationships. Here, then, personal control became personal discipline.

> I open the conversation by saying, 'Gill what makes a house a home?' She looks a little taken aback by this direct question, thinks for a few seconds and then responds, 'I think it's the human interaction.' She pauses then elaborates, 'happy cheerful interactions, harmonious relationships.' I ask whether she feels that control is a central part of a home. Here I am trying to see whether she feels as John (worker) does that tenant control is central to home. She says that she does see personal control as important and as she expands I realise that she is talking about *self control* on the part of the members of a home something quite different to John's usage of the term. She comments that because homes involve group living individuals need to control themselves in order to promote harmonious relationships (A1 8/11).

When operationalised, the two Alpha One workers' differing views of the central elements of 'home' had important implications for the house's

emotional environment. As was shown in Chapter Four, the Alpha One workers placed a strong emphasis upon the tenants' taking an active part in the communal life of the house and strongly encouraged tenants to take part in group decision making. Tenants were urged to express their disagreements openly and the workers were prepared to prompt and encourage tenants directly to confront each other where there were inter-tenant tensions. Indeed, in Alpha One conflict became seen as a positive thing and as evidence of the tenants' asserting themselves and throwing off the passivity caused by years of institutional living. In the following field-note extract the team leader outlines her position.

> The worker stresses that she feels that it is very important that tenants talk to each other directly when there is a problem. She adds that this seems to happen after people have been in Alpha organisation for a period of time.... She tells me that she doesn't see conflict as necessarily a bad thing and feels that conflict is a feature of all group living schemes. (She stresses however that she is not advocating conflict for conflict's sake.) She adds that the only group living schemes that she knows which work are the ones where people actually speak to one another and where difficulties are openly discussed (A1 8/26).

Somewhat paradoxically, the Alpha One worker who stressed harmonious relationships as an essential element of 'home' was also found to engage most frequently in direct criticism of tenants. These worker Critical Comments occurred largely because she became frustrated when tenants did not moderate their personal actions and behaviours in the interest of group harmony and cohesion. It will be shown below that much of the frustration experienced by this worker stemmed from the fact that she used a model of tenant behaviours based almost entirely upon willed and controlled action, rejecting mental ill-health as a possible cause of unwanted anti-social actions.

Workers in the second Alpha house did not spontaneously express the achievement of 'home' as a primary care aim. The Alpha Two workers were however notably cohesive in their own set of primary care aims and beliefs. They argued that due to the contradictions within the organisation's ethos it had been necessary for them to discuss the issues amongst themselves and decide upon how they would run the house. Alpha Two workers stressed the promotion of tenants' individual choice and control as their key care aims. As was noted in Chapter Four, Alpha Two workers had effectively removed

the compulsion to attend the communal meal and the fortnightly house meeting. The following field-note extract offers insight into the workers' perspective.

> He (worker) explains that neither Gerry (worker) nor himself felt that it was right to try and force people to attend the house meetings or meals. Rather, they felt that people should have more control and choice. He (worker) explains that it has been a deliberate intention to relax the expectations upon people surrounding the communal activities and that it would only be if someone completely withdrew that he would intervene (A2 3/30).

On occasions the emphasis which Alpha Two workers placed upon tenant autonomy and choice led them into becoming involved in encouraging tenants in some very unusual behaviours. The field-note extract below refers to a worker buying candles for a tenant to sit and burn in the living room, during the middle of the day, with the curtains closed. The worker argued that this behaviour did not harm anyone and that we must accept people's choices concerning different ways of living. Workers only considered this type of behaviour problematic if another tenant found it difficult or annoying, and was prepared to raise it as an issue.

> I arrive at the house at 12 noon, Joan (tenant) lets me in and we go into the sitting-room. The curtains are drawn, apart from a slight opening on one side. Both of the table lamps are on and the fire is at full power. ... Bob (tenant) and Colin (worker) arrive back at the house at 12.45pm. Colin (worker) enters the room and tells Joan (tenant), 'it's your birthday, I've brought you some candles, they're not the same as the others but they look like good ones.' Joan is very pleased and asks if she can light one. Colin replies that it is up to her, as long as she doesn't set light to the house. Joan disappears into her room and returns with an ashtray containing the remains of several candles. She lights a candle and places the ashtray in the middle of the room on the table (A2 3/30).

Alpha Two workers argued in a similar way to those in Alpha One that when there were inter-tenant disputes it was best if tenants discussed disagreements directly. The Alpha Two workers' emphasis upon the importance of individual tenants' choice and control meant however that they were not prepared, as Alpha One workers were, to become directly involved in prompting tenants during house meetings or manipulating situations in

order to encourage such interactions. Further, the removal of compulsion to attend the communal meal and the house meeting afforded tenants the opportunity to avoid situations where direct confrontation was likely.

> I then ask the worker whether he would ever intervene directly if one tenant complained to him about another. He tells me that he wouldn't, but that he would encourage the aggrieved tenant to talk directly to another person. He comments that it must be the tenant's decision as to whether to raise an issue, but if they decide not to, they must also live with the consequences (A2 4/12).

Beta Organisation

In Chapter Three it was shown that Beta organisation's internal literature presented an ideological view of care that involved strong emphasis upon the treatment and rehabilitation of residents. The nursing staff's own literature described a very linear and rationalised process involving the assessment of residents' abilities and needs, followed by planned interventions and an evaluation of the effectiveness of the intervention. Literature written during the early 1980s pointed to the fact that the Consultant responsible for the establishment of the rehabilitation houses saw them as primarily enabling people to acquire the skills necessary for resettlement. Thus the Consultant wrote;

> The object is to give everyone with potential the chance of adequate rehabilitation and resettlement training...
> ... the resettlement *houses* offer a programme of increasing responsibility and independence which is needed by many 'new chronics', the institutionalised and some medium-term patients with serious disabilities (italics added).

Jones (1987) has argued that an adequate analysis of staff/patient interaction patterns within psychiatric hospitals requires an understanding of the extremely stressful nature of psychiatric nursing. He suggests that the low social status of the profession together with low staffing levels, strict role demarcation and inadequate training, combined with the often drab physical environment and unpredictable patient behaviour patterns, frequently create a work environment that is fundamentally unfavourable to worker commitment and enthusiasm. Certain of the aspects discussed by

Jones were found to be useful in understanding the nursing staff's operationalisation of the Beta care ideology.

Beta organisation's nursing team should have consisted of 10.33 nurses. However, during both periods of field-work, because of frozen and unfilled staff vacancies, the team worked with only 8 members. This factor, combined with an organisational rule that effectively tied one trained member of staff to the close vicinity of the nursing office, placed severe restrictions upon the staff's ability to visit three out of the four rehabilitation houses. In the following field-note extract a senior nurse expresses his frustration concerning the staffing levels.

> Bob (nurse) asks how I am, I answer and return the question, he replies that he is battling against the staff shortages. He continues by telling me that Sarah (nurse) is off sick, just leaving him and one student. He comments that if this happened anywhere else there would be another staff nurse drafted in immediately. He continues, 'it's ridiculous, Steve, this isn't even custodial care, there is no point in having care plans that you just take down off the shelf and dust now and again' (B1 11/17).

When compared to the Alpha houses the physical setting and resource levels of Beta One also left a lot to be desired; Beta Two under the influence of the Assistant Cook fared much better. The following field-note extract offers an example of the difficulties encountered by a nurse in Beta One when attempting to teach a resident basic cooking.

> Kate (resident) then takes the pie out of the packet, Wil (nurse) tells her that they will put the beans on five minutes before the pie is ready. Wil then suggests that Kate lights the oven. It is an old fashioned gas oven that needs lighting with a match. Kate, somewhat gingerly, lights the oven and places the pie on the top shelf. I mention that it would be easier for people if the cooker was a little more modern, Wil tells me that they can't even get a new grill pan let alone a new cooker.
>
> After the pie is in the oven Kate tells Wil that they haven't got a tin opener. Wil looks through the kitchen but cannot find one, I offer to get one from next door and leave. When I return, I ask if the houses have a budget for such things, Wil tells me that they don't and says that everything has to be ordered separately from the hospital stores (B1 11/17).

Within this physical and organisational context the nursing staff did not display the same level of commitment to their care ideology as was witnessed in Alpha organisation. The nursing team was marked by low morale and expressed beliefs that many of the factors that affected the running of the houses were outside of their control. Further, important shifts in emphases were found in the nursing staff's operationalisation of the organisation's care ideology. Firstly, there had been a shift away from the houses' primarily aiming to resettle people into less supported accommodation, towards the houses providing some residents with long term care. In fact the nursing staff argued that many of the residents that were at present within the houses were not actually capable of achieving the levels of social and personal skills that they deemed necessary to move to less supported accommodation. The nursing staff stressed that rehabilitation did not always have to be aimed at resettlement.[1] The charge nurse responsible for Beta organisation argued that this shift in emphasis had occurred recently as a result of the closure of part of the hospital to which the rehabilitation houses were attached. Under the organisational changes the rehabilitation houses received several residents from a part of the hospital normally considered to provide people with long term care.

> Jerry (Charge Nurse) tells me that the closure of Thatcher House meant that they took a lot of residents that they wouldn't otherwise have received. He continues, 'This is something that was imposed upon us. We received 'the telephone call' (his terminology) asking us how many beds we had and were told that they were going to be filled'. He notes there was a lot of 'juggling of patients' (his term) between the various parts of the hospital and that they received six new residents (B1 11/10).

Interestingly, the individual nurses' estimates, regarding the exact proportion of residents thought not capable of moving to other accommodation, varied from as low as one-third to as high as two-thirds of the houses' populations. This suggests that despite the heavy emphasis that staff accounts placed upon the impact of the new residents, the change in emphasis probably pre-dated their arrival. That is to say, at the time when

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[1] The Beta nursing staffs' view of rehabilitation not always having to lead to resettlement is clearly not unique. It is also found in several important theoretical works dedicated to psychiatric rehabilitation (see Watts and Bennett 1986). What is important here is that the views expressed by the nurses represented a significant move from the organisation's previous policy statements.

the new residents arrived in the rehabilitation houses there were probably already a substantial proportion of residents that the staff perceived as requiring long term care.

What was perhaps more significant than the actual numbers of residents that came to the houses during the period of reorganisation was the feelings engendered in the nurses by the changes. The nurses felt that this was something that was imposed upon them, with the normal assessment processes prior to the admission of new residents not being observed. Moreover, two of the new residents filled beds that had previously been used for respite patients returning from the community; this effectively terminated this service, at least in the short term. These factors appear to have further lowered the nursing team's morale and level of commitment.

Within the social context of low staff numbers, low morale and the associated belief that many of the residents would never move on from their present care environment, the levels of staff contact with residents were very low. Staff tended to spend the majority of their time in the office engaged in clerical and general administration work or in social conversation amongst themselves. There was also found to be an inverse relationship between the seniority of nursing staff and their degree of contact with residents; thus the highest levels of interaction were between student nurses or nursing assistants and residents. These findings support the earlier observations of Armitage (1986) and Fraser and Cormack (1975).

Residents in Beta One were generally dissatisfied with the low levels of staff contact and argued that the situation was not beneficial to their care or treatment. In fact within Beta One it had become seen as a desirable social ability to encourage the staff to spend time within the house. The following field-note offers insight into the residents' perspective concerning the low levels of nurse contact.

> John (resident) returns to speaking to Wil (nurse) saying, 'Wil you should come in more often'. Wil replies, 'I do come in', John (resident) continues, 'no you don't Wil, you never come in. We need the kind of support that you guys can give us. We need to talk to you, to be told that we are getting there'. John (resident) then again explains that he is gets 'agitated', that he feels that he is 'on tenter-hooks' and that he feels that he needs to talk to someone at times like this. ... He then adds that he knows that Jean (co-resident) feels the same and that he thinks that Eddy (co-resident) does as well. Eddy (resident) joins in saying, 'Aye I get agitated, I worry about

my future and all that, I need someone to talk to'. While Eddy (resident) makes this statement he looks at the floor and wrings his hands. There is silence for a few minutes as everyone returns to watching the T.V. (B1 11/17).

In the description of the nursing process presented in the organisation's literature, one was left with a view of the assessment process whereby nurses withdrew active interventions, closely observed and recorded the behaviours of residents in a relatively unstructured way, and then after the assessment week, completed the REHAB scale (Baker and Hall, 1988). The reality of the three monthly assessment process within the Beta houses was somewhat different; because the nurses knew that they would be required to fill in the REHAB scale at the end of the assessment week they geared their observations to the categories of the scale. Completion of the scale was based upon the nurses' observations of residents during their minimal contacts, primarily during early morning waking calls, the administration of medication and at meal times. The even lower levels of nursing contact with the Beta Two residents meant that for two of the five residents, reviews had become six monthly. The result was that Beta One care plans revolved around practical items such as personal and domestic hygiene, retiring and rising from bed, and personal behaviours that were deemed to cause a nuisance: e.g. aggression, refusal to take medication, lack of attendance at day placements, etc. Noticeably absent from the nursing care plans were interventions aimed at the psychological or cognitive level. The nursing staff suggested that their training had not equipped them to undertake cognitive or more psychologically based interventions.

> I comment that the REHAB scale is geared towards highlighting a person's practical and social problems. The charge nurse agrees and then adds that he also thinks that the nurses don't feel that they have the necessary skills to address more cognitive problems such as the ones that I have described. He continues by telling me that during his training he had very little teaching on these issues. He adds that he feels that the students are now receiving more input (B1 11/24).

Moreover, the majority of nursing care plan interventions took the form of direct assistance with practical tasks, such as laundry, tidying of rooms, running baths, etc., or of merely verbally prompting residents to undertake a

task or activity. The behaviour modification programmes that were thought likely to result from the use of the behaviourists Hall and Baker's REHAB scale were not found to have materialised, (see sample care plans in Chapter Four).

Many of the care plans devised by the nurses were also found to be divorced from clearly identifiable end goals. The shift in the role of the houses, whereby many of the residents were considered long term patients, meant that many of the aspects in the assessment process had become effectively redundant. The processes of assessment and the designing of care plans had become end products in themselves, particularly in the case of residents who staff felt were very unlikely to move on to other accommodation.

> The charge nurse and I then turn to talk about the use of REHAB for the residents that are unlikely to leave the houses for a considerable period of time. I comment that for some of the longer term residents it appears that the use of the REHAB scale and the care packages that result from it are a little senseless. I give the example of a person being assessed as needing to learn to cook, being on a programme aimed at learning the skills and then afterwards going back to receiving hospital food which is cooked for her/him. He (charge nurse) tells me that in a case like that the only point would be if the person actually enjoyed the process of learning to cook. He comments that this is when rehabilitation isn't about resettlement but about developing personal and social skills.
>
> I then ask about a situation where the care plan is to get someone up in the morning, but the resident doesn't want to get up and has no real reason to do so, (i.e. no day placement to attend). Sean (charge nurse) replies that he thinks that logically they should be allowed to stay in bed. He adds that he feels that this would be quite difficult for the nurses because it would raise the question of what are they there for? He then comments that he sees what I am driving at and that basically I am questioning who are the processes for? Are they for the patients or are they for the nurses? I say that this is exactly the point and that while I don't want to be over critical it appears to me that the processes have gained a life of their own. The processes have become goals in themselves. Sean says that these are good points (B1 11/24).

Certain of the staff were aware of the ambiguity behind many of the care plans and this had the effect of further undermining staff commitment and

promoting greater staff withdrawal and avoidance of residents. Staff breaks became lengthened and care plans became implemented in only a half hearted fashion.

> At 7.25pm I leave Ken's room (resident) and go back downstairs, Kate (resident), who is pacing the hall, asks if I will help her make the telephone call to her sister. We leave Beta One and run through the snow to the intake house. We enter the hall and I try the office door. It is locked, the staff are still in the back office/ break-room. I am not sure what time they started this break but when I left the house at 5.45pm their cooked meal was already waiting for them on the table, I assume that they were not far behind. This means that at this point they have been there for 1hr. 40mins. I go into the office and tell the staff nurse that Kate would like to phone her sister, she asks me to tell Kate to wait in the sitting-room and says that she will be through in a little while. I relay the message to Kate who is waiting outside the office and then join the staff, they sit for another ten minutes (B1 11/10).

Here then within the nursing staff's operationalisation of the organisation's care ideology, insight is offered into certain central reasons behind the low levels of high E.E. interactions witnessed between nursing staff and residents. The combination of low levels of nursing contact, together with minimal expectations and demands upon residents, created a situation where residents were not really put under pressure to undertake new and challenging tasks. Nursing interventions tended to be very low key and the envisaged behaviour modification programmes were not found to have materialised. The low levels of nursing contact, however, also meant that the residents were largely left to resolve any inter-resident disputes themselves. As was shown in Chapter Four this on occasions led to inter-resident Critical Comments and displays of Hostility.

As was noted in Chapter Four, in Beta two the Assistant Cook had become involved in many more tasks and activities than were prescribed by her job description. These extra activities had the effect of lowering the demands upon the Beta Two residents, particularly in relation to communal household tasks. Underpinning the Assistant Cook's work was once more the wish to create a 'home' for the residents and again during the operationalisation of this key care aim she drew upon her own personal experiences. The Assistant Cook had been married for over twenty years and had brought up three

children. Her attempt to create a home environment began with the material context of the setting. Both historically and on a day-to-day basis she had a profound effect upon the level of material comfort within the house.

> I happen to mention that I have been looking for a table and admire Beta Two's oak dining-room table. Jeanie (cook) tells me that this table used to be in the previous house where she worked (she has been in Beta Two for four years)... she tells me that she arranged for several of the pieces of furniture from that hostel to be brought down. ... Jeanie recalls the job that she had to arrange for the furniture removal, she tells me that the porters told her that they would only move the table if she took it apart herself. She comments that she managed but that she had a bit of a job to get it back together again when it arrived. She adds that it had been suggested that the residents might be better off with a couple of the small square Formica tables. Jeanie comments that she felt that the big oak drop-leaf was much nicer (B2 6/15).

In part the cook's strong emphasis upon the importance of a house's level of material comfort rested upon her belief that the physical condition of the house actually affected the residents' abilities to cope with their mental health difficulties.

> Jeanie (cook) tells me that she thinks that the environment (here she means the physical environment) is very important to the residents' mental health. She comments that she is convinced that having to live in a dirty house must get residents down and cause them more problems. She says that she is sure that when the residents leave Beta Two they probably let their standards slip back a bit, but notes that at least they have had the experience of living in a nice tidy home (B2 6/1).

In Beta Two the cook often employed language which was suggestive of her seeing herself in a parental role. It was very common for her to refer to the residents as 'the boys' or 'the lads'. This again appeared to reflect a role with which she was familiar from her own family setting. The Assistant Cook was not, however, a judgmental or chastising mother figure, but rather one who would listen sympathetically to the residents when they wished to discuss their problems. She resisted becoming involved in pseudo assessments or attempting radically to alter residents' behaviour patterns or opinions. In some senses she was aided in this by her official job description. The extra

responsibilities and activities that she had taken on were just that, extra activities. She had control over what she did and did not become involved in. Her role as cook meant that there were no undue pressures from either the residents, the nursing staff, or herself, to become involved in areas where she did not feel confident, (for example undertaking systematic assessment or planing long term treatment plans for residents). In reality this meant that the cook's interactions were very low in E.E. The following field-note extract follows an incident where a resident had been expressing delusional ideas about a doctor being the devil.

> When Joey (resident) has gone I ask Jeanie (cook) whether she finds it difficult when Joey is like this. She tells me that he isn't like this very often and that he is a nice man when he is well. I then comment that I am never sure whether to tell Joey that I don't agree with some of his explanations of events. Jeanie tells me that she doesn't challenge him and just tries to be non-committal. ...She comments that it is not her job to become involved in trying to challenge people's delusions or ideas (B2 7/7).

THE EFFECT OF ATTRIBUTIONS TO WILLED AND CONTROLLED BEHAVIOUR OR TO A STATE OF MENTAL ILLNESS

Leff and Vaughn (1985) suggest that a central difference between low and high E.E. relatives is found in their views concerning the legitimacy of the illness. Leff and Vaughn argue that their data reveals that high E.E. relatives tend to be intolerant of sick talk and believe that the patient could control their behaviours if they so desired. By contrast, low E.E. relatives tend to view the illness as legitimate and display a greater ability to tolerate low levels of social functioning (Leff and Vaughn 1985 pp. 112-117). This section will review the dominant attributions used to explain unwanted or anti-social behaviours within the research sites and will explore the relationships between these attributions and the observed levels of E.E.

Alpha organisation

Alpha organisation's ethos stressed that the use of the medical bio-chemical view of mental illness brought with it certain negative effects for tenants. Thus the medical model was seen to place the tenants in an essentially passive position, leading to an emphasis upon people's disabilities

rather than their abilities. Medical labels were seen to suggest that the person was of a lower social value than other citizens and to encourage the stigma and prejudices that lead to secondary or social disadvantages: for example, discrimination in employment, housing, etc. (Wing 1978).

Within the first Alpha house, attributions pertaining to the causes of tenants' actions and behaviours were invariably to willed and controlled behaviour. In effect the medical bio-chemical model of mental ill-health was almost totally denied. Workers' expressed scepticism concerning the effectiveness of drug interventions and hospitalisation occurred only when the behaviours of a tenant could not be handled within the house. The following field-note quotations offer insight into the Alpha One workers' views concerning hospitalisation and medication.

> She (worker) continues by saying that folks (tenants) couldn't support Christina (tenant) through another 'difficult time' (her words), so soon after the last one. I ask whether there was a house meeting called to discuss the situation. She says that there wasn't, but that folks made it clear both by talking to John (worker) and herself, and through their actions (avoiding Christina), that they couldn't handle what was happening. She tells me that on the last occasion there was a house meeting prior to hospitalisation and Christina (tenant) attended and stayed throughout (A1 7/28).

> The worker goes on to say, ' I'm convinced that the tablets are for our benefit not the tenants, they just stop people expressing what they feel, they don't stop people feeling' ... I decide to try and clarify these remarks. I ask, 'Do you think that people experience the feelings of anger, paranoia, etc. when they are taking the medication, it's not that the medication stops them having these feelings and emotions.' John (worker) replies 'I know that it doesn't stop such feelings (A1 7/14).

Leff and Vaughn (1985) argue that the majority of their key relatives' Critical Comments referred to the negative symptoms of schizophrenia, namely under-activity, lack of drive, blunting of affect, etc. They suggest that relatives find it more difficult to equate negative symptoms with a state of illness (Leff and Vaughn 1985 pp. 64-74). In the first Alpha house attributions concerning both the positive and negative symptoms of mental illness were made to willed and controlled actions. Thus in Chapter Four it was shown that one tenant was held accountable to the house group for

behaviours that clearly stemmed from her mental ill-health and was ultimately asked to leave the house. A further example of the way in which Alpha One workers made attributions almost solely to willed and controlled behaviour is provided in the field-note below.

> After the worker finishes on the phone Simon (tenant) tells her that he has had a 'giddy turn'. He says that he feels pretty awful and that he is sorry but he hasn't managed to do the washing up. Gill (worker) asks him whether he thinks that it might be due to the heat, or whether he has possibly over done it at O.T. He says that he doesn't know ... Gill says that she will bring him in a cold drink in a little while. As he leaves she turns to me and smiles. I get the impression that she doesn't believe that he is really ill....
>
> As we cook I ask Gill whether she feels that Simon is skiving. She replies 'I'm sure that he is. I wouldn't be surprised if his psychiatrist told him something that he didn't want to hear. I'll try to find out later.' She goes on to mention that his friend is due to visit tonight and that he might want to rest before that. She continues, 'It depends on what mood I'm in, sometimes I just jolly him along, other times I really give him a hard time and make him do it (A1 7/28).

Workers in the second Alpha house also argued that they worked with a willed action model of tenant behaviours. One Alpha Two worker did, however, also acknowledge that he personally thought that the medical model was of some use for certain tenants in that it offered them a way of understanding their personal experiences. Alpha Two workers argued, in a similar way to Alpha One workers, that it was desirable for tenants to hold each other accountable for their behaviours and actions and that these processes helped to redress the passivity engendered by years of institutional living. Importantly however, as was shown in Chapter Four, the Alpha Two workers were less instrumental than their Alpha One counterparts in ensuring that these confrontational interactions took place.

Tenants in the second Alpha house remained predominantly committed to the medical view of their mental health difficulties, this contrasting significantly with their counterparts in Alpha One, who had largely embraced the willed action model that dominated within the organisation. The Alpha Two tenants' belief that certain types of behaviour were caused by a state of ill-health, rather than willed and controlled action, had the effect of further reducing the level of E.E. within the house. The following

field-note extract, which refers to a discussion during a house-meeting, offers an example of tenants invoking an illness model of action in order to avoid inter-tenant confrontation.

> Colin (worker) then turns to Bertha (tenant) and asks how she feels about her cleaning tasks. She says that she knows that she is lazy and that she hasn't been cleaning the dining-room as much as she should. At this point Eddy (tenant) comments that it is not her fault and that it is her illness. Bertha (tenant) mishears him and snaps 'shut up Eddy we're not talking about you'. Eddy continues, 'it's true, it's your illness and the medication that makes you like that it's not your fault'. Bertha (tenant) comments that she will try in future to do more and again apologises for not doing much recently.
> Colin (worker) then turns to Joan (tenant) and asks how she feels about her tasks. She comments that she finds it difficult sometimes and that some days she can't do anything, she adds that on days like that she often finds it difficult to even keep herself tidy... Both Gerry and Colin (workers) comment that they know that it is difficult for her. She comments that she does try when she is feeling well. Colin acknowledges that he noticed that she cleaned the sitting-room the other day and that that was really nice of her...Colin then turns to Eddy (tenant). Eddy comments that he can't do anything and that he has a hernia which means that he can't bend (A2 4/26).

Beta organisation

Attributions made by workers and residents in both Beta houses concerning the causes of unwanted or anti-social behaviours were primarily to a state of mental ill-health rather than willed and controlled behaviours. On occasion, however, the nursing staff also pointed to the effects of institutionalisation as causing certain resident behaviours; in fact, one of the main justifications offered by the nurses for their lack of contact with residents was a wish to promote resident autonomy through allowing residents to do as much as possible for themselves. Clearly the attributions used in Beta organisation must be seen within the wider social context of the psychiatric hospitals with its emphasis upon the treatment of mental illness.

The Consultant psychiatrist responsible for the rehabilitation houses appeared to view his role as lying primarily in the field of pharmacology. The doctor's ward rounds did not, as the name might suggest, involve the doctor walking around the houses seeing all the residents, but rather took

place behind the closed doors of the nurses' office. During the ward rounds the Consultant relied exclusively upon the nursing staff to draw matters of significance to his attention. The following recording made in connection to one weekly ward round illustrates the above points.

> Sean (charge nurse) tells me that the doctor is normally only concerned with medication levels. I tell him that I had noticed this and that I was struck during the reviews by the way that the nurses talked about the residents' behaviours and social functioning and the doctor always responded with the same question. Sean laughs and butts in, 'what medication is he on?' I smile and acknowledge that he is correct (B1 11/24).

Many of the nursing interventions that were witnessed involved the nurses attempting to change or control resident behaviours through the use of medication, or through notions normally found in the care of the physically ill, such as 'bed rest'. The impact of the nurses' use of bio-chemical explanations of unwanted resident behaviours was that they rarely held the residents directly accountable for their behaviours and actions. In turn they did not often criticise residents, instead seeing them as victims of an illness beyond their control.

> As Ken (resident) starts to take his tablets John (co-resident) starts to comment in a calm but intimidating manner, 'the coffee's crap, the tea's crap, the chocolate's crap, the food's crap, the place is untidy, people always argue, that's Ken. Why don't you leave then?' John (resident) repeats part of the sentence more loudly, Ken looks annoyed and walks towards the door, he tells John to shut up and walks out of the office. He slams the office door and then the house front door behind him.
> Sarah (staff nurse) asks, 'aren't you two getting on?' John (resident) replies that they never get on and comments that Ken is always moaning. The nurse responds, 'I think that it might be best if you go and have a lay down. She adds, 'I think that you are picking things up wrongly at the moment'. Sarah's (nurse) comments are presented very calmly. John (resident) replies that he isn't picking things up wrong. Sarah (nurse) continues, 'it might not seem that way to you but you are'. She comments that his medication should help and again suggests that he should go and have a rest (B1 11/3).

Residents in the Beta houses also primarily used a model of mental ill-health to explain difficult or annoying co-resident behaviours and in a similar way to the residents in Alpha Two, the Beta residents' use of the medical model had the effect of reducing the levels of E.E. in the Beta houses.

As noted in Chapter Four, some inter-tenant Critical Comments were witnessed in Beta One. However residents were generally tolerant of each other's behaviour and significant provocation was required to cause high E.E. reactions. Certain Beta One residents were seen to withdraw from social contact when they found co-residents' behaviours difficult and this led to some residents' spending significant periods, mainly during the evening, in their bedrooms. A further interesting aspect of the Beta One residents' use of the medical model was that certain residents expressed strong feelings of guilt after they had been involved in a confrontational situation. In some cases the effect of a confrontation, within a social context that stressed attributions to illness rather than controlled and willed action, was at least as difficult for the aggressor as the recipient.

> I ask Jean (resident) how Paul (new resident) is settling in. She tells me that he asks a lot of questions and that he isn't getting on very well with John (resident). She then tells me that she tries to ignore Paul's constant questioning but that sometimes it gets 'too much' for her and she shouts at him. She adds that she feels guilty afterwards because she knows that it is his illness that makes him act that way. Jean then tells me that Paul was 'too much' for her last night and that she had to go and sit in the kitchen in order to get away from him (B1 12/8).

In Beta Two the Assistant Cook also primarily used an attribution model based upon the medical concept of mental illness to explain difficult resident behaviours. The data suggests that the Assistant Cook's attributions had developed because of and with her experiences in the house and had not arisen from a formal mental health training. As the following field-note extract reveals there was some evidence to suggest that during her early days in the house she had tried to find her own rational explanations for the residents' more unusual actions and behaviours.

> Joey (resident) then changes the subject to tell us again about his out of body experiences. His story telling is quite intense and he follows Jeanie (cook) around the kitchen as she

prepares Pat's (resident) breakfast. Joey talks about seeing himself sitting on a wall in the hospital grounds before flying back into his body. He tells us that when he became conscious several months had passed by. Jeanie listens to this, she gives several verbal murmers to indicate that she is listening and paying attention. On a couple of occasions she comments to Joey that she thinks that his imagination is working overtime. When Joey becomes very excited Jeanie uses the excuse of having to take Pat's breakfast through to the sitting-room to leave the room. ...

On her return I ask her how she feels when Joey is like this. Jeanie tells me that she used to go home and think about the things that Joey said to her and tried to work it all out in her mind. She comments that she tried to make sense of it all to her own satisfaction. Jeanie then tells me that she doesn't do this now and that she just tries to listen to him and provide someone for him to talk to (B2 6/28).

THE SOCIAL CHARACTERISTICS AND COHESION LEVELS OF THE TENANT AND RESIDENT GROUPS

Alpha organisation

Certain significant differences were found in the social characteristics and levels of group cohesion in the two Alpha houses. Whilst recognising the difficulties involved in defining social class (Giddens and Held 1982), particularly when people are not presently employed, four of the Alpha One tenants could loosely be described as coming from middle class backgrounds. In Alpha One three of the seven tenants had attended university and another house member had run a large successful business for a number of years. The Alpha One tenants were all also broadly similar in age (45-55 years). By contrast, the second Alpha house was predominantly populated by people from manual and working class backgrounds and contained a wider age distribution (30-55 years). In Alpha Two only one member of the house group came from what might be described as a professional middle class background. The senior worker in Alpha Two suggested that the social differences between the two groups of Alpha tenants reflected the history of the organisation.

Colin (senior worker) tells me that Alpha One was one of the first houses that was opened and that he feels that the type of tenants that were taken into the organisation at that time

were very different to those that have come into the organisation more recently. He comments that there are only so many professional and middle class people that are in hospital and as the organisation has expanded people have come from different socio-economic groups (A2 4/26).

The differences in the social class of the two tenant groups had significant implications for the interaction patterns within the houses. Thus, in the first Alpha house it was normal at the communal meal for there to be a choice of main courses, one being vegetarian. The Alpha One meals tended to be more elaborate than the convenience foods of Alpha Two and in turn the Alpha One meals required greater preparation and involved higher demands upon tenants. The higher proportion of middle class tenants in Alpha One also appeared to aid their acceptance of the dominant organisational model of open discussion of inter-personal difficulties. The Alpha One tenants appeared to feel more comfortable with their verbal abilities and more prepared to raise issues of inter-personal tension directly with one other.

Although Alpha One had a wider class distribution within the tenant group, the workers had been active in attempting to create a cohesive group. The Alpha One workers argued that they aimed to create a situation whereby tenants would offer one another support. This worker goal was reflected in certain aspects of the language used within the house; thus tenants were nearly always referred to as 'the folks' and the house meeting had become known as 'the get togethers'. The Alpha One workers' desire to create a cohesive and supporting tenant group was however only partially successful and paradoxically, in a context of relatively high demands upon tenants and the dominance of attributions to willed and controlled behaviours, the increased level of social cohesion appeared to have had the effect of intensifying social interactions and further raising the level of E.E.

Beta organisation

The first Beta house provided the research house with the most socially heterogeneous resident group. Three of the nine Beta One residents could be loosely described as coming from middle class backgrounds and the group had the largest resident age distribution; two/three residents were 25-35 years, five residents were 45 to 65 years and one resident was in her early 70s. In Beta One there was also a noticeable division between five older residents who had spent a large proportion of their lives in hospital and four

younger residents who had experienced multiple 'revolving door' admissions. The result was that there was not a clearly identifiable Beta One resident culture in the same way as the other houses. In Beta One there was the sense of a group of people sharing a house but living quite separate lives.

By contrast, one of the most striking aspects of the second Beta house was the social homogeneity of the resident group. All of the residents were male and in their mid to late 50's. Two were ex-coal miners, one had previously worked in a dock yard and another had a lot of experience of factory work. The fifth resident became ill during his late teens while in the R.A.F. The over-riding values of the Beta Two resident group were concerned with getting along together and making the best of the present situation. These dominant resident values were reflected in the resident's use of the collective terms the 'lads'. As the field-note extract below indicates, to be known as one of the 'lads' was to be accepted and considered part of the house group.

> I spend the next ten minutes talking to Jock (resident). He recalls his docker days and the cases of whisky that used to be 'borrowed'. While we are chatting I ask Jock what he thinks about the new resident. He tells me that he seems O.K. and that he thinks that he will fit in with 'the lads' (B2 6/8).

Although the Beta Two resident group were socially very homogeneous there did not appear to be any internal group pressure for residents to engage in communal activities or spend substantial periods in social contact. In fact during field-work, one Beta Two resident spent long periods living alone in a tent in the garden. The residents were found to employ two central techniques to avoid direct confrontation. The first of these techniques involved the creation of house myths to explain troublesome patterns of behaviour or annoying co-resident actions. By creating myths, residents appeared to be able to justify any inequalities in task distribution and avoid confrontations. This tactic was seen most clearly when a new resident came to the house and refused to take part in the minimal communal tasks associated with the evening meal.

> On the bus I ask Joey (resident) if anything has been decided concerning what the new person will do for the evening meal. Joey tells me that he thinks that he probably won't do anything. Joey comments that he is quite an old man and that he is blind in one eye. (In reality the new person is no older than the other residents in the house and is not the

only resident that is blind in one eye.) Joey then comments that he supposes that they could make a rota so as to include the 'new boy' (Joey's term) but that it would be complicated because there are odd numbers (B2 6/8).

The creation of house myths was however only successful in explaining unwanted behaviours in the short term. Thus, as was shown in Chapter Four, the only area of Beta Two house life where Critical Comments were occasionally heard related to the preparation of the evening meal.

The second major tactic that Beta Two residents employed to avoid confrontation involved reference to what the Assistant Cook would do if certain tasks were not completed. It was relatively common for residents to say things such as , 'you better do 'x' or Jeanie will go mad'. In this way residents managed to give each other instructions without actually having to engage in directly telling each to perform communal tasks. In reality there was no evidence to suggest that the cook would have actually 'gone mad'. She herself claimed to have only spoken to the residents on one occasion; relating to the cleaning of the cooker.

> Jeanie (cook) says that, 'it's funny but the residents all say that they keep the house clean for me and that I will go spare if it is untidy when I come in'. She continues by saying that she thinks that it gives them a way of telling one another to keep it clean without having to tell each other to do things. She says that she thinks that by blaming her they can prompt each other without getting into confrontations (B2 6/1).

A further significant aspect of the cohesive Beta Two resident culture was their fairly united and consistent, albeit not completely conscious, effort to keep the nursing staff at arm's length. Thus the men kept their contacts with the nursing staff to a minimum and were very guarded about the information that they gave to the nurses.

> Joey (resident) then tells me that the nurses have reviews every three months but that he stays well away. I ask him why he doesn't attend, adding that this is his chance to have a say about what he wants and thinks that he needs. Joey explains that he has been in the hospital long enough to know that you have to be very careful what you say at these meetings. ... Joey pauses and then says that if he is there the staff might start trying to make him go back to a day activity. He says that he is supposed to go to the York Centre two days per

week but that he has stopped going. Joey continues by telling me that attendance used to drain him of all his energy and that he just couldn't keep going. ... He adds that when he used to try and go he could feel himself being dragged back to the acute ward and so he stopped attending (B2 7/7).

The Beta Two residents also attempted to maintain the status quo by treating the nursing staff as guests whenever they visited the house. This technique was remarkably efficient and had the effect of disempowering the nursing staff. The residents' host-like attitudes appeared to invoke certain social etiquette responses from the nurses which in turn pushed them into the role of 'entertained visitor'. This process was particularly noticeable with less experienced nursing staff.

> We go into the sitting-room again and Jock (resident) sits next to the student nurse. Jock has a can of beer and comments to the student, 'you'll think that I'm an alcoholic every time you come here I'm having a wee drink.' The student is very non-committal and just responds with a smile. Jock then asks her if her coffee is all right she says that it is lovely, he gives her a cigarette. She laughs and says that he is just encouraging her bad habits. Jock puts his arm round her and gives her a squeeze. He tells her that a cigarette will not harm her. Jock's whole approach to the student comes across as quite sexist. He is very kind but treats her more like a guest in the house than a visiting professional (B2 7/13).

It would be misleading however to give the impression that all of the Beta Two residents were completely satisfied with their care setting. The residents' lives were very routinised and predictable and on occasion residents expressed dissatisfaction with the wider quality of their lives. In fact, in the concluding chapter, it will be argued that the evidence from this study suggests that there exists a tension between, on the one hand, offering residents supported accommodation which is low in E.E. and general stress, and on the other hand providing them with a care setting which actively promotes resident choice and control via their involvement in the management and organisation of the setting.

THE IMPACT OF THE RECENT HISTORY OF THE HOUSES

This section attempts to locate the social actors' current interaction patterns within the context of the recent house histories. It must be stressed that the intention here is not to provide a comprehensive history of each research site but rather to point to particularly important recent historical events. Such events were of particular importance in shaping the observed differences between the two Alpha houses.

Alpha organisation

In the year prior to field-work Alpha Two saw an important change in staffing; a new team leader and one house-worker took up post approximately eight months before field-work, (the third worker had been in post for just over one year). By contrast, the first Alpha house had experienced a fairly consistent worker approach and there was no evidence to suggest that the house had seen a similar recent shift in staff priorities and care practices. The arrival of the new Alpha Two workers heralded a significant shift in the way that the house was run. The following field-note quotations offer insight into the care practices of the previous Alpha Two staff team; these ways of working involved more active interventions and higher demands upon tenants than were witnessed during field-work.

> Sue (worker) comments that the ex-senior was a trained psychiatric nurse and that she often felt that she was working with a type of nursing model. She gives the example of Bertha (tenant) and comments that she was asked to tap on Bertha's door at 11am each morning. She adds that she felt at the time that Bertha should have had more choice when to get up. Sue continues by saying that in those days the tenants viewed her as the boss and that her relationship with them was not very equal. ...
> Sue then pauses for a moment and adds that it is true that Bertha doesn't go out as much now as she used to and that she feels that it would be better for her to leave the house more often. ... Sue appears confused at this point as to which situation she preferred (A2 4/26).

> I then ask Bertha (tenant) if there were a lot of change when the new house-workers arrived. Bertha replies, 'Aye there was, things were err.... well now I help to make the

decision about when I go out. ...Things are not so err.... (She trails off and so I prompt.) 'What happened before?' Bertha laughs, a little nervously and Bessy (tenant) answers, 'She got telt to go, they used to make her go.' Bertha comments 'Yes that was it' and laughs again. I also laugh to relieve the slight area of tension, then comment that I have a mental picture of the house-worker dragging her out by her hair. I ask how the workers made her go. Again Bessy (co-tenant) answers the question saying, 'they just told her and she went.' Bertha laughs again and says, 'Aye that was it' (A2 4/6).

The new Alpha Two staff team's strong emphases upon the tenant choice and control aspects of the organisation's ethos, were in large part a reaction to the problems which they encountered upon entering the house. As the following field-note demonstrates, the workers found that some tenants were experiencing real difficulties with communal activities. The senior worker attributed a significant proportion of these problems to the previous workers' creation of an atmosphere of compulsion.

Colin (senior worker) pauses and then tells me that when he came to the house he found that the previous workers had been very keen on people attending the house meetings and communal meals. He comments that, 'there were more rules, or if you like expectations'. He continues by telling me that some of the tenants found attendance at these meals and meetings very difficult. He explains that the there was a lot of tension about before the meals and meetings and that it was a very stressful time (tension and stress are the words used by the worker). Colin then goes on to explain that the house-workers' attempts to ensure that people attended communal activities had actually made the situation far more difficult (A2 3/30).

It would, however, be wrong to give the impression that all of the tenants preferred the new staff team's ways of working. At least two of the Alpha Two house members commented that they regretted the departure of the ex-senior worker, that they telephoned her regularly and still occasionally met with her for coffee. These tenants noted that they felt secure under the previous workers and argued that the communal tasks were completed more equitably.

When Colin (senior worker) has finished speaking, Danny (tenant) comments that he misses Jean (ex-senior worker). He

says that with no disrespect to Colin (current senior), Jean was a very important person in his life. He says that she used to make him feel secure and that he felt that she could help him when he felt paranoid (his terminology). He comments that she was only the same age as him (33) but she was very experienced. He adds that she was a psychiatric nurse. Danny then comments that he knows that Colin was also a psychiatric nurse and that he is also experienced. Colin replies that he is glad that Danny is able to say these things to him (A2 4/26).

As was noted in Chapter Four, the Alpha Two tenants were found to be actively avoiding inter-tenant confrontation and again there were important historical forces behind these behaviours. In the recent history of Alpha Two there had been several minor incidents of violence. The reality of these incidents remained fresh in tenants' memories and affected their current interactions. The first of the field-notes below records one tenant's recollection of a previous confrontation with an ex-tenant. The second extract provides insight into a reaction previously elicited from a tenant who was still living in the house.

> During our conversation Eddy (tenant) tells me about two incidents of violence that he has experienced from ex-tenants. One involved his being chased up the stairs and having to defend himself by turning on the fire extinguisher. On the other occasion he received a punch in the face. He described how at one point he was so frightened of what this particular tenant might do he stayed in his room (A2 3/30).

> Colin (house-worker) goes on to talk about the house group dynamics. He tells me that there is one tenant in the house that is particularly dominant. She was apparently once challenged by another tenant over the fact that her boyfriend was taking greater and greater liberties in the house, staying over night, eating the food, coming and going as he pleased, etc. Her reaction when challenged was apparently extreme and verged on physical aggression. Since this incident other tenants have been very wary of her and not raised the subject again (A2 4/26).

A further force behind the Alpha Two tenants' desire to avoid direct confrontation related to the house's internal tenant economy. One tenant had a considerably larger income than the other tenants and an informal economy had arisen, whereby one tenant acted as banker lending co-tenants

money for cigarettes during the latter part of the benefit week. This led to a situation where three of the tenants had become financially dependant upon 'the banker' and wished to avoid challenging or confronting her, even though they believed that she did not undertake a fair share of the communal house-hold tasks. By contrast four Alpha One tenants had private incomes; the greater proportion of Alpha One tenants with personal incomes meant that there were not the same pressures towards financial dependence upon one house member.

The combination of the relatively recent shift in worker care practices, the history of minor violence within the house and the internal tenant economy were all important in explaining the observed differences between Alpha One and Two. Thus Alpha Two tenants wished to avoid direct confrontation and accordingly preferred to express their dissatisfactions to staff rather than each other. On occasions however, hidden frustrations, particularly concerning shortages of money or perceived inequalities in the distribution and completion of communal house-hold tasks, spilled over into the observed Critical Comments. Such Critical Comments normally took the form of 'sniper attacks' because tenants were not prepared to engage in open confrontations which risked changing the fragile status quo.

Beta Organisation.

The most important recent historical event in Beta organisation was the closure of a large part of the main hospital. The impact of this organisational change upon the nursing team's morale and its consequences for their views of the organisation's role, have been discussed above (see section on the role and ideological commitment of the workers). Accordingly this discussion is not repeated here. In Beta One, there were not found to be any significant patterns of resident economic interdependence, nor had there been any recent episodes of inter-resident violence.

During the year prior to field-work in Beta Two there had been a resident who had been involved in several minor violent incidents with co-residents. Moreover, in a similar way to Alpha Two these recent experiences appeared to have had the effect of discouraging current residents from engaging in inter-resident confrontation.

> Jeanie (cook) and I sit and chat, I tell her that Joey (resident) was telling me yesterday about Dan (ex-resident)

and the problems that used to exist in the house. I explain that he told me of two incidents of violence. ... Jeanie comments that since Dan left the house her life has been much easier. ...she continues by telling me that John used to blame everyone for his illness and that on one occasion he said that her switching on the hoover caused him to be ill (B2 6/28).

In Beta Two there was also one resident who had a substantial private income. He had not however become involved in lending money to other house members and instead preferred to buy them occasional gifts (chocolates, cigarettes, beers, etc.). In the social context of Beta Two this situation appeared to further reinforce the sense of the residents pulling together to make the best of their current situation.

> After about ten minutes Joey (resident) comes into the sitting-room holding a £5 note. He walks over to Jock (resident). It is obvious that he is going to give Jock some money for cans of beer. I ask Joey jokingly if he is giving away money today. He laughs and then says, 'here we are Jock get yourself a couple of cans of Export and a can of lager for me.' Jock replies with his normal phrase, 'oh I couldn't Joey, oh well if you're twisting my arm.' He then grabs the five pound note. Both the men laugh. Joey asks me if I would like a can of Coke and I accept. He then asks Mick (resident) if he would like a beer, Mick declines. Joey walks over to Pat (resident) who is still reading the paper and asks if he would like a drink, Pat also declines (B2 7/7).

CONCLUSION

In 'The Social Construction of Reality', Berger and Luckmann (1979) argue that it is incorrect to see Durkheim's dictum to, 'treat social facts as things' (Durkheim, 1950) and Weber's view that, 'both for sociology in the present sense, and for history, the object of cognition is the subjective meaning-complex of action' (Weber, 1947) as contradictory and mutually exclusive. For Berger and Luckmann, at the heart of social reality lies a dialectical process that is simultaneously both objective and subjective in nature.

> Society does indeed possess objective facticity. And society is indeed built up by activity that expresses subjective meaning. ... It is precisely the dual character of society in

terms of objective facticity *and* subjective meaning that makes its 'reality *sui generis*' (Berger & Luckmann 1979 p.30).

Berger and Luckmann argue that people are born into specific cultures with pre-defined meaning sets, norms, values and a language. This is the society's objectified common reality, which, in the 'natural attitude', appears to the individual as an external and objective reality. Through the processes of primary socialisation[2] society's members learn historically and culturally specific common-sense-knowledge; that is, the taken-for-granted reality of everyday life. During daily interactions society's members use and employ their internalised common-sense-knowledge in order to make social life manageable, predictable and indeed possible. The very act of using the collective common stock of knowledge, or in Berger and Luckmann's terminology 'externalising', further serves to reinforce the validity of such common understanding and to legitimise the objectified prevailing social reality. Dialectically, however, a society's stock common-sense-knowledge is also not static and immutable but is prone to change and redefinition during use.

For Berger and Luckmann these essential social processes exist not only at the macro socio-cultural level but also at the micro level of individual social institutions. Indeed, the overall stock of societal common-sense-knowledge is, in large part, the sum of smaller institution specific sets of meaning and common understanding. Specific organisations within society also have their own internal common-sense, taken-for-granted, sets of knowledge. Through the processes of secondary socialisation, the members of an organisation learn the objectified knowledge that is applicable to that social setting. Once learnt the organisational knowledge provides the social actors with the collective sets of meanings and definitions that make smooth social interaction possible. Thus for example new members of an organisation learn the official goals and purposes of the organisation, the roles and responsibilities of various individuals, the appropriate ways of acting within

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[2] Berger and Luckmann define socialisation in the following terms, 'the comprehensive and consistent induction of an individual into the objective world of a society or a sector of it. Primary socialization is the first socialization an individual undergoes in childhood, through which he becomes a member of society. Secondary socialization is any subsequent process that inducts an already socialised individual into new sectors of the objective world of his society' (Berger and Luckmann 1979 p. 150).

various settings, the socially correct ways to interpret and explain various social actors' behaviours, etc.

As Berger and Luckmann are keen to point out, however, the learning of an organisation's/institution's objectified knowledge does not lead to a situation whereby the social actors' behaviours are subsequently determined. Individual social actors must interpret, understand and act upon the received organisational knowledge within a concrete historical context. As the various social actors interpret and utilise the organisation-specific knowledge and integrate it into their wider biographical experiences, so the observed empirical reality of organisational life is created. The social actors' subjective meanings are influenced by the organisation's objectified knowledge, but in turn individuals' subjective meanings contribute to and shape the objectified communal stock of knowledge and meaning. The processes involved in the social construction of organisational life are therefore dynamic and living. In short, through their daily interactions social actors are dynamically involved in the construction of the observed empirical social reality.

This chapter has attempted to utilise these theoretical insights in order to provide an adequate understanding of the social construction of daily life within the research houses. Beyond this, the analysis has attempted to identify the key elements within the social construction of reality that accounted for the differing patterns of observed E.E. in the four sites. The qualitative data reveals that within the care organisations studied there were in fact several layers of objectified knowledge. There were the formally stated goals of the organisations, the care ideologies and the administrative structures. There were also, however, the common-sense-knowledges created and used by front-line social actors (workers and tenants/residents), within their concrete historical care settings. The observed empirical reality of life in the houses resulted from the complex interplay of these factors. This observation is not in itself entirely new as the work of Lipsky (1980), concerning the role of 'front-line bureaucrats', bears testimony.

In this study it was found that in Beta organisation there had been a significant movement in the role of the houses; away from their focusing primarily upon rehabilitation towards their providing a continuing care environment for many of the residents. A clear dislocation was found between the nursing team's common-sense-knowledge and resultant behaviours, and the formally stated organisational goals.

The nursing team was marked by low morale which stemmed primarily from low staffing levels, limited material resources and a drab physical environment. Nursing staff argued that certain administrative changes and the arrival of several new residents had led to a situation whereby the houses now contained many residents that did not have the potential to move to less supported accommodation. The situation had arisen whereby the formalised nursing care processes had often become divorced from clearly identified end goals and instead served primarily to provided structure to the nurses' working days.

Nursing contact with residents was found to be low, with the majority of interactions being primarily instrumental in nature, focusing upon patient management issues such as drug administration, personal hygiene, laundry, retiring and rising from bed, etc. The Beta nursing staff remained committed, however, to the prevailing organisational view of psychotic mental illness primarily stemming from bio-chemical processes. These dominant attributions meant that nursing staff did not generally hold residents accountable for their behaviours and tended to treat residents as passive victims of an illness beyond their control. The nurses primarily attempted to change residents' unwanted behaviours through drug administration and interventions more normally associated with the care of the physically ill. As the following field-note quotation reveals, this movement in the nursing team's role had taken place within the care setting's organisational and structural position of relative managerial and geographical isolatation.

> Sean (charge nurse) tells me that the nursing staff like the position as it stands and notes that he as charge nurse is offered a lot of autonomy to run the unit as he sees fit. I then ask whether his nursing officer ever comes down and suggest ways to do things. He tells me that if he did he would tell him to, 'p... off, but in professional terms' (Sean's words) (B1 11/24).

Thus, within Beta One a complex combination of factors had led to a situation where the demands upon residents were minimal and the pressures thought likely to be associated with the rehabilitation process were not found; for example, patients were not being strongly encouraged or pushed to undertake new and challenging tasks. The result was that nurse/resident interactions in Beta organisation tended to be very low key and contained

hardly any examples of high E.E. interactions. The low levels of nursing staff contact also led however to a situation whereby residents had to resolve any inter-resident dispute amongst themselves. Some residents were found to withdraw from confrontational situations, spending periods in their bedrooms. Others however engaged in direct confrontation and this often resulted in significant levels of Critical Comments.

In Beta Two the Assistant Cook was the primary care giver. Her organisational position was also one of geographical and administrative isolation, from both the nursing and catering management structures. In this situation she was found to have extended and developed her role within the house. In so doing she drew primarily upon her wider biographical experiences and in particular upon her familiar role of mother. Within the house she had become involved in performing many practical daily living tasks, which should, in theory, have been undertaken by residents. This had the effect of lowering both the demands upon residents and the levels of inter-resident dependence. The Assistant Cook had also become involved in providing the residents with a listening ear. Importantly, however, she managed to refrain from judgmental attitudes, or attempts to change people, and she appeared genuinely able to accept the residents as they were.

In Alpha organisation it was found that the internal contradictions within the organisation's ethos and the prescribed role of the workers, had led to a situation whereby the two worker teams had to make decisions concerning which aspects of the ethos to emphasise within their particular concrete care settings. In Alpha One the workers primarily stressed the creation of 'home'. However their respective operationalisations of this concept differed; both workers drew upon their personal biographical experiences in order to make sense of their key care aim. For one worker, the core elements in creating a home revolved around encouraging tenants to take increasing control over the running of the house. He was prepared to intervene directly in order to facilitate tenant group decision making or the open discussion of inter-tenant disputes and conflicts. The second Alpha One worker stressed that she saw harmonious inter-personal relationships as the primary constituent element of a 'home'. She argued that tenants should control their individual behaviours in order to promote goodwill and congruity within the house. When this did not happen she became frustrated and examples were observed of her holding tenants accountable for their actions. Both Alpha One workers, in line with the organisational ethos, had rejected the medical

model of mental illness and invariably made attributions to willed and controlled actions.

The result was that the Alpha One workers' operationalisation of the organisation's care ideology contributed significantly to the observed high levels of E.E. Moreover, in looking at the workers' contribution to the social construction of life in the house, insight is also gained into why certain Alpha One tenants found attendance at the communal house meals and fortnightly house meetings so difficult. The situation had been created whereby tenants were required to attend these communal activities and at any time during the events they could potentially be held accountable to the house group for their actions and behaviours.

In Alpha Two the workers stressed the importance of individual tenant choice and control as their over-riding care aim. The worker team had consciously decided to remove the compulsion to attend the communal house meals and the fortnightly house meetings. Their stress upon tenant autonomy and choice also meant that they were not as prepared as Alpha One workers to intervene directly in order to facilitate direct inter-tenant discussion of disputes and tensions. Alpha Two workers argued that individual tenants should have real choice concerning whether to raise an issue for group discussion. They also noted however that if tenants chose not to they must also live with the consequences of that decision. The decisions taken by Alpha Two workers concerning which elements of the organisation's ethos to emphasise, stemmed largely from the recent history of the house. There had been several relatively recent incidents of minor inter-tenant violence and a previous set of workers' insistence that tenants attend communal activities had caused certain tenants real difficulty.

The afore-going brief summary of the house workers' common-sense-knowledges and operationalisations of the organisations' care ideologies, should not be read as suggesting that the tenants and residents were passive in the social construction of daily life within the four houses. In fact, several clear examples were found of resident or tenant group beliefs and actions that stood in direct opposition to worker goals. Thus for example, in Alpha Two it was found that the actions and beliefs of tenants largely circumvented any worker attempts to encourage direct inter-tenant accountability. Alpha Two tenants actively avoided situations where confrontation was likely and employed attributions based upon medical bio-chemical definitions of mental illness; such attributions were found to have the effect of largely exonerating

individuals from personal and communal responsibilities. Similarly, in Beta Two the resident group were found to be employing certain very effective techniques to maintain the status quo against the perceived outside threat of the nursing staff. Thus, residents kept their contacts with the nurses to a minimum, were guarded in the information that they passed on and treated the nursing staff as guests whenever they visited the house. Conversely, in Alpha One the tenant group culture was found to be aiding the workers' attempts to encourage 'open and honest communication'. The Alpha One tenants had largely accepted the organisation's rejection of the medical model of mental illness and were prepared to hold co-tenants publicly accountable for their actions and behaviours.

As indicated above, a central and striking feature of the qualitative data related to the differing levels of worker commitment in the two research organisations. Thus whilst the staff teams within Alpha organisation operationalised the organisation's ethos in significantly different ways, they were both marked by a high level of commitment to the organisation in general and to their own key care aims in particular. Alpha staff accordingly spent the majority of their working time in direct contact with tenants and were observed on several occasions to reorganise their shifts in order to facilitate support for a tenant attending a leisure activity. By contrast, within Beta organisation the nursing staff were found to have undergone a process whereby they were in many ways alienated from both the organisation's formally stated goals and the residents. It has been noted above that, to a significant extent, these differences in worker commitment resulted from differences in the material resource levels, staffing levels and degrees of bureaucratisation within the two organisations.

For Berger and Luckmann however differing organisational roles also require the institutional stock of knowledge to be internalised and accepted by the individual at differing levels; this results in variation in the processes of secondary socialisation. In turn the depth of internalisation, that is the extent to which the knowledge becomes an integral part of the individual, appears to be a crucial factor in level of commitment that an individual has to the institution. Berger and Luckmann offer the following example to illustrate the point.

> Engineering education can take place effectively through formal, highly rational, emotionally neutral processes. Musical education, on the other hand, typically involves much

higher identification with a maestro and a much more profound immersion in musical reality. This difference comes from the intrinsic differences between engineering and musical knowledge, and between the ways of life in which these two bodies of knowledge are practically applied (Berger & Luckmann 1967 p. 164).

In this study broad parallels can be seen between the role of the engineer and that of the Beta nursing staff, and between the training of the musician and that of the Alpha workers. Thus in Beta organisation the emphasis was upon the role or 'job box' (Handy 1988) of 'nurse'. The organisation's definition of 'nurse' was largely void of individuality and instead stressed the technical competence to perform certain tasks. The organisation's view of the nurse as technician or technician's (doctor's) assistant was further reinforced by the dominance of the medical bio-chemical model of the mental illness. Within the medical model the individual patient comes to be seen in an atomised mechanical way, consisting of a collection of parts that can be treated or repaired; normally through the use of pharmaceutical, electro-convulsive or surgical interventions. Traditionally, psychiatric nurse training has also been conducted in a way that is not so dissimilar from the education of the engineer, involving formal lectures, block practice placements and the successful completion of formal written examinations.

By contrast, the relative smallness of Alpha organisation meant that workers were known as individuals rather than merely by their institutional role. Within Alpha organisation the role of worker was defined primarily in person-centred ways, which revolved around interpersonal relationships and certain organisationally prescribed moral values. Thus within the organisation it was not uncommon to hear comments such as, 'there are certain kinds of people who are Alpha type people and others who are not'. Alpha's 'training' was largely informal and stressed the internalisation and acceptance of the organisation's ethos; a set of attitudes and beliefs based upon moral prescriptions concerned with the rights and responsibilities of individuals within the organisation. The ethos was transmitted, maintained and legitimised through regular staff support sessions both within and across the organisation's houses. In short in order satisfactorily to perform the role of house-worker within Alpha organisation a more profound level of commitment and belief in 'the cause' was required than in Beta organisation.

It is suggested therefore that, the two research organisations' respective views of the roles of their workers and the divergence in their respective processes of secondary socialisation, resulted in a significant difference in the propensity of workers to withdraw their support from the formally stated organisational goals. The actuality of the workers' respective levels of commitment to their organisation, resulted, however, from the front-line workers' experiences within their concrete care settings.

To summarise, the analysis in this chapter suggests that the observed empirical reality of life in the four research houses resulted from a complex interaction of factors. The formally stated goals of the organisations, the administrative structures, the processes involved in the secondary organisational socialisation, the material resources and staffing levels, all contributed significantly to life in the houses. It would be wrong however to see these factors as determinant of the observed patterns of interaction in the four sites. The front-line social actors had to interpret and operationalise these factors within concrete historical contexts and in so doing they also drew upon factors external to the organisation; namely their wider biographical experiences.

The analysis presented in this and preceding chapters raises interesting questions for the future of E.E. theory as it relates to collective care settings. These issues will be discussed in depth in the following chapter. However, at the risk of pre-empting the discussion that is to follow, the analysis raises certain questions. Firstly, concerning the wisdom of attempting to measure the level of E.E. in a collective care setting through the administration of the Camberwell Family Interview to key workers. This study found that the majority of observed high E.E. interactions were between co-tenants or co-residents rather than staff and clients. This is not to suggest however that staff did not play an important role in facilitating these interactions. Secondly, the analysis points to the importance of understanding the meaning of events, actions and behaviours within their social context, particularly when attempting to assess their effect as stressors upon individuals. Thirdly, the analysis raises questions concerning the possibility of creating an instrument that is capable of efficiently and effectively measuring the level of E.E. across various collective care settings.

CHAPTER SEVEN

Methodological considerations for future work attempting to relate the concept of Expressed Emotion to collective care settings

INTRODUCTION

In this and the final chapter the conclusions from this study will be drawn together and made explicit. This chapter will primarily focus upon the methodological implications of this study's findings for past and future attempts to relate E.E. to collective care settings. The organisation of this chapter will be around three main sections: the first will be concerned with the existence, direction and focus of face-to-face high E.E. interactions within the four research houses; the second will offer a discussion of whether high E.E. interactions within collective care settings are likely to have the same effect as those recorded in family settings; and the final section will make explicit the methodological implications of the study's findings for past and future attempts to relate the concept of E.E. to conditions in collective care settings.

Prior to the commencement of the main body of this chapter it is necessary to briefly recall the central starting point of this study. This study began from the position that a family's rating on the Expressed Emotion (E.E.) indices represents real differences in attitudes, behaviours and family interaction patterns. The viewpoint that E.E. is more than just the responses that a key relative/s gives to the semi-structured Camberwell Family Interview (C.F.I.), is supported by a growing volume of evidence (see Chapter One). Thus for example, the Miklowitz et al. team (1984 & 1989) have shown that there is a strong correlation between families that rate high in E.E., as measured by the C.F.I. and negative Affective Style (Doane et al. 1981). Moreover, in a laboratory based 'family problem solving' study of forty-two American patients (30 male and 12 female) and their families, Miklowitz et al. (1984) demonstrate that it is possible to distinguish between relatives rated as high in E.E. due to Critical Comments and those rated as

high in E.E. due to Emotional Overinvolvement solely on the basis of observed family interactions.

> High E.E. critical parents use a pattern of affective communication in direct interaction marked by frequent negative evaluations of the offspring's behaviour and/or character. High E.E. overinvolvement parents, on the other hand, can be distinguished from high E.E. critical as well as from low E.E. parents by their greater usage of neutral-intrusive statements. Such statements are indicative of poorly defined or undifferentiated boundaries between parent and child (Miklowitz et al. 1984 p. 486).

THE EXISTENCE, DIRECTION AND FOCUS OF HIGH E.E. INTERACTIONS WITHIN COLLECTIVE CARE SETTINGS

A central aim of this study has been to determine whether high E.E. type interactions exist within collective care settings. The study thus sought to observe and record face-to-face naturalistic interactions within four collective care settings, (ten weeks being spent in each site). The data collected from the four research houses reveals that face-to-face Critical Comments and some displays of Hostility, very similar to those described in family oriented studies, were found in the research houses. However, no examples of Emotional Overinvolvement[1] were recorded (this finding will be discussed further in the final sections of this chapter). Beyond this, it was also found that the periods of participant observation offered the researcher a means of assessing the respective levels of E.E. within the four houses. It therefore proved possible to rank the houses in terms of the levels of observed high E.E. interactions; the four research sites ranked from highest to lowest E.E in the following order Alpha One, Alpha Two, Beta One, Beta Two.

As was shown in the literature review (see Chapter One), to date there have only been two attempts to relate the theory of E.E. to residential care settings (Berkowitz & Heinl 1984; and Ball, Moore et al. 1992, Moore, Ball et al. 1992). Both of these research teams have implicitly assumed that, when studying E.E. in a collective care setting, the nurse or care worker can be

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[1]It will be recalled that Emotional Over-involvement (E.O.I.) is seen as involving reports and displays of unusually self-sacrificing, devoted and extremely over-protective behaviours by relatives. Emotionally over-involved relatives are very involved in the patient's life and find it difficult to allow age-appropriate autonomy (Leff and Vaughn 1985 pp. 44-48).

substituted for the family's key relative/s. Thus Berkowitz and Heinl (1984) utilised a case vignette approach to examine the reported attitudes and behaviours of twenty-two nurses across a variety of psychiatric wards (general, locked and chronic long-stay) and concluded that the nurses who took part in the study (all volunteers) primarily displayed attitudes similar to low E.E. relatives. Ball and her colleagues (1992) administered a slightly adapted version of the C.F.I. to key workers in two London hostels and then proceeded to rate the key worker/client relationships as being either high or low in E.E. (see Chapter One for a discussion of Ball et al.'s findings). This study's central findings raise certain serious issues concerning the validity and reliability of the methods employed by the Berkowitz et al. and the Ball and et al.'s research teams.

Firstly, with regard to Ball et als' work this study's data raises significant questions concerning the legitimacy of assuming that the key worker's relationship with a particular client is a reliable measure of the high E.E. interactions to which a resident is subject. Issues are raised concerning the level of face-to-face contact that the key worker has with their key client and the degree of emotional engagement or closeness that exists between the client and the key worker. It was in an attempt to address these issues that Ball et al. limited their administration of the C.F.I. to workers who spent more than twenty percent of the working week in direct contact with clients. However, twenty percent of a thirty-five hour working week is only seven hours face-to-face contact per week; this appears likely to be substantially less time than the average family carer spends with a relative. Leff and Vaughn (1985) have argued that high E.E. families that are particularly at risk are those that spend more than thirty-five hours per week in face-to-face contact.

Within this study it was found that formally designated key workers often actually had quite limited direct contact with their key clients and moreover that the key workers were not always the staff members who had the closest emotional relationship with the client. The prime example within this study was found in the second Beta house. In Beta Two the Assistant Cook, rather than the staff nurse key workers, was found to be the primary carer and to have the highest degree of face-to-face contact with the residents. Her relationships with residents were also affectively closer than were those between key workers and clients. Somewhat similarly, in Beta One residents were found to have higher levels of direct contact with the lower grade

workers (nursing assistants and student nurses) than their key workers (the staff nurses and charge nurses). In fact it was the student nurses or nursing assistants who primarily implemented the key-worker devised care plans and who on occasion went on social trips with residents, (to coffee houses or shopping for clothes). Purely in terms of the level of face-to-face contact and the emotional intensity of the key worker relationship it would therefore appear ill-advised to rely solely upon the administration of the C.F.I. to key workers to measure the level of E.E. to which a client is subject. The data from this study suggests that the level of contact between key workers and clients will vary and depend upon numerous factors including staffing levels, the workers' operationalisations of the formal care ideology, the workers' administrative duties, shift patterns, holidays and sickness levels, etc.

The important point to be stressed here is that the C.F.I. essentially focuses upon dyadic relationships. In family studies the C.F.I. has therefore attempted to measure the very limited number of dyadic emotional relationships. In family settings this approach appears legitimate due to the fact that there are normally only one or two key relatives and one patient. Ball et al. attempted to transfer this methodology directly to residential settings and accordingly sought to identify key dyadic relationships within their study sites so as to administer the C.F.I. This study's findings point to the problematic nature of Ball and her colleagues methodological approach and in particular their failure to recognise that residential care settings involve the collective care of many patients by many carers. Moreover, the recognition of the multiplicity of relationships within collective care settings also raises the interesting theoretical question of whether emotionally-overinvolved relationships are possible in such settings. The fact that, by definition, collective care settings involve the care of several residents/tenants by more than one carer appears likely to negate the development of the extremely intense and suffocating emotional relationships which constitute E.O.I. The issue of theoretical applicability of E.O.I. to collective care settings is discussed in greater depth below.

A second and equally important challenge to the previous attempts by Ball et al. and Berkowitz et al. to measure the level of E.E. in collective care settings comes from the fact that within this study the vast majority of observed face-to-face high E.E. interactions were between co-residents or co-tenants rather than carers and residents. Only one worker in the first Alpha house displayed significant levels of high E.E. attitudes and

behaviours towards tenants. These findings suggest that adequate methods for assessing the levels of E.E. within a collective care setting need to be capable of measuring all the high E.E. interactions that a patient is subject to; this should include high E.E. interactions with all staff as well as those between co-residents/tenants. (The question of whether high E.E. interactions between co-residents/tenants are likely to have the same effect as those observed within family settings between relatives is an important question and will be discussed below.)

The fact that most of the observed face-to-face high E.E. interactions within the research sites were between co-residents/tenants, rather than between workers and residents/tenants, does not however mean that the workers did not play an important role in mediating the levels of E.E. in the houses. As was shown in Chapters Four and Six, the workers' operationalisations of the care ideologies were important variables in the determination of the levels of E.E. in the houses. Thus, for example, the Alpha One workers were instrumental in ensuring that tenants voiced any concerns and tension openly and directly to one another; in turn this worker policy increased the level of critical exchanges within the house. By contrast, the Assistant Cook in the second Beta house was found to be having the important effect of lowering the demands upon residents and also reducing the likelihood of inter-resident disputes.

In previous E.E. studies it has been found that the majority of Critical Comments expressed during the C.F.I. focus on the negative symptoms of schizophrenia; this has been the case in both family oriented work and recent attempts to relate E.E. to collective care settings. Accordingly, Leff and Vaughn report that in their 1976 study only thirty percent of critical remarks related to florid symptoms such as delusions and hallucinations, while seventy percent were directed towards, 'negative symptoms, such as apathy, inertia, and lack of affection' (Leff and Vaughn 1985 p. 126). More recently, Ball and her colleagues (see Moore et al. 1992) undertook a content analysis of sixty-one C.F.Is administered to care workers. The Ball team note that:

> The only positive symptoms that attracted criticism were suspicion (n=1); agitation (n=2); talking nonsense (n=2) and inappropriate affect/appearance (n=3). No first rank symptom of schizophrenia was the focus of criticism in any interview. In marked contrast, the problems associated with long-term mental illness and chronic schizophrenia received

considerably more criticism. Problems most frequently cited within this category were: apathy and lack of initiative (n=17); tendency to do nothing (n=11); poor self care (n=12). Staff members in high-E.E. relationships were more likely to criticise aspects of the patient's personality, especially those who were thought to be stubborn, awkward or manipulative (n=7 interviews) (Moore, Kuipers and Ball 1992 p. 30).

Leff and Vaughn, and Ball et al., argue that relatives and workers find it easier to attribute the positive symptom of schizophrenia to a state of illness than they do negative symptoms. Thus Leff and Vaughn comment:

> The florid symptoms give rise to abnormal behavior, which is readily identifiable as part of an illness. By contrast, the negative symptoms are manifested as the absence of normal behavior. As such, they are not obviously the products of illness, and indeed most relatives viewed them as long-standing personality characteristics that were under the patients' voluntary control (Leff & Vaughn 1985 p. 126).

The data gathered during this study concerning the focus of critical remarks presents a more complex picture than that of the past literature. On the one hand this study's qualitative data supports the findings of previous researchers, in that attributions concerning the causes of anti-social behaviours to willed and controlled actions, as opposed to a state of illness, were found to be more likely to lead to critical remarks. On the other hand, however, the data also points to the fact that within collective care settings it is not merely ignorance of symptomology that leads to social actors' making attributions to willed and controlled behaviour.

Within this study it was found that the two organisations' care ideologies were important in shaping the attributions that front-line staff and residents/tenants used. Thus for example, it was found that Alpha organisation's ethos and care ideology actively promoted the rejection of the medical model of mental illness. Alpha organisation's ethos suggested that attributions to a state of illness left tenants essentially passive and detracted from their being seen as whole people who deserved the same respect as other members of society. Beyond this, within Alpha organisation it was argued that the promotion of inter-tenant accountability helped to redress the passivity caused by years of institutional living. By contrast, in Beta organisation the medical model was found to dominate and this resulted in a

greater propensity to make attributions to illness rather than willed and controlled action.

The crucial point that is being made here is that organised collective care settings vary from families in the important respect that they contain formally stated objectives, aims and organisationally prescribed ways of achieving desired goals. Moreover, through secondary organisational socialisation the social actors are inducted into the organisationally correct ways to see things and the appropriate attributions to use concerning each other's behaviours. It is not being suggested here that a collective care organisation's ethos or ideology determines in any simple way the attributions used by social actors within a care setting (indeed the Alpha Two tenants' retention of the medical model refutes such an assertion), but rather that the care ideology will be a significant variable in the social construction of daily life. The collective care organisation's care aims and ideology will have an important bearing upon the attributions that are made concerning the causes of anti-social behaviours within the setting.

Birchwood and his colleagues (1987 & 1988) have argued that early work in the field of E.E. was wrong to see high E.E. as an enduring trait of relatives. They argue that high E.E. is more likely to be something that may emerge as a response by certain relatives to the considerable stress of living with someone suffering from schizophrenia. Birchwood et al. therefore present a feedback or adjustment model wherein they suggest that a family's coping efficiency involves a dynamic process that will change and develop over time.

In this study a process that bore certain similarities to that described by Birchwood and his colleagues was found to occur between co-residents/tenants. It was found that inter-resident/tenant face-to-face Critical Comments were more likely to occur when there is a high level of resident/tenant interdependence and where a resident/tenant persistently failed to discharge their communal responsibilities. Therefore when a resident or tenant had responsibility for the provision of co-residents' or co-tenants' evening meals, or the collection of communal provisions, or communal cleaning, etc. and repeatedly failed to complete these tasks, there was a strong likelihood of critical interactions. This likelihood further increased when the dominant attributions within the social setting stressed that residents/tenants were able to control their behaviours and levels of activity. These findings point to the fact that Critical Comments result from

the inter-play between the actions of the patient and the meanings that these actions have for the other social actors within the care setting.

Finally, in discussing the focus of the observed inter-resident and inter-tenant Critical Comments it must be noted that on occasion there were highly conflictual interactions which appeared to have no easily identifiable rational precipitating cause. Within the collective care settings studied there were instances when individuals' mental illnesses led them to engage indiscriminately in direct confrontation and criticism of their co-residents or staff without rational reason. Moreover, these Critical Comments were some of the most severe that were observed. The following Alpha One field-note quotations offer examples of the type of confrontational situation which occurred when a tenant was unwell.

> Gill (worker) continues by telling me that when she arrived on Wednesday Christina (tenant) was very distressed. She recalls that when she entered the house Christina was standing very close to Jim (tenant) and screaming that his brother was the one who was sending the laser beams to burn her. Apparently Jim (tenant) was visibly shaking with anger and telling Christina to F... off. Christina returned the insult (A1 7/28).

> The worker then begins to talk about the manifestations of Christina's (tenant) 'illness'. She tells me that Christina picks up on very personal things about people and then uses them in an extremely vicious way. She gives several examples saying; 'with Jane (tenant) she calls her a lazy fat slob', (Gill (worker) looks at me as if to say you can see how near to the knuckle that is); Gill continues by saying that with Bill (tenant) Christina goes on about his greasy hair and personal hygiene and with Jim (tenant) it is normally remarks about his family, (who he is still very close to) (A1 7/28).

It appears to be an unpleasant fact of life that within collective care settings which cater for people with mental health problems there will be occasions when illness-initiated high E.E. interactions take place. What then appears to be important in relation to the on-going level of E.E. is the way in which these situations are dealt with and the coping strategies that are made available to co-residents or co-tenants. This is something that will be explored further in the following section.

DO INTER-RESIDENT/TENANT CRITICAL COMMENTS HAVE THE SAME EFFECT AS THOSE MADE BY RELATIVES?

Once it is recognised that high E.E. type face-to-face interactions are present within collective care settings, key questions are raised concerning whether, and subsequently at what level, such interactions have negative effects similar to those observed in family settings. In turn, these questions raise the related issue of whether Critical Comments and/or displays of Hostility between residents/tenants or staff and tenants/residents are chronic stressors in the same way as is hypothesised in high E.E. families. Here it should be recalled that chronic stress and cognitive overload are seen by Leff and Vaughn (1985) as forming the link between high E.E. attitudes and behaviours in the family and deterioration in the patient's mental health.

Before turning to a discussion of the potential stressor effects of high E.E. interactions in collective care settings it is however necessary to be clear about the methodological design of this study. This project was primarily designed to gather first hand descriptive material concerning the existence or otherwise of face-to-face high E.E. interactions and beyond this to provide information on the aspects of the social settings that contributed to or negated such exchanges. This study was therefore primarily concerned to take an in-depth qualitative look at the processes of care within the four sites and not to prove a statistical link between high E.E. interactions and patient relapse/deterioration. However, whilst bearing in mind the design of this study, it does appear appropriate to draw together some important points which have emerged from the data.

To begin with, it is necessary to recognise the social position of many of the people who live in mental health supported accommodation. As Otto and Orford write;

> Most adults make their way without the need for professional help, or other special care, because they have accumulated personal and social resources that enable them to do so. People who come to hostels or halfway houses have usually lost many of the skills and resources they had, as a result of illness or long periods of institutionalisation. Hewett et al (1975), in their study of residents of psychiatric hostels in England, noted...
> The majority of the people studied were without significant family support. They were a special group of single, homeless

people who had particular accommodation problems (p.402) (Otto & Orford 1978 p. 28).

Many of the residents of mental health supported accommodation are, then, single unemployed people, who are reliant upon state benefits and who often lack family and other social support networks. In this study it was found that the combination of residents' or tenants' low income levels, their lack of organised day activities and personal problems concerning motivation, led to many of the residents/tenants spending long periods inside the houses. For the majority of residents/tenants their principal social contacts were within their care settings and accordingly their personal relationships with co-residents/tenants and staff were significant to them. It is suggested, then, that for many residents and tenants their lack of social support networks and social isolation led to a situation where high E.E. interactions within their homes were at least potential stressors.

In the preceding chapter it was argued that the observed empirical realities of daily life in the research sites resulted from the coming together of a complex cluster of factors and that in order to understand the observed levels of E.E., it was necessary to understand the processes involved in the social construction of house life. It was suggested that within the organisations studied, there existed various interconnected layers of objectified knowledge: common-sense organisational knowledge that the social actors learnt and subsequently used in their daily interactions. Thus, on one level there were the formally stated goals of the organisations, the care ideologies, the formal organisational roles and administrative structures, and the levels of material resources. On another level, however, there were the front-line social actors' interpretations and operationalisations of the formally stated care aims and administrative structures; and there were the common-sense-knowledges and cultures created by the front-line social actors, which brought together and involved recourse to, the individuals' biographical experiences and the histories of the houses. As Berger and Luckmann (1979) argue, to any one individual many of the patterns and expectations of daily life appear objective, external and beyond personal control, but on another level the social actors are found to be constantly constructing and legitimating the observed reality. From this position it becomes apparent that the individual experiences social situations as exerting certain demands upon him or her.

From the phenomenological perspective, the person is not a private subject standing over against (in opposition to) an "objective" situation. Although it is true that a situation is always interpreted, the interpretations available to the person are neither completely private nor under the complete control of the individual. One might choose to 'put the best face' on a bad situation, but there is a limit to this form of wilful optimism...

Personal interpretation of the situation is bounded by the nature of the situation and the way the individual is *in* it (Benner & Wrubel 1989 p. 83-84).

The work of Lazarus (1984), as reviewed by Benner and Wrubel (1989), provides a good theoretical framework within which to draw together this study's observations with certain key theoretical ideas from the field of stress research. As Benner and Wrubel write;

Early work on stress focused on discussions of whether stress lay in the event or in the person's response to the event. Lazarus's theory of stress and coping posits that stress involves both the person and the situation. It results from the person's appraisal of his or her adaptive relationship to the context. This relationship is called a *transaction*.

...the transactional approach views stress as the result of the person's grasp of the meaning of a situation for the self when that meaning conveys, challenge, loss, threat or harm (Benner & Wrubel 1989 p. 59).

Seeing the degree of stress that an individual experiences as resulting from a transactional relationship between the social situation and the social individual provides a theoretical framework within which to understand further the levels and likely effects of high E.E. interactions within collective care settings. Here it is important to recognise that Critical Comments form part of the environmental demand upon a resident or tenant. Further, the meanings that interactions involving criticism have - in terms of potential 'challenge, loss, threat or harm' and the coping responses that are available to the individual - will to a large extent be mediated by wider aspects of the social setting and in particular by the social actors' common-sense-knowledge. In order to understand the meanings that Critical Comments have for the individuals involved (both the aggressor and the target) and the demands that these interactions place upon the various parties, it is therefore necessary to locate the exchanges within the broader social

milieu. However, it must also be recognised that individuals will have differing tolerance levels to criticism and that their individual susceptibility to stress may vary over time and with the cyclical nature of their illness.

The demands that a Critical Comment places upon an individual can be seen to result from the interplay of the substantive content of the comment, the possible coping responses available to the individual and the wider expectations of the setting. Here it is useful to distinguish between Critical Comments that emanate from the positive symptoms of a resident's/tenant's mental illness (i.e. hallucinations, delusions, feelings of paranoia) and those that occur because the target (criticised) tenant/resident has failed satisfactorily to complete a communal responsibility. In the case of the inter-resident/tenant Critical Comments that clearly emanate from a resident's/tenant's mental illness there may be no explicit response required by the targeted individual, but they may nevertheless and quite understandably feel the need to withdraw from the situation. The following field-note quotation gives an example of an illness-based Critical Comment.

> (Simon a tenant comes into the room and asks) 'Christina (tenant) how are you.' She seems to be struggling for a reply, after several seconds she answers, 'Not very well really.' Kevin (tenant) remarks that he is sure she will be better soon. Christina (tenant) then turns to look directly at him and says, 'You're su su.' The conversation continues; 'Sorry Christina?' Christina (tenant), You're 'su su.' Kevin (tenant), 'I'm sorry Christina (tenant) I don't know what that means.' Christina (tenant) now getting quite angry, 'It means bloody, your an optimist, it's all of your faults, and I'm the one that is being punished' (A1 7/21).

The possible coping responses available to a resident/tenant in a critical exchange such as that given above, will in large part depend upon the wider social reality of the setting. Thus whether the 'attacked' individual can withdraw from such an interaction and avoid the aggressor in the immediate future, will depend upon such factors as, whether s/he has their own private personal space, the level of tenant/resident mutual interdependence and the amount of contact that tenants/residents are required to have during daily life, for example during the preparation and consumption of meals, house-hold cleaning, the collection of daily provisions, etc. The analysis presented in the preceding chapters reveals that this study's four research sites varied in respect of the expected levels of resident/tenant interaction and the related

coping options which were available to residents/tenants. The case studies of Alpha One and Beta Two provided contrasting examples of the ways in which the wider social environment can mediate the potential stressor effects of inter-resident/tenant Critical Comments.

Within Alpha organisation the communal activities/responsibilities were explicitly designed to bring tenants into close interpersonal relationships which involved quite high levels of mutual interdependence. The organisation argued that they wished to avoid the situation where their houses became essentially bed-sits, where a group of people lived very separate lives within the same house. In Alpha One tenants were expected to come together at least once a day for the communal meal, to take part in house cooking, the collection of shopping, to attend the house meetings, etc., (in Alpha Two on the other hand these communal expectations and responsibilities had been reduced). Alpha One workers also actively encouraged tenants openly to voice and discuss their feelings and to tell each other when a behaviour or action was annoying or distressing.

In Alpha One therefore the objectified social reality placed significant limits upon the possibilities open to tenants wishing to avoid a co-tenant who was displaying difficult illness behaviours. In this situation, as the following field-note quotations reveal, both staff and tenants recognised the negative effects upon tenants.

> Simon (tenant) ... walks into the kitchen and makes a sandwich, he returns to join Frances (tenant) and me. Frances tells him that Paula (an ex- tenant) has been back. Simon does not respond for several seconds, then asks me what she wanted. I am deliberately evasive not wanting to influence his conversation with Frances. I tell him that Paula brought some books back for one of the workers. Frances tells Simon that Paula is on a weeks' trial at her new hostel... Simon then turns to me and says; 'you don't know what she can be like, Steve, she's spoilt the atmosphere in here for months, she's made me feel ill' (A1 7/7).

> The worker tells me that Jane's (tenant) verbal attacks don't worry her personally and says they are like water off a duck's back. She then continues by telling me that she does, however, think that they have a real impact on the other tenants. She says, 'they (the tenants) take the attacks on board personally' (Gill's words). I ask Gill what she means by this and how it manifests itself in the tenants' behaviours. She says

that when Jane is 'being difficult' (Gill's words) there is a noticeable increase in the tension in the house, she says, 'you can never tell when she is going to start.'

Gill (worker) then says that different people react in different ways and starts to talk about individual tenants. She tells that Gerry's (tenant) desire to leave the house corresponds with 'the difficult times in the house' (Gill's words). She continues by saying that Simon (tenant) withdraws into his room and tries to avoid the person in question. She again mentions that Simon is worried about controlling his feeling of aggression. Cathrine (tenant) apparently becomes more excited than normal and follows the house-workers around very closely. Gill concludes by saying that, Bessy (tenant) becomes very difficult and verbally aggressive (A1 7/28).

By contrast, residents in Beta Two had considerable freedom concerning their levels of inter-resident contact. The Assistant Cook was found to have removed many of the pressures upon residents to engage in communal interactions by undertaking many supposedly communal tasks herself; for example, she often left ready prepared food for residents' evening meals and she cleaned both the communal areas of the house and residents' bedrooms. Beta Two residents were not therefore dependant upon one another for the provision of meals, the cleanliness of the house, etc. There were also no strong pressures upon the residents to come together for the meals; the cook was quite prepared to take meals into the residents' own rooms when they did not feel able to be within the larger group. In fact, as was indicated in Chapter Four, one resident spent the majority of the research period living alone in a tent in the backgarden. In Beta Two, therefore, the social setting provided the residents with more opportunities to avoid co-residents who were experiencing difficulties, with the result that residents were not pushed into close interpersonal relationships. Consequently both the levels and the stressful effects of illness-initiated high E.E. interactions were reduced.

An essentially similar analysis can also be undertaken with regard to Critical Comments that relate to a resident's or tenant's failure adequately to discharge a communal responsibility. Therefore the degree of stress that an individual is likely to experience will largely result from the interplay of the demands that the Critical Comment make upon resident/tenant, the responses available to him/her and the perceived implications of failing to react in a socially adequate way. Thus, for example, whether a Critical Comment such

as 'you're so lazy, you never take your turn at getting the shopping or washing-up' is experienced as stressful will depend upon whether, within the specific care setting, it is expected that residents get the shopping and do the washing-up, whether the resident/tenant feels capable and able to go shopping and/or wash-up, and the resident's/tenant's perception of the likely consequences if they fail in future to fulfil the social obligation. Again it was found that four research sites provided examples of social settings which varied with regard to these dimensions.

Once it is recognised that an individual's experience of stress results from the meaning of the event in a specific social setting, that is from the interplay between the demands of the situation, the coping options open and the perceived potential consequences of failing to respond adequately, it becomes apparent that Critical Comments are only one of many potential sources of chronic stress within collective care settings. Within this study it was found that communal meals, house meetings and communal daily living tasks could also prove to be significant stressors for an individual, (see Chapters Four and Six). Importantly, however, these activities were not always experienced as stressors in all the research houses. What was important was the collective and personal meanings that were attached to these activities within the specific settings, the demands that these communal activities placed upon individuals and the coping options open. Thus, for example, in Beta One meal times were experienced by many residents as very stressful, primarily because residents had to queue for their food and eat in a very large group of people in a dining area which had insufficient seating (the nine Beta One residents ate in a dining-room in the adjacent seventeen bedded intake house). Meal times were also social situations where it was common for personality differences to erupt into heated arguments.

> At this point I hear shouting and a crash from the dining room. I decide to go and investigate. I meet Joe (resident) in the hall, I ask what the noise was, he tells me that they (other residents) were fighting but that he doesn't know what it was about. Later I ask Jean and Jane (residents) what happened, they explain that someone left his pudding to get a spoon and when he came back someone was in his seat. The returning resident apparently got angry and threw the other person out. Jane tells me that she shouted at them to stop, but felt that she couldn't get too involved as 'they were both big men' (Jane's words). She comments 'I can't fight them, can I?, I can't fight them, can I?, I can't fight them, can I?' (B1 11/3).

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By contrast and as shown above, meals in Beta Two were a pleasant and relaxed time: attendance was not compulsory and residents could choose to eat alone if they so desired. All the Beta Two residents had their own regular places at the table and the Assistant Cook served the meals and cleared away between courses. In this social situation two of the residents actually returned from their day placements, via public transport, in order to eat lunch at home.

Similarly, the house meetings in Alpha One were often very difficult for tenants. This was primarily because meetings were social situations where tenants could and would confront each other over their actions and where staff would prompt tenants to raise issues of concern for discussion. In the following field-note, which relates to a researcher/worker discussion about the allocation of cleaning tasks in Alpha One, a house-worker recognises and acknowledges the link between the meaning that the house meeting had for an individual and the tenant's display of discomfort.

> I ask what Simon (tenant) actually does at present. John (worker) replies 'bugger all basically'. I comment that Simon looked very uncomfortable at the last house meeting. John (worker) agrees and says, 'Yes he thought that someone was going to raise the issue of him not pulling his weight'. I acknowledge that I had a suspicion that that might have been the reason (A1 8/26).

Again, by contrast, Beta One provided an example of a social setting where the community meetings were very rarely stressful. In Beta One the meetings were merely used for the exchange of information between staff and residents. There were certain 'safe issues' that were discussed regularly and did not involve any challenge, threat or potential harm to participants. Attendance at the Beta One meetings was voluntary and so residents could choose not to attend if they did not feel able to cope on a particular day.

The important point that is being made here, both in relation to Critical Comments and other communal activities which sometimes created difficulty for residents/tenants, is that the experience of stress involves a transaction between the social actor and the social environment. In McGrath's (1970) words, stress involves;

the *anticipation* of inability to respond adequately (or at reasonable cost) to perceived demand, accompanied by anticipation of negative consequences for inadequate response (McGrath 1970 p. 23).

Social situations in collective care settings always place demands upon participants but whether a situation is experienced as stressful will depend upon the meaning that the situation has for the individual, the levels of demand, their personal resources, the possible coping strategies that are open, and the individual's perception of the consequences if they fail adequately to meet the situational requirements. In turn, the meanings that an individual attributes to an interaction or social situation will be in large part dependant upon the objectified socially-constructed reality of the care setting. Thus, in this study it was found that the four research sites placed differing demands upon the residents/tenants, made available or limited various coping strategies/options and promoted differing consequences in cases of failure to meet situational demands.

It appears therefore that it would be ill-advised to attempt without qualification to claim that in collective care settings, Critical Comments whether between co-residents/tenants or between workers and clients, will always be stress inducing. What appears to be important is to locate the interaction within the wider social setting and to take account of the meaning that the interaction has for the participants. Moreover, the data from this study points to the usefulness of recognising that Critical Comments are only one potential form of chronic stress within a collective care setting and the importance of taking account of all potential stressors when attempting to ascertain the level of stress to which a resident/tenant is subjected.

IMPORTANT POINTS FOR CONSIDERATION IN FUTURE ATTEMPTS TO RELATE THE CONCEPT OF E.E. TO COLLECTIVE CARE SETTINGS

In this final section of this chapter the implications of this study's findings for future attempts to relate E.E. to collective care settings will be made explicit. This will involve drawing together certain points already made implicitly above and the section will therefore also serve as a conclusion to this chapter. To commence, this study found that within the four care settings studied, face-to-face Critical Comments and displays of Hostility

were present and bore a close resemblance to those reported in earlier family studies. Moreover, it was also found that there were variations across the houses with regard to the levels of Critical Comments and displays of Hostility. These findings suggest that there is potential merit in pursuing the measurement of Critical Comments and displays of Hostility and that these types of interaction are likely to be one important aspect of the social environment of mental health collective care settings.

This exploratory study did not, however, find any examples of Emotional Overinvolvement (E.O.I.). This finding provides support for the previous observations of Moore and her colleagues (1992), who also report that during their administration of the C.F.I. (n=61 care workers) they were not able to find any examples of worker E.O.I. Taken together these findings raise important theoretical issues for the concept of E.E. Firstly, questions are raised concerning the reason for combining the three predictive elements of Critical Comments, displays of Hostility and Emotional Overinvolvement into the single concept of E.E. Whilst empirically there does appear to be evidence for a relationship between the notions of Critical Comments and Hostility it is unclear how E.O.I. relates to the other two elements. The observational data from this study and that of Ball et al. suggests that, in collective care settings at least, it is quite possible for criticism and hostility to be present without Emotional Overinvolvement. This is in fact an issue that Halford (1991 & 1992) has already highlighted as being problematic within the family studies E.E. literature.

> High E.E. probably constitutes a heterogeneous grouping of family interaction processes, which may be better analysed separately. A convention has developed of combining high criticism or high EOI (Emotional Over-involvement) or hostility into a single construct of high E.E. In the original development of the C.F.I. the criticism and EOI scales were seen as independent, and subsequent research has shown low to moderate inter-correlation between the scales [Leff & Vaughn 1985] (Halford 1992 p. 262).

In the first chapter of this thesis it was suggested that, at the theoretical level, Critical Comments and displays of Hostility within family settings were likely to be experienced as stressful primarily because the carer (parent or spouse) was normally a significant other in the patient's life. The family carer's expressed opinions and emotions concerning the patient appeared to

be likely to carry important implications for both the patient's definition of self and their level of self esteem (Mead 1934). The empirical data from this study, however, suggests that within collective care settings it is not necessary for the perpetrator of a Critical Comment to be a significant other in order for the targeted individual to experience the interaction as stressful. As was shown in the preceding section, in this study the mechanism by which Critical Comments and displays of Hostility were experienced as stressors involved the interplay between the demands that such verbal exchanges placed upon the individual, the available coping options both at the personal and the social levels and the perceived consequences of failure to fulfil the situational requirements. What is important to note here is that the data from this study suggests that it is not crucial for there to be an intense emotional relationship between the criticised and criticising individuals in order for a Critical Comment or display of Hostility to be experienced as stressful.

By contrast, as Leff and Vaughn note the stressor effects of E.O.I. appear to rest essentially in the emotional intensity of the relationship between the family carer and the patient.

> Overinvolvement tends to develop within the mothering role, although not exclusively. One of the components of overinvolvement is overprotectiveness, which can be seen as a normal mothering function protracted into a period of the child's life when it is inappropriate. Mothering is usually provided by mothers, but can of course be taken over, at least partially, by fathers (Leff & Vaughn 1985 pp. 87-88).

The mechanism involved in E.O.I. acting as a stressor appears to revolve around the carer's not allowing the patient emotional space and instead engaging in suffocating and emotionally stifling relationships. Thus the mechanism by which E.O.I. is experienced as a chronic stressor appears to be different in important respects to those involving in Critical Comments and displays of Hostility. The data from this study suggests that the relationships within collective care settings are significantly different to those found in family settings and do not typically involve the degree of emotional engagement between the carer and client which is necessary to produce E.O.I. Whilst Critical Comments and displays of Hostility may be present within collective care settings and act as significant stressors it appears unlikely that there will be the level of emotional engagement between client and carer that is necessary to create E.O.I. It is recommended

therefore that future researchers in the field of E.E. (both in family and collective care settings) consider carefully their reasons for combining the measures of criticism and hostility with that of E.O.I. and provide some theoretical justification for such a methodology. Although studies of E.E. in collective care settings remain in their infancy at the present time it appears potentially more profitable to concentrate on the measurement of Critical Comments and displays of Hostility rather than Emotional Overinvolvement.

With regard to the use of the C.F.I. within collective care settings, this work's findings highlight significant theoretical and practical difficulties. The C.F.I. essentially measures the emotions expressed in an interview situation pertaining to a specific dyadic relationship. The data from this study has demonstrated that in collective care settings there are many more dyadic relationships than are found in normal families and beyond this, that Critical Comments or displays of Hostility are possible between any two or more social actors. The fact that in this study the majority of high E.E. interactions were between co-residents or co-tenants points to the importance of taking account of all of the emotional relationships within a specific care environment. It appears therefore that the only logical way to use the C.F.I. within a collective care setting, would be to ask each resident to complete a separate interview pertaining to each of their co-residents, whilst also ensuring that care staff complete a separate C.F.I. for all of the residents with whom they have significant contact. Given that even the streamlined C.F.I. (Leff and Vaughn 1985 pp. 28-36) takes between one and two hours to administer and a further three to four hours to code, on purely practical grounds this appears infeasible.[2] Further, it should be remembered that an important premise of the E.E. concept is that people who suffer from schizophrenia are vulnerable to stress (see Chapter One). Ethical issues are therefore raised concerning the potential effects of subjecting residents/patients to the completion of several two hour C.F.I.s.

A further theoretical problem that must be addressed by future researchers wishing to use the C.F.I. in collective care settings relates to the

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[2] At present two short-hand measures of E.E. are being developed; the Five Minute Speech Sample (FMSS Magana et al. 1986) and the Videotaped Expressed Emotion Measure (VEE Schweitzer et al. 1988). Both of these instruments require a relative to talk for five minutes about the patient and their relationship with him/her. The FMSS and VEE both correlate highly with the C.F.I. in terms of classification of families as high or low in E.E.. To date however there is no published data on the success of these instruments in predicting relapse in schizophrenia. If these two instruments prove successful in predicting relapse/deterioration within family studies it may at some point prove possible to transfer their use to collective care settings.

timing of the administration of the interview. Within the original family studies (Brown et al. 1972, Leff and Vaughn 1976a &b) the C.F.I. was administered very close to the point of a patient's admission to hospital. During the interview relatives were requested to focus on the three-month period preceding hospitalisation and asked questions concerning the onset of the illness episode, its impact upon family routines, the frequency of irritability and quarrelling, the amount of contact between the patient and the rest of the family, the patient's participation in domestic tasks, etc. (Leff and Vaughn 1985 pp. 26-28). The C.F.I. is essentially concerned with two sorts of information: one is to do with recent events and activities and the other is to do with attitudes and feelings about the patient (Leff and Vaughn 1985 p. 27). The follow-up ratings of deterioration or otherwise in the patient's mental health were normally made nine months after discharge.

The recent attempts to use the C.F.I. in collective care settings mark a significant departure from earlier procedures. Ball and her colleagues interviewed carers of residents/patients who were already in a residential care setting and who were not at the point of hospital admission. In the study reported herein there were two cases where residents/tenants had to be moved to an acute hospital ward. In both of these instances the period preceding the move saw the volume of Critical Comments increase significantly. This finding points to the fact that the attitudes and feelings that are elicited from carers in discussions about a resident's or tenant's activities during a non-acute period are likely to be significantly different to those expressed just after an acute admission has become necessary. Ball et al's procedure of not interviewing at the point of acute breakdown therefore differs fundamentally and significantly from the procedures used in earlier studies. Future work that attempts to use the C.F.I. in collective care settings should therefore consider carefully the timing of the administration of the interview and the implications that this has for the results obtained.

The findings from this study also point to the fact that it is over-simplistic to assume that face-to-face Critical Comments within a collective care setting will always be experienced as stressful. The observations reported herein point to the fact that in order adequately to understand the stressor effects of an interaction it is necessary to locate the exchange within its wider context and to attempt to understand the meaning that the exchange has for both the aggressor and the targeted individual. In turn, the meanings that events and interactions have within collective care settings are not based

solely on an individual's idiosyncratic meaning set but are mediated by the communal taken-for-granted objectified social reality. The effects of a high E.E. interaction within collective care settings will depend upon the emotional closeness of the relationship between the individuals concerned, the demands that the Critical Comment places upon the individual, the coping options that are open both at the personal level and the situational level, and the perceived and actual consequences for the criticised individual if they fail to meet the situational requirements. Future work should therefore take account of the communal taken-for-granted meanings within the specific care setting when attempting to understand whether a high E.E. interaction is stress inducing.

The author's position here in pointing to the importance of understanding the meaning of events within the social milieu is very close to that reached by Day (1986) in his review of the 'life events' literature. Day argues that a significant problem of past life events studies has been the failure to take adequate account of the meanings that these events have for the individuals concerned. Beyond this, by drawing upon the phenomenological writings of Schutz (1967), he argues that researchers can gain an understanding of the meanings of the life event for the individual only by locating the event within the individual's wider sub-cultural value system (Day 1986 p. 77).

> The problematic nature of the relationship between changes occurring in the patient's routine life world and assumed levels of stress ultimately raises the issue of 'meaning' in life event research. That is to say, how are we to assess for a given patient the 'meaning' of a reported change in his/her life world, e.g. whether it is a stress provoking or stress reducing event? I think it is important to begin by recognising that the problems of meaning with which we should be concerned in life events studies are primarily determined by social and cultural rather than by an individual's personal psychology. ... In other words, the stressfulness of life events must be assessed in terms of the group's culturally patterned consensus (i.e. norms) concerning the significance of reported changes, rather than an individual's personal assessment of idiosyncratic response to a specific situation (Day 1986 pp. 76-77).

In the present study the periods of participant observation revealed that high E.E. interactions were not the sole potential source of chronic stress within collective care settings. Thus the four research houses were found to

contain different expectation levels for resident/tenant functioning and to place varying demands upon residents/tenants in such areas as communal meals, house meetings, communal shopping, household cleaning, etc. What was again important in trying to ascertain the impact of these social obligations as on-going stressors was to understand the meanings that such events had for the social actors within the specific social setting.

Again this study's observations find support in the work of Day et al. (1986) at the Biometrics Research Unit. Thus Day and his colleagues claim that they have been able to locate four inter-related classes of social environments that may be routinely experienced as chronic on-going stressors. These they term, Cognitively Confusing Environments, Emotionally Critical or Intrusive Environments, Overly Demanding Environments, and Threatening or Demoralising Physical Environments. Day thus coins the term 'toxic environment' to capture the way in which many aspects of a social environment may combine and interact to form a setting that is detrimental to vulnerable individuals. Beyond this he argues that it is important for future research to move away from looking solely at the effects of single factors such as life events or high E.E. attitudes/interactions and to embrace methods that are capable of assessing the multiple sources of stress to which a patient is subjected.

The findings from this study lead the author to endorse the recommendations made by Day et al. It is suggested therefore that future projects should attempt to assess collective care settings in terms of the total levels of chronic on-going stressors rather than focusing exclusively upon one potential stress source, i.e. Expressed Emotion. In turn this will necessarily require researchers to locate interactions within the communal taken-for-granted knowledge of a specific setting so as to facilitate gaining an understanding of the meanings that interactions and events have for the social actors involved. A central challenge for future studies of collective care settings is then to design instruments that are capable of capturing the meanings of interactions and events to the social actors involved but which also facilitate ease of cross-site comparison and the possibility of establishing measurable cut-off points which are detrimental to vulnerable individuals.

CHAPTER EIGHT

The implications of this study's findings and the theory of Expressed Emotion for the future design and management of mental health collective care settings

INTRODUCTION

The preceding chapter drew together and made explicit the methodological and theoretical implications of this study's findings for future attempts to assess the levels and effects of E.E. in collective care settings. Within this final chapter the discussion will be broadened in order to consider the implications of this study's findings and more generally the theory of E.E., for the future design and running of residential care settings for people experiencing severe mental illness. The chapter will be organised around three sections. The first will offer a discussion of the type of social care environment that E.E. theory promotes and it will be suggested that, at the extreme low E.E./low stress end of the continuum, such a care setting bears certain similarities to the often criticised stereo-typical institutional care regime. Some of the major criticisms of this type of care will be considered and it will be argued that there exists a tension between the kind of care environment that E.E. theory prescribes and what might be termed the residents' wider quality of life: viewed in terms of the degree of residents' involvement in the running of the care setting, their opportunity to exercise meaningful choice and control in their lives and their degree of involvement in certain important areas of daily living. The second section will consider more broadly the concept of 'client need' in relation to collective care settings. Through a review of the work of Smith and by drawing upon this study's findings it will be argued that there exists some ambiguity in the concept of human need and that care organisations and professional carers play a central role in determining and defining what are to count as clients' legitimate and meetable needs.

The final section of the chapter will draw together the central elements from the preceding discussions. The earlier work of Apte will be reviewed and it will be argued that the findings from this study support his assertion that front-line care workers necessarily enjoy considerable freedom in shaping and determining the overall level of social expectations and stress within collective care setting. However, it will also be suggested that there are significant social processes which place important limits upon the degree of flexibility open to residential care workers when responding to individual clients within a given concrete care setting. It will be argued that if a client's needs and requirements lead them to consistently breach norms and values which are central to the maintenance of the care setting then it becomes likely that workers will not be able to support them in that environment. The notion of 'person-environment fit' will be advocated as a non-pejorative way of enabling clients who are in such a situation to move smoothly between resources as their needs and requirements dictate. In conclusion it will be suggested that due to the complexity of the needs of people with severe mental illness and the organisational and managerial requirements of collective care settings the most sensible policy path is one which promotes a variety and range of residential and other services.

THE TYPE OF CARE ENVIRONMENT IMPLICITLY PRESCRIBED BY THE THEORY OF E.E., A REVIEW OF LIKELY CRITICISMS AND THE TENSION WITH RESIDENTS' WIDER PERSONAL AND SOCIAL NEEDS

The methodology employed by previous writers within the field of E.E. has placed certain limits upon their ability to describe the central features of low E.E. family care environments. That is to say, because previous researchers have normally attempted to gauge the level of E.E. through key relatives' responses to the Camberwell Family Interview (C.F.I.), rather than through direct observation, they have encountered difficulty in adequately describing the central elements of very low E.E. care settings. However, having noted this difficulty, Leff and Vaughn do suggest that;

> a nonintrusive, tolerant approach by relatives is most effective for ensuring that a schizophrenic patient remains well... Brown has postulated that certain environments produce high and sustained levels of arousal in schizophrenic patients, which make them more likely to become ill again. In

our experience, these environments are characterized by disorder and/or intrusive attempts on the part of a relative to advise, complain or merely 'get through to' a patient (Leff & Vaughn 1985 p. 119).

Within this thesis it has been shown that the four care settings studied varied both in terms of the observed levels of Critical Comments and displays of Hostility and the overall stressor effects of the social milieu. Beyond this, the data from this study suggests that Critical Comments and displays of Hostility are most commonly found in social situations which place relatively high demands upon tenants/residents in terms of their levels of social functioning. Thus the data revealed that the high levels of Critical Comments in Alpha One were associated with a setting in which: there were high levels of mutual interdependence between tenants in such areas as, the provision of the evening meal, house-hold cleaning, the collection of house-hold provisions, etc.; tenants were expected to take an active part in decisions which affected the running of the house; and tenants were expected to control their actions and behaviours and to hold co-tenants accountable to the house group if communal responsibilities were not discharged satisfactorily.

By contrast, the low levels of Critical Comments and displays of Hostility in Beta Two were found to be associated with a socially very undemanding care setting. Within Beta Two the Assistant Cook was found to have created an environment wherein the residents' physical needs for shelter and nourishment were catered for without significant involvement from the members of the house. Beta Two residents did not rely strongly upon one another for such daily necessities as meals, the cleanliness of the house, house-hold provisions, etc. and were not expected to engage in significant levels of social interaction. Beyond this, within Beta Two there were no formal house meetings wherein residents were expected to take communal decisions regarding the running of the house or to discuss openly tensions and/or disputes.

The findings from this study point therefore to an association between social care environments that are low in E.E. and settings which place very minimal demands upon residents/tenants. Indeed, if one were to try to envisage a care environment at the extreme low E.E. end of the Expressed Emotion continuum many of the features which might spring to mind would reflect a somewhat caricatured institutional setting. Thus one might envisage a care environment where staff contact with residents might be minimal, in

order not to place too high demands upon patients, with staff/patient interactions pertaining primarily to instrumental tasks such as the distribution of medication or physical tending. In such a setting residents might spend most of their time passively, possibly in a hospital day-room, watching the television and endlessly smoking cigarettes. Further, residents might have little or no responsibility for the provision of their physical needs for shelter, food, clean clothing, etc., with such needs being met by an impersonal but undemanding institutional machinery. What is important here is to note that the kind of care environment that appears to be implicitly promoted by the theory of E.E. is one that, if taken to its logical conclusion, would potentially look very much like the often criticised stereo-typical institutional care setting: a care setting apart from mainstream society, where residents are 'warehoused'.

In view of the fact that within the theory of E.E. there appears to be an implicit promotion of a type of care setting which resembles certain traditional forms of institutional care, it is appropriate to look briefly at some of the major sociological criticisms which have been levelled at this form of environment. Probably the best known academic analysis of institutions is that presented by Goffman in his seminal work 'Asylums' (Goffman 1961). In reviewing Goffman's work it is important to bear in mind that the analysis which he presents is, by his own admission, based upon his view of an ideal-typical institution rather than any one concrete empirical example. Within 'Asylums' Goffman presents a damning critique of the 'total institution', which he sees as being marked by a strict segregation from the outside world, the completion of normally separated daily living activities (such as sleep, work and play), within the same location under a single unified authority, and a strict separation between the supervisory staff group and supervised inmates (ibid. pp. 17-19).

In relation to the present discussion, one of the most important aspects of Goffman's critique relates to the effects of the total institution upon the individual's definition of self and related social abilities. Thus Goffman argues that;

> The recruit comes into the establishment with a conception of himself made possible by certain stable social arrangements in his home world. Upon entrance, he is immediately stripped of the support provided by these arrangements. ... His self is systematically, if often unintentionally, mortified. He begins

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some radical shifts in his *moral career,* a career composed of the progressive changes that occur in the beliefs that he has concerning himself and significant others (Goffman 1961 p.24).

Goffman uses the terms 'disculturation' and 'institutionalisation' to capture the way in which the inmate eventually becomes, 'incapable of managing certain features of daily life on the outside if and when he gets back to it' (ibid. p. 23). For Goffman then the most striking features of the total institution lie in the way in which inmates become segregated from the rest of society, classified as a group of inferior individuals who are subsequently treated in a uniform 'batch oriented' way and deprived of many social rights and stimuli. The effects of living in such a setting are seen to be profound and most clearly evident in the 'assault on the self' whereby inmates become passive, culturally deskilled and compliant with the routine of the institution. The empirical work of King, Raynes and Tizard (1971) into the administration of homes for mentally handicapped children, draws heavily upon Goffman's theoretical work. Thus King et al. argue that certain 'restrictive' managerial patterns within 'institution-oriented' hospital-type care settings actually have the effect of compounding the residents' mental impairments and further reducing their social capacities and capabilities.

A further and more explicitly value based attack upon institutional care is found in the development of the concepts of 'Normalisation' and 'Social Role Valorisation' (SRV), (see Wolfensberger 1980, 1983; Ramon 1991; Nirje 1969). These concepts, which developed primarily in North America and the Scandinavian countries during the 1970s and 1980s also owe much to the earlier works of Goffman; however, they extend the earlier writings by pointing out that the problems of institutionalisation lie not in the locale of care but in the type of care regime. Thus normalisation theorists argue that community based care settings outside of traditional large scale institutions can continue to perpetuate many of the negative practices highlighted by Goffman and others. Normalisation theorists appeal for the central promotion of the value of equality for people with disabilities. Thus Nirje (1969) in attempting to define the concept of normalisation argues that people with disabilities should have equal access to:

> ...patterns and conditions of everyday life which are as close as possible to the norms and patterns of the mainstream society. An ordinary life includes a normal rhythm of days,

weeks and years, normal-sized living units, adequate privacy, normal access to social, emotional and sexual relationships with others, normal growing-up experiences, the possibility of decently paid work, choice and participation in decisions affecting one's future (Nirje 1969 p.257).

Ramon (1991) provides some further clarification of Nirje's statement by expanding upon the use of the problematic phrase 'norms and patterns of mainstream society'. Thus she acknowledges that modern industrial societies contain a multitude of different patterns of living but notes that when these are compared to the experiences of many people with disabilities it is possible to pin-point important inequalities. For Ramon these inequalities include people with disabilities having; 'an inferior degree of control over their lives, choice, richness of stimuli and social encounters, starting with being poor' (Ramon 1991 p. 7).

Ramon therefore argues forcefully that, in order to redress the cultural processes which devalue people with disabilities and compound their physical and mental difficulties, it is necessary to pursue an openly value based approach to the provision of services. Thus she argues that ideally services should be based upon the following central principles;

> *People First*
> The most fundamental value of the normalisation approach is the belief that despite their problems, the people with a disability are first and foremost people just like those without....
> *Respect for persons*
> This value follows directly from the belief in the personhood of people with a disability. It is also related to the concept of SRV (social role valorisation) because the demonstration of respect is one of the sanctions attached to socially valued people...
> *The right to self-determination*
> This value is related to the first two. It accords people the right to decide for themselves, based on their capability to reach sensible decisions and to have more in-depth knowledge about themselves than others would possess. These assumptions clash with the popular belief that professionals know best...
> *Empowerment*
> This is one of the latest catch phrases to be introduced in and out of the normalisation approach, to emphasise the need to give power to people with disabilities, and for them to take

it and use it. The focus on this concept illustrates the awareness of the relative lack of power by most service users,... (Ramon 1991 pp. 13-17).

What emerges from the above discussion is that it is over-simplistic for policy purposes to evaluate a care environment simply in terms of its level of E.E. It is apparent that a care environment which rates favourably in terms of very low levels of E.E. may not fare so well if the environment is created within the type of institution described by Goffman; wherein there appears to be the danger that people may become depersonalised and deprived of social and cultural stimulation, potentially leading to a decline in self esteem and the loss of important cultural and social skills. Somewhat similarly very low stress/low E.E. care settings, may not be regarded very favourably by normalisation theorists if the care setting consequently denies people the opportunities of 'normal life'. The central point being made is then that a care environment that is benign by one criterion, namely E.E., may be undesirable or even detrimental by others. This is in fact a point that Leff and Vaughn acknowledge in one small passage of their 1985 work.

> The E.E. studies to date have been concerned with one measure of outcome only: the reappearance or exacerbation of florid symptoms... Other measures of outcome, such as presence or severity of secondary impairment or handicaps, were not attempted. There is some evidence that when a low-EE relative of a schizophrenic patient has no expectations for the patient and exerts no pressure to perform, there may actually be an increase in negative symptoms and higher levels of social impairment (Leff & Vaughn 1985 pp. 118-119).

Leff and Vaughn's recognition of the fact that people who suffer from schizophrenia are vulnerable not only to over-stimulation but also under-stimulation is also supported by Wing and Brown's classical study of three mental hospitals over the period of 1960 to 1968. Thus in summarising their findings they write:

> ...thought disorder is usually present in chronic schizophrenic patients, who react by cutting down their communication with other people, thus showing the negative symptoms such as social withdrawal, blunting of affect and poverty of speech. ... In understimulating social surroundings this tendency is given full rein and tends to proceed too far.

The patient may become completely pre-occupied with inner experiences such as hallucinations, or appear to have little inner life at all. In over stimulating social surroundings, the patient is unable to withdraw into a protective shell, but forced to interact and communicate. Florid symptoms then manifest themselves more openly and the resulting speech and behaviour abnormalities lead to a 'crisis' (Wing & Brown 1970 p. 181).

Beyond this, the findings from this study point to a tension between care settings characterised by very low levels of stress and/or E.E. and the residents' wider quality of life within such environments. Thus in order to protect residents from undue stress it may be necessary to create a very routinised and unstimulating care setting, wherein residents are not expected to take responsibility for or control over important areas of their life and are not expected to engage in new or challenging activities.

The comments below, which were made by one resident in the lowest stress, lowest E.E. care environment from this study (Beta Two), point forcefully to the tension between low levels of social stimulation and the resident's perception of his wider quality of life. This particular resident had previously worked four days a week in the green-houses in one of the main hospital gardens: however, the recent closure of this part of the hospital meant that this day activity was no longer available. In spite of the gardens being abandoned and the green-house heating being turned off, the resident continued to attend sporadically and unsupervised for over two months until all the plants died. At the point of field-work the resident had no day activity and spent nearly all of his time watching television. The field-note quotations below provide insight into his perspective on his quality of life. The first quotation refers to a conversation between the resident and myself after a trip to a local snooker hall; the second is typical of many comments made by this resident during the long afternoons spent in the house.

> In the car Jock (resident) tells me that he gets really bored sitting in the house all day and that he really appreciates me keeping him company. He then goes on to say that Simon (resident) just sits in front of the T.V. during the afternoons and falls asleep, and that Pat (resident) just sits in the corner and reads the paper. He adds that trying to make conversation with Pat is like trying to get blood out of a stone. Jock pauses for a couple of seconds and then continues by saying, 'I think

the reason that I drink so much beer in that place is because I get so bloody bored (B2 7/13).

Jock (resident) continues by saying, 'it's the same old f..ing routine day after day, it's driving me up the f..ing wall. I just sit here day after day with nothing to do. It's enough to drive you to drink, never mind make you fancy one.' Simon (co-resident) laughs and says, 'you don't need an excuse to drink'. Jock snaps at him, 'it's all right for you laughing but it's driving me crazy the same thing every day.' Jock's mood is now quite aggressive, this appears to some extent related to the amount of alcohol that he has consumed (B2 6/8).

The work of Norman and Parker (1990) provides further support for the assertion that there exists a tension between residents' quality of life, viewed in terms of greater individual freedom and autonomy, emotionally close inter-resident relationships, resident involvement in communal decision making, the daily running of the establishment, etc., and certain residents' need to be protected from over-stimulating or over-demanding social situations. Thus Norman and Parker followed ten long-stay psychiatric patients, who were not that dissimilar from the participants involved in this study, (four female, six male, aged between twenty and fifty-four, who had been in hospital for between fourteen months and twenty-five years), during their move from a hospital ward to a community based hostel. In order to gain insight into the patients' perspectives and experiences the team interviewed the patients twice; once two weeks before the move and again six week after commencing residence in the hostel. The semi-structured interviews covered;

best/worst aspects of hospital life, privacy and comfort, independence and freedom, social life, occupation, preparation for moving, choice and staff (Norman & Parker 1990 p. 1040).

Norman and Parker conclude that the patients in their study expressed both positive and negative aspects to the quality of their lives after the move to the community based hostel. Thus, on the positive side, the patients generally felt that in the hostel staff were more available and approachable, even though the same personnel were employed. The patients also noted that after the move there seemed to be less rules and regulations and more privacy in terms of single lockable bedrooms, together with free access to

the kitchen and communal food. Further, Norman and Parker suggest that these changes lead to important increases in the self esteem of their participants.

On the negative side, however, several of the patients studied also described difficulties in coping with such daily living tasks as cleaning, cooking and shopping. Moreover, only a small minority of patients felt able to take advantage of local facilities such as 'parks, pubs and shops' and several patients expressed boredom and commented that they felt that there was more to do in the hospital setting. Importantly, several of the patients studied also expressed problems in their inter-personal relationships with co-residents. Accordingly, Norman and Parker report;

> Social interaction was particularly stressful for some residents who had felt able in hospital to merge into the background and get away from people they did not like (Norman & Parker 1991 p. 1041).

THE CONCEPT OF 'SOCIAL NEED' AND THE ROLE OF CARE ORGANISATIONS AND PROFESSIONAL CARERS IN DETERMINING AND DEFINING CLIENTS' LEGITIMATE AND MEETABLE NEEDS

Thus far within this chapter the concept of 'need' has been discussed in a very individualised way and as residing essentially within individual clients. In reality however there exists significant philosophical debate concerning the existence and measurability of universal human needs (Doyal & Gough 1991, Plant 1991 chp. 5, Smith 1980). Recently, in reviewing works from such diverse positions as Marxism, the New Right and Phenomenology, Doyal and Gough (1991) have argued that at a philosophical level basic human needs are ultimately reducible to 'physical health' and 'autonomy'. Beyond this, they suggest that by viewing basic human needs in such a way it is possible to impose some order upon discussions of what are to properly constitute 'needs' and what are more accurately termed 'wants' or 'culturally desirable goals'; in this way they argue that it is possible to avoid many of the difficulties posed by cultural and historical relativism. Accordingly Doyal and Gough write;

> since physical survival and personal autonomy are the preconditions for any individual action in any culture, they constitute the most basic human needs - those which must be

satisfied to some degree before actors can effectively participate in their form of life to achieve any other valued goals (Doyal & Gough 1991 p. 54).

Within Doyal and Gough's framework the collective care settings studied herein are best seen as 'need satisfiers' which attempt to promote the 'autonomy' and 'physical health' of suffers of severe mental illness. Further, as Doyal and Gough argue that one 'key determinant of autonomy is the individual's cognitive and emotional capacity - ultimately their mental health' (ibid. p. 61), the residents/tenants of such settings can be said to have a genuine need for an environment that is not overly stressful or excessively high in E.E. However, at the same time, Doyal and Gough also propose that a second key determinant in the achievement of the basic need of 'autonomy' involves the individual having the opportunities to initiate new and meaningful action (ibid. pp. 66-9). Here then sufferers of severe mental illness can also be said to have a need for a social environment which offers them the possibility to experience new and challenging activities; in short to have access to a culturally normal level of social participation, stimulation and individual responsibility.

The difficulty here, as argued above, is that in the case of residential care for sufferers of schizophrenia and similar mental illnesses, there exists a tension between the care environment's offering its inhabitants asylum from the stresses of daily life and its providing the possibility of significant levels of social simulation and individual responsibility. Whilst Doyal and Gough's work remains of interest, it does not therefore appear to offer a satisfactory resolution to the tensions encountered in the reality of attempting to meet the competing social needs of sufferers of severe mental illness.

In reviewing the way in which the concept of human need has historically been operationalised within social work related research, Smith (1980) points to the dangers of taking an over-simplistic view of the needs which care organisations and professional practitioners actually attempt to meet. For Smith the 'traditional view' of need within care related research involves; firstly, need being seen as essentially an attribute of the client; secondly, need being viewed as an unambiguous and objective phenomenon; thirdly, human needs being seen as essentially static and unchanging; and lastly, due to the above premises, normally attempting to measure need through the administration of a standardised research instrument (Smith 1980 pp. 66-7).

As Smith highlights, this 'traditional approach' essentially fails to take account of the reality of the social processes which are involved in the determination of what are to count as legitimate needs, or the interests of the professionals charged with the assessment and subsequent meeting of needs. Accordingly, he argues for an 'alternative approach', based upon social construction theory. Smith's alternative social approach advocates that;

> 1. Need is viewed as socially constructed reality; as the objectification of subjective phenomena. As such it is closely dependent upon the concepts of professional practitioners.
> 2. The central topic of enquiry is therefore the ways in which need, thus viewed, is practically managed or accomplished. Need is viewed as closely dependent upon those organised professional practices that routinely establish its fact and nature.
> 3. Need is viewed as situated. Attention focuses upon the context of need
> 4. A distinction is drawn between 'topic' and 'resource'. Need is viewed as a research 'topic' and as a welfare professional's 'resource' (Smith 1980 p. 68).

The importance of this social construction approach lies in the recognition of the important social processes which are involved in the assessment of clients' needs and the attention which is drawn to the possibility of discrepancy between the client's perception of his/her paramount needs and the assessment made by a professional carer; or indeed the potential for disagreement between the various professional carers involved with any one client. This perspective therefore suggests that in reality the needs which service providers attempt to meet are socially constructed through processes of negotiation and legitimation between professional worker/s and the client, within the environmental context of the care agency or agencies.

For the purpose in hand the significance of Smith's social construction approach to human needs is that it highlights the fact that the needs which are actually met within collective care settings are not based simply upon some criterion that rests solely within the individual client but are also actively constructed and maintained by caring professionals. It is apparent that during the social construction of reality within specific care organisations there are on-going and important social processes surrounding the determination and definition of clients' valid and meetable needs. On a formal level these social processes often result in statements of the organisation's goals and envisaged

ways of working. At a more informal level, however, the negotiation of need takes place constantly at various strata within organisations as workers and clients struggle to define, shape, construct and legitimate daily reality. A central aspect of this thesis has been to provide insight into some of these social processes within two organisations and four ground level care settings.

The data from this study has shown that the ideologies and administrative structures of the two care organisations studied promoted different views of the primary or central needs of their clients. Alpha organisation stressed very strongly the need for their tenants to be treated as 'whole people' with the same rights as other members of society. The organisation provided accommodation based upon values and principles which quite closely resembled those outlined above as being advocated by normalisation theorists. Alpha tenants all had their own lockable bedrooms, they had free access to the kitchen, communal food, etc. and were urged to see themselves very much as ex-patients. Moreover, Alpha tenants were encouraged and on occasions expected, to take part in communal decisions concerning the running of the house. The organisation encouraged what they termed the development of 'real relationships' based upon open and honest communication between both co-tenants and tenants and staff.

Beta organisation offered a different type of care setting to that of Alpha organisation and an accompanying alternative definition of their clients' primary needs. Beta organisation provided residents with space and asylum from many of the stresses of daily living and important on-going medical support and care. Within Beta organisation residents were seen and encouraged into 'the sick role' and allowed a significant level of exemption from responsibility for their actions; moreover they were not expected in any real sense to be involved in the day to day management or running of the houses. Within Beta Two in particular, the Assistant Cook provided residents with a comfortable physical environment, good meals and what might be termed genuine care. (For a full discussion of the two care organisations' ideologies see Chapter Three.)

The important point here is that the two research organisations defined their respective roles in somewhat different terms and set out to achieve differing objectives. Or, from a slightly different angle, the two organisations defined the primary needs of their clients in different ways and accordingly offered different types of care setting. The approaches of both organisations had identifiable strengths but also certain weaknesses. Thus,

for example, Alpha organisation was very strong on the promotion of the rights of individuals and attempted to give its tenants significant choice and control in the running of the houses. The trade-off for the rights embodied in the notion of tenancy were found, however, in the social responsibilities which individuals were expected to discharge. On occasions certain tenants had difficulty in coping with their responsibilities and this led to their experiencing quite high levels of stress. By contrast, Beta organisation provided its clients with a form of care that did not place significant demands or stresses upon residents and which afforded residents significant control over their levels and types of social interactions. On the negative side, however, Beta residents did not have much overt control over the way in which the care settings were managed and organised. Moreover, in terms of the values advocated by the normalisation theorists the quality of life in Beta organisation was in many ways limited; thus most residents shared bedrooms with only a very limited say in whom they shared with, bedroom doors were not lockable resulting in little privacy, many residents did not have personally meaningful day activities and there was limited resident choice in timing of meals, the menus, etc.

Within the final section to follow it will be argued that, due to the complexity of the needs of people who experience severe mental illness and the role that care organisations and front-line workers play in determining what are to count as the clients' legitimate and meetable needs, the most sensible policy path is one which promotes a patch work of different residential care options, together with a well co-ordinated path between resources. At this point, however, it is worth noting that the social construction approach to human need highlights the fact that under the new community care legislation the case manager is likely play an important role in gate keeping access to residential and other care options.

Within the White Paper, 'Caring for People' (D.H.S.S. 1989) and resultant 'N.H.S. and Community Care Act' the Government makes a praiseworthy call for assessment procedures to involve meaningful client participation. Thus 'Caring for People' states,

> Assessments should take account of the wishes of the individual and his or her carer, ... and where possible should include their active participation. Efforts should be made to offer flexible services which enable individuals and carers to make choices (paragraph 3.2.6.).

The stated aim is to move away from assessments of needs which revolve around a client's suitability for existing services or resources, towards ones which attempt to genuinely identify and meet the client's needs. Whilst the white paper advocates a 'lead role' for local authorities it also recognises that in many cases multi-disciplinary assessments are both necessary and desirable. Thus the white paper lists no less than twenty different groups of professionals who may potentially become involved in community care assessments; these include, Social Workers, General Practitioners, Hospital Consultants, Community Psychiatric Nurses, Occupational Therapists, Housing Officers, Employment Department Resettlement Officers and Voluntary Workers, (paragraph 3.2.5.). The white paper suggests that complex assessments and the subsequent design of care packages are normally best achieved by the designation of a 'case manager'; who has explicit responsibility for the co-ordination of the assessment process and the subsequent design and management of the care offered. Further, the white paper suggests that individually tailored care packages should, where appropriate and necessary, combine and draw from resources across the statutory, voluntary 'not for profit', private and informal care sectors. Indeed local authorities are explicitly charged with the development and promotion of a 'mixed economy of welfare' (paragraphs 3.4.6 - 3.4.14).

What the white paper does not consider in detail, due to its reliance upon a 'traditional notion of need' (Smith 1980), is that the needs which emerge from the new assessment procedures will in large part be a reflection of and result from the social processes involved in client assessments. Thus such factors as the relationships between the client and the various professionals involved in the assessment, together with the degree of co-operation and co-ordination between professionals, will be crucial to the social construction of what are in reality to count as the client's needs and the subsequent design and implementation of the care package. Here it becomes apparent that the role of the case manager will be vital, since it will be in this key relationship that the client must attempt to negotiate and voice their opinions concerning their primary needs. In the following section it will be argued that particularly at the point of leaving hospital, although not only at this time, clients are often in a fundamentally vulnerable position, often desperate to secure accommodation or other forms of care and support. It is suggested then for the new legislation's stated aim of consumer empowerment to be

achieved, it is crucial that professionals and particularly case managers, make every effort to provide clients with time and accurate and meaningful information in order to facilitate their involvement in decisions concerning their future care.

Moreover, the social processes involved in the new Community Care assessment procedures are likely to be further complicated by the fact that the white paper's enthusiasm for needs-based assessments and meaningful user involvement is qualified by statements to the effect that assessments must be made within the available resources and against the background of Local Authority priorities (paragraph 3.2.12.). The shift in the primary source of financing of residential care from the Department of Social Security to the Social Work departments also heralds a movement from a situation where financing was essentially demand-led, to a scenario where the monies for residential care must now come from the finite Local Authority Community Care budget.

The important point here is that, as Smith has shown, the agency context of client assessments is often a crucial factor to the outcome and determination of needs. The current changes to the system of financing of residential care bring with them important new factors to the social context of clients' assessments for residential care, as budgetary pressures are explicitly drawn into the key relationship between the case manager and client. An important potential danger appears to lie in the creation of a situation whereby people in need of residential care may be steered away from or even denied access to this option because of budgetary constraints. In such circumstances questions obviously arise as to whether the new legislation will genuinely promote greater user involvement in the assessment and determination of their needs.

THE NEED FOR A PATCHWORK OF RESIDENTIAL SERVICES AND FLEXIBILITY TO ENABLE CLIENTS TO MOVE SMOOTHLY BETWEEN RESOURCES

The central conclusion to be drawn from the discussion presented in the preceding sections is that the needs of people with mental health problems are complex and diverse. People who suffer from schizophrenic type illnesses do appear to be particularly susceptible to high levels of E.E. and the general degree of stress within a care setting; moreover, this is

undoubtedly one important need. At the same time, however, it is equally important to remember that people with mental health problems also retain the same broad social needs and rights as other members of society. Therefore in the planning and delivery of services there is an imperative to balance individuals' needs to be in control of their lives, to have real choice, to be treated with dignity and respect, to have privacy, etc., with their needs for protection from overly demanding or extremely unstimulating care settings. Further, it is necessary to recognise that an individual's susceptibility to stress is likely to vary over time and with the cyclical nature of many mental illnesses.

Beyond this, the findings from this study support the earlier work of Smith in highlighting the ambiguity involved in the human needs which care agencies attempt to meet and the important role that professional carers play in determining what are to count as the client's legitimate needs. Within actual collective care settings managerial and administrative imperatives lead to the situation whereby the organisation plays a significant part in defining the clients' paramount needs and determining the ways in which these needs are to be met. In order for formal care settings to function effectively there will always be a need for the organisation to have explicit aims, goals and administrative structures; these aspects of organisation inevitably play a large part in determining the type of care setting that is offered. However, such organisational objectives must also be subsequently interpreted by staff and clients during their daily construction of social reality and this results in variations in the type of care offered at ground level, within the same organisation.

It was Apte's recognition of the complexity of actual collective care environments that led him, as far back as 1968, to call for a system of halfway houses for the mentally-ill which were graded in terms of their levels of social expectations and stress. Apte suggested that there are at least three ways in which stress can be graduated and controlled within collective care settings.

> 1) Stress is exerted on the resident by being required to assume a social role different from that of a patient. He is expected to behave, in fact, as an ex-patient and to drop many of the vestiges of the 'sick role'. ... 2) stress can also be purposely controlled on an individual basis by the warden or professional staff who work with the ex-patient. In the case of an individual who is not yet ready for full time work, the

staff can adjust the conditions of employment to suit his capacity. ... 3) Conversely the staff can grade stress by deliberately planning tasks for the resident so that he is encouraged to increase his ability to tolerate stress and is gradually exposed to more demanding social and occupational situations (Apte 1968 p. 23).

As Apte notes the first of these methods of graduating stress depends in large part upon conscious attention to the design and structure of the resource. The resulting care ideology or organisational ethos will entail expectations, levels of demand and ultimately levels of E.E. in the setting which will broadly speaking apply equally to all residents. Within this study Alpha and Beta organisations provided contrasting case examples of two care ideologies which placed differing social demands and expectations upon their clients. In the light of the fact that the structure and design of a residential care setting place important demands and expectations upon clients it is important that potential residents are made explicitly aware of the level of organisational expectations before entering the care environment.

The degree of complexity involved in enabling clients with mental health problems to make informed choices regarding the suitability of a residential care setting should not however be underestimated. At the point of leaving hospital many clients are in an extremely vulnerable position, desperate to secure accommodation and often without significant informal support. Further, clients who have spent many years within an institution may understandably be apprehensive about a move to an unknown environment. They may underestimate their abilities and/or may have little drive or skills in the area of self determination, either because of the effects of their illness or the more negative effects of spending long periods in an institutional care regime. Conversely, clients may have unrealistic expectations of life outside of the hospital, may over-estimate their own abilities or not be aware of the degree of stigma and prejudice which they are likely to encounter. In such situations it is imperative that the professional workers involved aim to provide accurate relevant information and time for potential residents to discuss their aims, goals, fears or worries in order to enable informed and realistic client self determination and choice. As noted in the preceding section under the new legislation the role of the case manager will be central to the achievement of such consumer empowerment.

The second and third methods of graduating stress which are advocated by Apte involve workers in tailoring the demands of treatment or care plans to the needs and requirements of individual clients. The findings from this study suggest that Apte was correct in pointing to the fact that front-line care staff enjoy significant freedom in their interpretation and operationalisation of the stated aims and goals of the care organisation. The two Alpha houses therefore provided case examples of workers using their front-line discretion and flexibility, in different ways, in order to create two care settings which varied in important respects, (for further elaboration see Chapters Four, Five and Six). However, the findings from this study also suggest that within specific care settings there are important social processes which place significant limits upon the flexibility available to workers in their responses to the needs of individual clients.

The communal nature of residential care settings means that a set of collective norms and values will inevitably develop. Such norms and values provide residents/tenants and workers with a social base from which to engage in interactions and communal behaviours; however, they also play an important role in maintaining and defining the social setting. The data from this study suggests that some norms and values within collective care settings arise from the explicit aims and ways of working of the organisation, whilst others result from the ground level social actors' daily construction of reality. To the individuals involved such norms and values often appear as objective facts which cannot easily be altered or breached. It is this aspect of collective care settings that Moos attempts to capture in his notion of 'environmental press' (see Moos 1974).

The point of central importance here is that the degree of flexibility that is available to workers when responding to the needs of individual residents appears to bear a direct relationship to the degree to which the client's individual requirements breach norms and values which are central to the maintenance of the setting. That is to say, the degree of flexibility that workers are able to offer will be directly related to whether the needs of the particular client in question violate the central defining norms and values of the care setting. A brief example from this study's data will serve to illustrate this important point.

Within Alpha One a central worker goal was the creation of a 'home' for the tenants. A crucial subsequent aspect of the workers' operationalisation of this goal was the encouragement of tenant mixing and interdependence

between tenants. Thus, in Alpha One, the norms of attendance at the daily communal meal, involvement in the house meeting and the communal cleaning, became central and defining features of the setting. Consequently, whilst Alpha One workers were prepared to allow occasional non-attendance at the meal they did not feel able to allow any tenant to completely withdraw from this obligation. Similarly, attendance at the house meeting was expected, as was involvement in communal cleaning and the preparation of the evening meal. Tenants were not free to opt out of these communal obligations because doing so would have threatened important fundamental features of the care environment. In short, within Alpha One the tenants' attendance at the evening meal, the fortnightly house meeting and to a lesser extent their involvement in communal cleaning, were central to the maintenance of the care setting and consequently workers felt constrained in the degree of flexibility which they could offer tenants who found these social obligations difficult. In other areas of daily living, such as rising from and retiring to bed, personal hygiene habits, the cleanliness of individual bedrooms, attendance at formal day activities, etc., the workers were able to allow tenants considerably more freedom and choice.

By contrast, within Alpha Two workers did not place the same emphasis upon the importance of tenant mixing or the creation of tenant interdependence, rather they had taken the decision to place primary emphasis upon the aspect of the organisational ethos which stressed the encouragement of individual tenant choice and control. Consequently, attendance at the communal meal, house meeting and participation in the communal cleaning were not norms central to the maintenance of the care setting and in this situation the workers felt able to offer tenants greater flexibility concerning their involvement in these areas of daily living. On an individual level front-line workers often experience the social constraints upon their front-line flexibility in terms of an issue of equity or fairness; whereby they do not feel that it is right that one resident/tenant be exempt from a particular obligation, while other residents/tenants are expected to participate or even take on the responsibilities of the 'offending' client.

It is argued then, that although Apte is correct to highlight the important role that front-line care workers can play in graduating and controlling the degree of stress and social stimulation that residents are subject to, the findings of this study suggest that there are also important social processes which place limits upon the degree of flexibility available to residential care

workers. If the needs and requirements of an individual client repeatedly lead them to breach norms or values which are central to the maintenance of the care setting then it is unlikely that the workers will be able to offer sufficient flexibility to support the person within that particular setting.

Murrell and Norris (1983) have suggested the concept of 'person-environment fit'[1] as a way of bringing together the concepts of social environment, personal needs and the individual's quality of life. As they write;

> person-environment fit ... [is] a nonprejorative (sic) way of viewing problems that the medical model defined in terms of illness, symptoms, or deficits within persons. Rather, different persons would fit some environments better than others; the goal ... [is] to improve the fit.... (Murrell & Norris1983 p. 89) (brackets added).

Although Murrell and Norris made the above observations in relation to people's fit within the general community, their notion of 'person-environment fit' provides a good perceptual basis from which to think about the design and subsequent management of collective care settings. Thus when designing and running collective care settings, planners, managers and front-line workers are advised to consider carefully which groups of people the care settings is designed to support and the limits to the flexibility which they can offer when responding to individual clients. The strength of the concept of 'person-environment fit' lies in the way in which the individual client is located at the centre of the equation and potentially given a greater say in determining how and where they wish to live. Thus, the notion offers the opportunity to move away from some of the worst excesses of professionally directed views of the 'correct way to live' or what is and is not a 'good quality of life'. Moreover, people are no longer deemed to have failed if at a certain time they wish or need to move to more supported accommodation or wish to stay for a further period within a hospital setting; thus, such a decision is framed in terms of the current care setting suiting or not suiting a particular individual at that point in time.

To summarise and conclude, within the first section of this chapter a tension was identified between the desire to ensure that clients in residential

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[1] As Murrell and Norris (1983) acknowledge the concept of 'person-environment fit' was first developed in the work of James Kelly (1968).

care settings are offered the best possible quality of life (in terms of providing them with opportunities as close as possible to those of other members of society and maximising their meaningful choice and control over their lives), and the need to ensure the possibility of asylum from the demands and stresses of daily living and/or intolerable levels of E.E. In the second section of the chapter the ambiguity inherent in the concept of human need was recognised and it was noted that in reality care organisations and front-line workers play an important role in determining what are to count as clients' paramount and meetable needs.

In this final section the arguments from the preceding discussions have been brought together via a review of the work of Apte. It has been argued that Apte was correct to note that the design of a care setting will place certain social demands upon its inhabitants. Apte was also correct to argue that front-line workers necessarily play an important role in determining the levels and types of social expectations within a care setting. However, the findings from this study suggest that there are important limits upon the flexibility which front-line workers can offer when responding to the needs of particular clients. The flexibility available to workers within collective care settings appears to be constrained by the extent to which the needs of the client breach the norms and values that are central to the maintenance of the care environment.

The central policy implication which follows from this analysis is that there is a need for a variety of residential care settings that offer clients different ways to live with varying degrees of social stimulation. During some periods people may experience personal problems which mean that they wish and need genuine asylum, at other times they may wish and feel able to cope with a care environment that provides less care and more individual autonomy, choice and responsibility. The concept of 'person-environment fit' is advocated as a non-pejorative way to view the location of clients within such a patchwork of care options.

Moreover, it is clearly important that such a patchwork of residential care services is accompanied by a system which allows clients to make smooth transitions between resources as and when their needs and requirements dictate. Under the new community care legislation, case managers will play a vital role in enabling such movements, as they are charged with the co-ordination of professional assessments and the construction and management of individual care packages. In turn it is important that case managers strive

to genuinely involve clients in the determination of their needs and requirements. This must necessarily involve case managers in providing clients with accurate and relevant information, together with time and advice, so as to facilitate informed and meaningful client involvement in crucial decisions concerning how and where they live.

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Appendix One

i) STAFF INFORMATION SHEET

ii) RESIDENT INFORMATION SHEET

iii) STAFF AND RESIDENT CONSENT FORM

STAFF INFORMATION SHEET

The aim of my research is to undertake a comparative study of two Health Board rehabilitation houses and two broadly similar voluntary sector resources. In order to achieve this I would like to spend ten weeks in each of these four units working as a volunteer. During this period I will be keeping a written record of my observations. Confidentiality of this material is assured, it will be kept in a secure place and I will be the only person with access to it.

In order to further aid the comparative analysis I would like to utilise the Sheltered Care Environment Scale (S.C.E.S.) a standardised environmental measure. This will involve you being asked to fill in a simple questionnaire concerning your view of the house.

In addition I would also like to use a time sampling technique to gather information on how staff and residents spend their days. This schedule has been designed to further facilitate my objectives of making a descriptive comparison between the units. The actual mechanics of this technique will involve 30 minute sweeps of the house, over specific periods of time, when I will make a written recording of where residents and staff are and what type of activity they are engaged in. (for example, interaction with resident, interaction with other member of staff, administrative task, etc.) Names of individuals will not be recorded only whether the person is a member of staff or a resident.

It is usual for people who participate in studies to feel apprehensive and somewhat nervous. I would like to stress however that my particular interest is the way in which the differing organisational structures in the Health Board houses and voluntary sector houses translate into care processes and practices. Your views and experiences are considered to be genuinely important in this study. On completion of the research a PhD thesis will be compiled and submitted to Edinburgh University. In this thesis no individual will be identified by name or location.

If you agree to participate in this study you retain the right to withdraw at any time.

I thank you in advance for help.

Stephen Pavis
Dept of Social Policy & Social Work,
University of Edinburgh.

RESIDENT INFORMATION SHEET

Researcher information.

My name Stephen Pavis and I am a student at Edinburgh University. My study is being financed by the Economic and Social Research Council.

Purpose of the research.

The aim of my study is to gain an understanding of the experiences of residents and staff within this house. I will be working in the house for ten weeks as a volunteer in order that I might better understand what life is like here. I will also be working in a similar way in other group living schemes in the community.

Benefits

You will not benefit directly from participating in the study. It is hoped however that the information gained through this work will help nurses and others to plan future services for people who experience similar needs and difficulties to yourself.

Procedures

It is not my intention to intrude into your lives to an unacceptable level, and I hope that I will not affect your usual routines and activities. I will however ask you to help me at certain times and your help will be very much appreciated. I am interested in your experiences and the way you feel about the house. I may ask you to help me fill in a simple questionnaire over a cup of tea or coffee.

Voluntary Participation/confidentiality.

Your participation in the study is voluntary and you can withdraw from it at any time. Information that I collect will be marked with a code, not your name, and will be stored in a secure place. I am the only person who will have access to this information and I will not pass it on to anyone else. When I write my final report for Edinburgh University no individual details or the location of the study will be revealed

Stephen Pavis
Dept of Social Policy & Social Work,
University of Edinburgh.

PARTICIPANTS' CONSENT FORM

An explanation has been given to me concerning the nature of the study and I agree to participate.

Signed..

Date...........................

Appendix Two

i) ALPHA TENANCY AGREEMENT

ii) STANDARD SHORT ASSURED TENANCY AGREEMENT

ASSURED TENANCY AGREEMENT

between

Alpha LIMITED

(THE LANDLORD)

and

. . . .

(THE TENANT)

1. ADDRESS

        offers and the tenant accepts, under an assured monthly
tenancy, the accommodation in

Room No . . . . (the room)

Address . . . .

from the . . . . day of . . . . 19... (the date of entry). This
tenancy shall continue on a monthly basis thereafter until
terminated by you or by the Landlord giving four weeks notice in
writing. The room is for the exclusive use of the tenant. The
common parts are for the shared use of all the tenants in the
house.

2. SUPPORT

The tenancy is offered with the sole object of providing the tenant
with accommodation and support to meet the tenant's needs.

Please refer to the Tenants handbook for more information.

3. RENT

The rent (which includes charges for services) is payable by the
tenant weekly in arrears. The total weekly rent to be paid by the
tenant at this time is £ . . . .   (the Landlord) will
provide the following services :-

        Staff Support and Administration, food and other supplies,
        heating and lighting, furniture and soft furnishings,
        insurance.

Please refer to the Tenants Handbook for more information.

4. RENT REVIEW

The rent payable under this agreement will be subject to review
from time to time, to take account of actual expenditure and any
known or reasonably anticipated changes in costs. The landlord
undertakes to provide a written statement and to give the tenant
four weeks written notice of changes in the rent payable.

REPAIRS AND MAINTENANCE - THE TENANT'S RESPONSIBILITIES

a) The tenant agrees to reasonably maintain the room. The tenant also agrees to share the maintaining and cleaning of the common areas in the house, and maintaining the garden of the house, if any, with the other tenants.

b) The tenant agrees to allow persons authorised by the landlord into the room or house to inspect and/or carry out repairs. Reasonable notice will be given by the landlord. In the case of an emergency immediate access will be required.

c) The tenant agrees to report any breakages or losses, whether to fabric, fittings or furnishings, to the landlord immediately. When repairs are required as the result of misuse or damage caused by the tenant or their visitors, these will be charged to the tenant.

6. REPAIRS AND MAINTENANCE - THE LANDLORD'S RESPONSIBILITIES

a) The landlord will (in conjunction with the owners of the house, if appropriate) keep the house in good repair and will decorate the room and house on a regular basis.

b) The landlord will maintain, and replace when necessary, the furniture and fittings in the room and house supplied by the landlord.

c) The landlord will insure the landlord's contents against loss or damage by fire and other risks covered by a normal contents insurance policy. The landlord will also insure the tenant's belongings up to the value of £ .... against the above risks.

d) The landlord will ensure as far as is practicable, that the tenant enjoys peaceful and undisturbed occupation of the house.

7. USE OF THE HOUSE

The tenant agrees to :-

i) occupy the house as his/her only or principal home.

ii) attend any meeting called by the landlord to discuss any problems in the house.

iii) co-operate with the landlord and support staff in the management of the tenancy.

iv) Sweep and clean, in turn with other tenants the stairs external to the house as required.

The tenant also agrees not to :-

i) endanger or cause a nuisance to other tenants in the house or to neighbours. The landlord will be the sole judge of 'nuisance'.

ii) allow any guest visiting the house to cause a nuisance to other tenants in the house, neighbours or workers.

iii) behave violently towards, or threaten violence to other tenants of the house, neighbours or workers. The landlord will be the sole judge of 'violence'. The landlord will remove any tenant who behaves in a violent manner from the house immediately.

iv) take in lodgers or sub-let the room.

v) use any part of the room or house for carrying on a business or profession or as a workshop for carrying out a trade.

vi) make any alterations to the structure, fittings, fixtures or furnishings of the room or house without written permission from the landlord.

vii) keep pets without written permission from the landlord.

viii) use portable or fixed oil-fired, paraffin or bottled gas appliances.

ix) bring, or permit to be brought, any illegal drugs into the house, nor to use or allow the house to be used for illegal purposes.

8. ENDING THE TENANCY

This assured tenancy may be ended by :-

a) the tenant giving the landlord four weeks' notice in writing during which time the rent will continue to be payable or

b) by the Landlord giving the tenant four weeks' notice and subsequently by order of the Sheriff Court on the grounds that :-

i) The tenant has not paid the rent which is lawfully due and is in arrears at the time of legal action being taken.

ii) The tenant has broken or failed to carry out any of the conditions of this tenancy.

9. ALTERNATIVE ACCOMMODATION

In the event of us, the landlords, having to quit or give up occupancy of this property, we reserve the right to remove and relocate the tenant to alternative accommodation.

ACCEPTANCE OF THE PROPERTY

By signing this agreement, the tenant accepts the room and house as let in good order and condition. The tenant also undertakes to leave the room and house in a similar condition on his/her departure.

The parties now consent to the registration of this agreement for preservation and execution.

IN WITNESS WHEREOF these presents (this and the preceding pages) are subscribed by the parties hereto on the

.... day

of 19

**

....

Signature

....

For and on behalf of   Limited :

....

(. Limited Authorised Signatory)

** The words : 'Adopted as Holograph' should be written above the signature in the signatory's own handwriting, thus making this Agreement binding without the need for witnesses.

If the Tenant feels that the Landlord has broken this Agreement, or not carried out any responsibility contained in it, he or she should contact the Landlord for details of the Complaints Procedure.

AGREEMENT 3

8. An Inventory will be made of furniture and furnishings and condition will be checked at outgoing and the Tenant agrees to accept the Landlord's Agents' assessment of making good the cost of any article which may be broken, damaged or missing during the tenancy, or any damage to the property (fair wear and tear excepted). When the tenancy expires the Tenant will leave the furniture and furnishings throughout the house in their present positions in the same rooms as shown in the Inventory.

9. No redecoration to the house or alterations will be made without the prior consent, in writing, of the Landlord, or his or her Agents.

10. The Tenant will remove from and vacate the house on the termination of this tenancy without any legal warning or process of removal and it is specifically accepted as a condition that, in any case of default of payment of rent, or breach or non-performance of any of the conditions contained herein the Landlord or his Agents may give notice, in writing, to terminate the tenancy within two weeks from the date of such notice and without further warning to re-enter and take possession of the house and appurtenances together with the furniture and effects, and that without prejudice to his/her right to recover any of the rents that may be due or may become due.

11. The Tenant by acceptance and holograph signing hereof acknowledges receipt of notice by the Landlord that this property has been let by the Landlord during his/her absence and will be required for his/her own use at the termination of the tenancy notified above. Accordingly the Landlord being the owner/occupier o. the property within the meaning of Ground 1 of Schedule 5 of the Housing (Scotland) Act 1988, hereby notifies the tenant that possession of the property may be recovered by the Landlord under the said Ground 1 of Schedule 5 of the Housing (Scotland) Act 1988, all prior to the commencement of the tenancy.

12. The Tenant will not keep or allow to be kept any animals in the house or ground attached hereto.

13. The tenant will for the whole period of let occupy the subjects of let as his ma residence for the purposes of the Abolition of Domestic Rates, (Scotland) Act 19 and hereby accepts responsibility for payment of all Community Charges arising i terms of said Act to the termination of the period of let hereinbefore. If the Community Charge is levied on the Landlord the appropiate proportion thereof for period of let will be refunded to the Landlord by the Tenant within one month of payment of same by the Landlord.

14. Notice is hereby given to the Tenant that the Landlord has granted a heritable security over the subjects of let in favour of a heritable creditor and that possession of the subjects of let may be required by the heritable creditor in t event of a default by the Landlord in terms of Ground 2 of Part 1 of Schedule 5 the Housing (Scotland) Act 1988 and the tenant acknowledges by acceptance of the presents such notice to have been duly given.

15. It is an essential condition of this leasing agreement that the tenant also undertakes the responsibilities which are listed on the attached sheet relating the 'Care of Property by Tenants'.

hereby accept the foregoing offer of let and acknowledge receipt of requisite not. inder Clauses 11 and 14 above, including Form AT5 (served with initial lease).

_____ Adopted as Holograph _____ (Adopted As Holograph)

_____ (Signature of Leaseholder)

ours faithfully,

_____ Adopted — Holograph _____ (Adopted As Holograph)