# Mental Disorders and Community Care:

# A Discourse Analysis

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## Abstract

Talk about people with mental disorders and community care was examined using Potter and Wetherell's (1987) system of discourse analysis. Participants were ten members of the public, resident in a suburban community. They were interviewed on the topics of community care policy, rights, responsibility and care, the location of community residences, and general knowledge about people with mental disorders. Verbatim transcripts from interviews were analysed, and six interpretive repertoires identified, these being, rights promotion, dual community, patronisation, affiliation, solicitous control and disorder repertoires. While participants' talk often contained content indicating support and concern for people with disorders, the repertoires were constructed in a way which functioned to promote and protect their own interests. Analysis of linguistic devices revealed how participants used language to distance themselves from socially unacceptable talk, and claim consensus for their views. The social consequences of discourse constructed in the form used by participants was discussed. Overall the analysis suggested that the way ordinary members of the public talk about people with mental disorders and their care in the community has a negative influence on the social interaction between the two.

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# OVERVIEW

Over recent years the number of people with mental disorders living in the community has increased. A number of factors have contributed to these increases, including more efficient medications, enlightened treatment approaches, and the introduction of The Mental Health (Compulsory Assessment and Treatment) Act 1992 which intends hospitalisation of those with disorders to be restricted to crisis and chronic conditions only. In the United States, following policy changes which resulted in closures of mental hospitals, there has been a growing hostility from members of the public against the increased numbers of people with mental disorders living in the community (Hall, 1985). The outcome of the New Zealand endeavour at community care for those with disorders may also result in social disharmony and rejection unless they can become accepted as part of the community.

The first step towards ensuring a successful integration of people with mental disorders into the community is to understand the concerns of members of that community, then where possible to address those concerns. With this in mind, research investigating public attitudes towards mental illness and community care has been carried out over the past twenty years. (See Rabkin (1980) for a review of the literature - discussed further in Chapter One). The findings of this earlier research consistently point to negative attitudes on the part of members of the public towards having people with mental disorders living in close proximity to themselves. How to change those attitudes has become a most pressing question.

Potter and Wetherell (1987) propose an alternative to research focusing on attitudes and attitude change. Their approach is based on the assumption that language is used to construct and create social interaction. They would argue that it is the way language is used which maintains the negative social environment regarding community care for people with mental disorders. This approach suggests that change will only occur when the way in which language is being used changes. The first step being to identify exactly what people are saying about those with mental disorders and their care in the community.

Chapter One briefly backgrounds the concept of mental disorders and what is generally involved with community care in New Zealand. Also the factors

believed to contribute to public attitudes to community care are discussed. This is followed by a short summary of previous research investigating public attitudes to mental illness and community care. The limitations of previous research approaches are discussed in Chapter Two.

Because Potter and Wetherell's (1987) approach to discourse analysis is used in the present study, Chapter Three outlines the main components of their theory, and discusses how a discourse analysis approach may overcome some of the limitations evident in other methods of research. The subsequent chapters present the current research report, with detail of the process followed and discussion of interpretive repertoires and linguistic devices identified from the analysis. The social consequences associated with the way participants constructed their discourse are considered, and finally, in Chapter Nine the potential use of findings are discussed.

# CHAPTER ONE

# BACKGROUND

## MENTAL DISORDERS

There is no commonly agreed criteria for the concept of mental disorder, and no single statement adequate to define exactly what is meant by the term. Even so, mental health professionals use the term to describe a wide variety of different conditions which are separately defined and elaborated in the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R; American Psychiatric Association, 1987). The appropriateness of applying labels to people whose behaviour contravenes the norms of society has been the subject of much controversy (Sarbin, 1967; Scheff, 1975; Szasz, 1974). This particular debate highlights the social and medical implications inherent in the use of terms such as 'mental illness' or 'mental disorder', and raises awareness of the potential for stigmatisation such labels attract. Nevertheless for the purpose of the present study, and in the context of discussing people with conditions described in the DSM-III-R, it is necessary to use a term believed to be generally understood by ordinary members of the public. The term 'mental disorder' however inexact, fits this criteria. It is a term widely used by health professionals and lay people to describe a broad range of problems associated with thought or behaviour perceived as undesirable by society.

The concept of mental disorder proposed by Wakefield (1992) describes a disorder as existing "when the failure of a person's internal mechanisms to perform their functions as designed by nature impinges harmfully on the person's well-being as defined by social values and meanings." (Wakefield, 1992, p. 373). This perspective highlights the aspect of social norms, the contravention of which can result in intolerance and rejection by other members of society. Although research has found people to be increasingly tolerant and prepared to accept a broad range of non-conformist and disruptive behaviours, three major factors have been found to influence a rapid diminishing of this tolerance. These include, the behaviour being perceived as unpredictable, the individual being deemed unaccountable for the behaviour, or when a label of mental illness is applied to explain the behaviour (Rabkin, 1974). When tolerance is exhausted psychiatric intervention is sought. This action may be taken by the individual,

their family or some community agency such as medical, justice, or educational professionals. In extreme cases the individual is admitted to hospital where observation and treatment is conducted.

Before the advent of psychotropic drugs, patients in mental hospitals were often destined to remain institutionalised for long periods. However more recently, with effective drug treatment and the influence of political and public pressure it has become more likely that a person deemed to be suffering from a mental disorder is treated while continuing to live in the community. Alternatively, after a brief period in hospital the individual is discharged and receives ongoing care in the community.

In New Zealand The Mental Health (Compulsory Assessment and Treatment) Act 1992 is the legislation defining the nature of assessment and treatment for people suffering from a mental disorder. Under the terms of the Act, the term mental disorder "means an abnormal state of mind (whether of a continuous or and intermittent nature), characterised by delusions, or by disorders of mood or perception or volition or cognition, of such a degree that it; (a) poses a serious danger to the health or safety of that person or of others, or (b) seriously diminishes the capacity of that person to take care of himself or herself" (p.4).

This definition sets the threshold for compulsory psychiatric assessment and treatment. It does not apply to voluntary patients. The focus of the Act is on treatment rather than hospitalisation, with the intention of facilitating any treatment required in the least restrictive environment possible. Where people are required to be hospitalised for a period the Act refers to 'restricted patients' in the normal hospital context, however compulsory treatment orders may apply to restricted patients or community treatment. As long as the patient can be treated adequately in the community this option is presumed to be the norm.

## COMMUNITY CARE

A major consequence following the introduction of the Act is the impact on ordinary members of the public. All forms of social change result in some uncertainty and apprehension, and the experience of increasing numbers of people, who previously would have been institutionalised, now living in the community, does constitute a significant social change. However, before

discussing this impact and it's repercussions it is relevant to look at what 'community care' actually involves.

Any care provided for people with mental disorders, apart from hospital in-patients, is community care. This includes people who are the subject of compulsory treatment orders. However, community treatment orders under the terms of the Act are not the same as community care. Simply because the Act focuses on assessment and treatment, a person diagnosed with a mental disorder does not find themselves relieved of the disorder simply because the Act no longer applies to them. They still need treatment (often medication), and many need care, particularly those who are unable to adequately care for themselves. These people who are not in a crisis state (which would have them hospitalised under the terms of the Act) but who are subject to a community treatment order, or who remain incapacitated to some degree by a mental condition, are the ones to whom community care applies.

The need to provide care for people with mental disorders in the community is recognised by the Department of Health, and in general terms by ordinary members of the public. Some of this care is facilitated by Government initiatives through Regional Health Authorities, and some is provided privately by commercial enterprise and non-profit making organisations, for example, Salvation Army and Richmond Fellowship. Still, the amount and nature of the care being provided is the subject of much criticism from the general public, the media, and people who use the services.

Even though frequent criticism is levelled at the scarcity of care facilities, these exist, and the number of such facilities is increasing. There are a wide variety of community care facilities ranging from support groups to residential houses with full time staff. For example, the Community Mental Health Directory for the Wellington Region (1994) lists and provides information about thirteen community residential homes for people with disorders. Some of these have full time staff and others have day staff or on-call support if required. A number of agencies provide accommodation in boarding houses or flats specifically set up for mental health consumers. Support groups which operate as day centers or by regular meetings also offer services, these generally being accessed by people who live in private accommodation.

Community care facilities are needed in greater numbers if adequate services are to be available for the growing number of people who need such care. As can be seen from the description of facilities provided in the Wellington region, the predominant type of facility needed is residential. These being staffed or unstaffed group homes, or boarding houses and flats. As the term community care suggests, these residences are located in the community. This can not occur in isolation. Each residence established impacts on other members of the community, particularly those who live in close proximity. The reactions and actions of people towards residential facilities for people with mental disorders can influence the success or failure of community care of this type.

Public attitudes to community care have been the subject of a considerable amount of research conducted with the purpose of providing a basis for the formulation of community mental health policy. Before discussing this research it is appropriate to comment on a number of factors which may contribute to the development and maintenance of public attitudes in this area.

## FACTORS CONTRIBUTING TO PUBLIC ATTITUDES REGARDING COMMUNITY MENTAL HEALTH

Social agencies to help people who need assistance in the community are many and varied. Government agencies such as the Social Welfare Department are funded by taxes, and operate on a measured need basis. Many other agencies operate on a voluntary basis, sometimes supported with financial grants or Government subsidies. The same as anyone else in need, people with mental disorders can make use of the services and assistance offered by these agencies.

The provision of special services for any one group of people, such as those with disorders, is addressed by Government policy in the form of a requirement for Regional Health Authorities to fund assistance where necessary. To a large extent the Government requires the 'community' to look after it's own. Unfortunately people with mental disorders do not generally elicit benevolence from people in our society. Indeed, if Cree and Curson (1985) are correct, the increasing number of people with mental disorders in the community is associated with a decrease in public tolerance for them.

To understand why there may be diminished tolerance it is relevant to consider how opinions on the topic are formulated. People form opinions about all types of events in their social environment, with information being absorbed from reading, listening, watching or experiencing. Probably the most influential source of information is the news media.

Although Cross (1983) may be overstating the case he proposes our survival as a species may depend on the nature of the information we get from the news media, the most important of which he considers to be the television news. Describing how television reaches all social classes, all educational levels, and influences the thinking of more people than any other single social institution, Cross invites people to consider how they developed their present set of values. He suggests they generally adopt the implicit assumptions of society which are constantly reinforced in the media, which in turn both reflects and reinforces that society.

The reality which is projected and absorbed by the public via the media has been the topic of a considerable amount of research. A number of studies, particularly those conducted by Gerbner and colleagues, described in Condry (1989), reveal that television viewing has a small but significant influence on attitude and belief systems. People reportedly use television to provide them with information regarding crime, fashion, and health, among other things. In other words, to give them a picture of what the world is like. Early studies revealed that impressions and beliefs held by the public about people with mental illness were much closer to media depictions of psychologically disturbed people than to characteristics established by mental health professionals (Gerbner & Tannenbaum, 1962; Nunally, 1961). These early studies, and more recently a report by Wober and Gunter (1988), reveal how the media reinforces inaccurate stereotypes and traditional prejudices rather than cultivating a greater public understanding of mental illness.

It is not often that ordinary members of the public take steps to fully inform themselves and obtain a balanced view on many issues which affect their lives. This does not prevent them from developing an opinion on a great number of issues, one of which relates to the care for people with mental disorders in the community. While these opinions may be based on individual thought given to a particular matter, frequently they are influenced by the occurrence of, and publicity given to, sexual or violent crimes committed by people who have been

released from mental hospitals. Unfortunately these situations often impact on opinions regarding community care for the mentally ill.

Social learning also forms the basis for opinions. The application of a stigma to a person, or groups of people, who do not fit the ideal norm of society is often the result of learning. Children observe stigmas being applied to people, and witness the undesirability of such labels (Goffman (1965). The effect of stigmatisation and intolerance of others who are different, can result in prejudice against anything to do with mental illness. This type of prejudice, reinforced by the negative impact of the mass media, work together to perpetuate the view that association with people with mental disorders is socially unacceptable.

Because it is likely that an increasing number of people with mental disorders will be living in the community (Hall, 1985), and in the interests of harmony in our social structure, it is important that the general public come to accept the integration of these individuals as actually constituting part of the community. A dilemma exists where people in a modern western society are opposed, on the grounds of human rights, to seeing people locked away for no valid reason, and this includes the institutionalisation of people with mental disorders, however they are not comfortable with having these same people interacting with them in their local communities.

Public ambivalence towards community care for those with mental disorders is often indicated by research in this area. While research participants report acceptance of those with mental disorders, and in favour of community care, they also report negative attitudes such as fear, apprehension and general discomfort at the prospect of being around them (Dear & Taylor,1982; Patten, 1992).

**Consumer perspectives of community care**

If living in the community rather than hospital is to be a healthy experience for people with mental disorders the environment needs to be positive, accepting and supportive. Unfortunately public ambivalence often has negative consequences for those with disorders. Life in the community is often not a positive experience as the following quotations reveal;

> *"The collective negative public attitude usually surfaces when halfway houses and group homes are being set-up.. The proposed neighbours start reacting.*

> *They involve the media, petitions are taken up, councils are bought into the fray. The media coverage causes distress to people with psychiatric illness."* (Patten, 1992, p x)
>
> *".....when we hear these comments about our collective selves our well-being is affected, our ability to achieve is reduced because the supportive general community isn't visible."* (Patten, 1992, p xi)
>
> *" How I cope in these situations depends on how I'm feeling at the time. Sometimes I handle it OK but if I'm feeling "off" it gets to me. At least three of my hospital admissions in the past five years have been due to the community not wanting me / us."* (Patten, 1992, p x).

Uncertainty about acceptance, and distress resulting from rejection, as reported in the last quotation, can often result in a relapse requiring admission to hospital. One of the consequences of this type of occurrence is to reinforce the preconceived negative ideas about mental illness held by the public. Steps need to be taken to eliminate negative and prejudicial views, with the first step being the acquisition of clear and comprehensive information about what the public say on the subject.

## PREVIOUS RESEARCH INTO PUBLIC ATTITUDES TOWARDS COMMUNITY MENTAL HEALTH

For community based mental health care to be successful public attitudes must be taken into account when planning community based facilities. Although the media reports on public reactions to situations involving mentally disordered people in the community, these reports often follow incidents which have received a lot of publicity. In order to obtain a more balanced picture of the views held by the general public, and the implications for community care, a considerable amount of research has been conducted, (good reviews of the literature are presented by Rabkin (1974, 1980) and Segal (1978). There are two findings consistently reported from research in this area. First, that under most circumstances (excluding chronic and violent cases) people do not consider institutionalisation to be satisfactory and accept that people with mental disorders should be cared for in the community. Second, that people are reluctant to welcome a care facility for people with mental disorders in their immediate neighbourhood.

One of the most comprehensive studies in this area was reported in 1982 by Dear and Taylor. Their research investigated community attitudes to mental health

care in Toronto Canada. They reported a number of findings, most of which indicated negative public attitudes towards close involvement with people with disorders, and resistance to residential facilities located nearby in the community. Factors influencing the successful integration of mentally disordered people into the community included the characteristics of both those with disorders and members of the receiving community, the behaviour of people with disorders, and the location of care facilities. These results are similar to those reported from earlier research into this area, indicating little change in public attitudes to community mental health from the time of Rabkin's (1974) review.

The results from this research remain relevant to the current New Zealand situation. In 1992 The New Zealand Department of Health commissioned a study of public attitudes to mental illness, primarily aimed at obtaining information for policy development (Patten,1992). This study revealed that despite some positive attitudes and concern, mental illness continues to be viewed negatively with many misconceptions. People believed the process of deinstitutionalisation was based solely on economic considerations, rather than on the benefits for people with mental disorders. The report also indicated two major concerns held by the public. Firstly, that professional support for people with disorders in the community was lacking. Secondly, based on their association of mental illness with violent behaviour, people reported considerable concern regarding community residences being located close to their homes.

With the amount of information collected over the past twenty years it could be expected that a comprehensive knowledge base now exists on the topic of public attitudes towards community care for the mentally disordered. Unfortunately, due to the nature of the research, the data obtained has limited practical value when it comes to enhancing the success of community care. A different approach which will provide information useful for practical application is indicated. In the following two chapters the limitations of some previous research in this area is discussed, and a research alternative proposed.

# CHAPTER TWO

# RATIONALE FOR THE CURRENT RESEARCH

## LIMITATIONS OF PREVIOUS RESEARCH

A number of recommendations for further research were made by Patten (1992) similar to those made earlier by Rabkin (1974). These included, investigating links between attitudes to people with mental illness and behaviour towards them, and how negative attitudes could be changed. It is debatable whether or not research studying links between attitudes and behaviour will provide useful information. Prediction of behaviour from attitude has consistently been found to be unsuccessful, a failure which is even more marked when the attitudes measured are towards a class of people (Ajzen & Fishbein,1980; Fishbein,1966; Lalljee, Brown & Ginsburg, 1984). This failure to establish behavioural links with attitudes towards mental illness is emphasised by Rabkin (1974), even though she recommended further research in the area.

It is questionable whether research investigating how attitudes can be changed is likely to produce information of any more value than that already obtained, particularly if similar methods of research are used. The nature of research which focuses on attitudes, and the traditional research methods used, impose a number of limitations which it is relevant to discuss.

### Attitudes

The concept of attitude raises a number of problems in traditional methods of research. Attitudes have been typically measured with reference to general objects or groups of people, and behaviour measured in terms of specific actions. For example, in the context of community mental health, this would mean relating a persons attitude towards people with disorders living in a local community residence, to their willingness to talk to them. Because the attitude being measured does not correspond with the behaviour in question Ajzen and Fishbein (1980) contend that research using this type of measurement can only reveal weak relationships between the two. In this case Ajzen and Fishbein would suggest a more appropriate measure would be of the person's attitude towards talking to a resident from a community care house.

As well as the difficulties which arise from trying to identify links between attitudes and behaviour Potter and Wetherell (1987) discuss two other limitations of research involving measurement of attitudes. The first of these is the assumption that attitudes are constant across contexts. The problem with this assumption can be clearly demonstrated using the example given above, i.e. if a person reveals a favourable attitude towards talking to someone with a disorder. Does that attitude hold the same across different social situations, and is it relative across different disorders, for example one which involves erratic and loud behaviour, and one which involves quiet introverted behaviour?

The final problem raised by Potter and Wetherell (1987) in relation to traditional attitude research involves the way participant responses are constrained by a limited range of predetermined categories provided by the researcher. Alternatively the statements or terms they use are interpreted by the researcher in order to fit the categories. These problems indicate that a less constrained approach may provide more useful information.

**Research Methods**

The suitability of research methods traditionally used in studies of this nature must also be considered. For example, where the ultimate purpose of research is to obtain information which can be used to change peoples perceptions of the mentally ill and community care, the primary aim must be to determine an accurate picture of what views they actually have on the subject. Traditional research methods fall short of achieving this. The following brief commentary on the methods used by Dear and Taylor (1982) and Patten (1992) demonstrate this point.

Patten (1992) used a random nationwide telephone survey of 1001 people, focused group discussions with members of the public, and key informant interviews with providers of mental health services. The telephone survey was based on a questionnaire designed to take five minutes to complete. The standard questionnaire style used invited response categories. Examples include response options ranging from 'object to this' to 'actively support this', and 'strongly agree' to 'strongly disagree'.

The group discussions were free flowing beginning with the researcher asking an initial question to promote discussion, then if necessary prompting further discussion in key areas of interest. The researcher noted major points raised in the discussion, and recorded frequency of those points. The results presented consisted of percentage responses from the telephone survey and relevant material from group discussions. Contributions from key informant interviews, although clearly subjective, were based on professional knowledge, and were included in the results where relevant to the topic being presented.

Dear and Taylor (1982) used a more empirical approach in their research. They used a questionnaire survey with elaborate sampling selection from the Metropolitan Toronto population. The questionnaire sought responses on topics such as 'your feelings on ...', 'your awareness of ...' , 'your beliefs about ...' . Respondents were also required to indicate their general perceptions on a number of topics, by way of marking against a presented list of adjectives, and by rating comprehensive scales designed for the purpose, such as a nine-point labelled category scale with the range from 'extremely desirable' to 'extremely undesirable'.

It is not my intention to critique the comprehensiveness or structure of either of these two studies, but rather to discuss the relevance of the results produced. Both had specific but different objectives in their research and both produced results which satisfied those objectives to a point.

Patten's aims were to investigate:

a. knowledge and beliefs about mental illness;
b. familiarity and contact with people living with mental illness;
c. perceptions about mental illness and people living with mental illness; and
d. attitudes about care and treatment of people living with mental illness.

What he achieved was to produce percentages of the sample population who responded to some stipulated degree on a presented scale, and the frequency of which specific views were discussed in a group discussion.

Dear and Taylor had the stated objectives;

a. to explain the attitudinal and behavioural responses of non-users to neighbourhood mental health facilities;
b. to determine the nature and extent of the impacts of mental health facilities on residential neighbourhoods; and

c. to establish the planning and policy implications of individual and community responses to facilities.

What they achieved was to present a considerable amount of statistical data which provided a picture of how the sample population responded to some stipulated degree on a presented scale, and their beliefs about a number of topics related to the mentally ill in a form reconstituted to fit a pre-prepared scale.

Looking at methods used in the two studies cited reveals the use of common techniques such as surveys and questionnaires. By their very nature these eliminate opportunities for participants to add provisos and conditions to their answers. Responses must fit into pre-categorised options offered by the researcher. This 'restriction' strategy' described by Potter and Wetherell (1987) prevents participants from giving contrasting views on a topic, leaving no room for doubts or conditions to be expressed. For example, looking at the response categories offered by Patten (1992) the first category presented is 'object to this idea'. A respondent ticking this option provides information on the question topic which is then available to be included or compared with other respondents who either did or did not select this option. What it does not tell us is why that particular respondent selected that option, and under what conditions that option might be changed.

Even in interviews and group discussions where people are able to express their views freely, procedures are used to categorise and quantify the data. This process of content analysis results in what Potter and Wetherell refer to as 'gross categorisation', whereby a researcher generates categories then conducts a frequency count of all examples of talk which fit the definition given to the category. What people say involves a lot more than content, and it is this unrecorded, subjective, context driven talk which contains important information for researchers interested in what people are saying on the topic of interest.

Using interviews as a means for data collection also has other weaknesses. The interview process is influenced by a number of factors, including the natures of both the interviewer and interviewee, and the predetermined structure of the questionnaire. For example, there is no way of being confident that the interviewee understands the questions in the way they were intended, or that the interviewer interprets the responses in the same way they were conceptualised by the interviewee (Harre, 1979). As the aim of social psychological research is to

gain a better understanding of social behaviour and the nature of social events, confounding factors such as these need to be minimised.

Community care is part of a relatively new treatment approach for people with mental disorders, an approach which is creating a form of social change for all people in the community. It should be recognised that the research findings from both studies cited above make an important contribution to a knowledge base in this area. However the social changes associated with the assimilation of increasing numbers of these people into the community can only be successful if reactions from members of the community are properly understood and where necessary addressed. Failure to achieve this will result in the changes being rejected (Wood, 1975).

Research in this area so far has revealed (amongst other things) that public reaction is generally negative, and accompanied by misconceptions about mental illness. This information has been provided in the form of statistical data collected by way of fixed response questionnaires and frequency measures recorded on pre-prepared scales. What this type of research does not achieve is to provide detail on the complexity of views people have, that is their own freely expressed views rather than best fit measures of those views as predetermined by a researcher.

## A RESEARCH SOLUTION

One method which does provide a closer look at what people are saying involves analysis of verbatim dialogue from interviews with research participants. The process enables the researcher to study how each person expresses their own versions of events, and their own opinions on topics which have been formulated in their own way. This approach called discourse analysis (Potter & Wetherell, 1987) is based on the theory that through language people not only formulate their own reality, but also actively cause things to happen. Language is seen as the most basic and pervasive form of social interaction. The proposition being put is that discourse analysis achieves three things; firstly, it provides an opportunity for detailed analysis of what people say about a topic; secondly, it reveals the ways language is used in social interaction; and finally, the information obtained may provide an understanding of the process needed to effect change.

## CURRENT RESEARCH AIMS

The focus of the present study is on what ordinary members of the public say about people with mental disorders living and being cared for in the community. The aims are to identify exactly what people say on the topic, show how they functionally construct the language used, and to recognise the social consequences of this construction.

# CHAPTER THREE

# DISCOURSE ANALYSIS

## BACKGROUND OF DISCOURSE ANALYSIS

Before discussing Potter and Wetherell's (1987) approach to discourse analysis it is relevant to comment on the disciplines which form the foundation of their work. These include speech act theory, ethnomethodology, and semiology. Speech act theory proposes that words are important for what they do (Austin, 1975). Based on the premise that people use words to do things this theory relies heavily on explicit statements, however it does not account for context in which indirect speech can also have an implicit function.

Ethnomethodology as a discipline involves the study of how people develop methods to make sense of their social environment, and behave in ways they believe appropriate to the situation. This sociological approach is based on the work of Garfinkel in the1960s and described in depth by Heritage (1984). By it's very nature ethnomethodology involves looking at language as an integral part of how people understand and react to their social environment. Early research in this field drew criticism due to the use of techniques which relied on researchers describing the collected data and making analytic conclusions based on their own descriptions. More recent research in this area involves observation of social interaction which is recorded and developed into verbatim transcripts. These become the focus of conversation analysis (Potter & Wetherell, 1987).

Semiology or the 'science of signs' grew from the work of de Saussure in the early 1900s. His theory is based on the concept that people have a system of rules which when applied in acceptable sequences and combinations allow them to develop and make sense of their social environment. The key to de Saussure's approach is in the way he distinguishes between what he referred to as the 'signified' (the concept), the 'signifier' (the speech sound), and the linguistic 'sign' being the combination of the two. The 'sign' according to de Saussure is arbitrary with no inherent relationship between the signified and the signifier, but rather is dependent on the meaning applied to the relationship. (Potter & Wetherell, 1987)

Each of these theories contribute a different perspective on language use in the social environment, by introducing the concepts of language function, organisation and meaning. Building on this foundation Potter and Wetherell (1987) developed an approach to discourse analysis which focuses on the constructive and functional use of language, and the potential for social consequences of this linguistic activity.

## DISCOURSE ANALYSIS: THE POTTER AND WETHERELL (1987) APPROACH

Potter and Wetherell focus their approach of discourse analysis on the ways in which language, written and spoken, formal and informal, is an integral part of social being. They propose that language creates our perceptions, and the use of language causes things to happen to ourselves and our social environment. The system of discourse analysis they devised allows for close scrutiny of social texts, acknowledging that each person has his or her own reality of the world which contributes to all social interaction. The major underlying components of the Potter and Wetherell approach to discourse analysis are function, construction and variation. Uncovering these features in discourse provides an insight into how people use language to do things. To understand the significance of these components a brief description of each is warranted.

### Function

A major component of discourse analysis, function relates to how people use language to make things happen. This focus on doing things with language has foundations in both speech act theory and ethnomethodology, however in discourse analysis it is developed further with context being particularly relevant. With contextual information it becomes possible to identify the purpose and intentions of what people are doing with language.

### Variation

Variation becomes evident when what people say is analysed particularly as the function or purpose of their dialogue changes. The concept of consistency in accounts, which is a basic feature of traditional attitude research, is challenged when this variation in accounts is recognised as being significant. Due to the changing nature of social interaction which determines changes in the purpose of

talk variance is recognised as an important component of the functional aspect of language.

**Construction**

Construction relates to how people use language to construct versions of their social world. Construction of accounts occurs naturally as people use pre-existing language resources. This concept suggests that people actively select or omit some resources depending on the intended function of their discourse, which accounts for the variation over time and context. The way people perceive themselves, their behaviour and their place in the word is also constructed linguistically. Drawn from a variety of sources such as tradition, along with influence from cultural and social perspectives, language is selected to construct an image of self which is desired or appropriate for a particular situation. This selection is active and varies depending on the function of the talk. In constructing accounts of events and images of self, people create their own reality or version of their social world. Consequently all social interaction (in which language plays a predominate part) is influenced by how people have constructed their own reality.

The combination of these three major components of discourse analysis allows investigation of what people are saying from a far broader and more comprehensive perspective than practiced in conventional empirical research. As well as providing an insight into how people functionally construct versions and accounts, and how these vary across different situations, such an approach reveals effects which may lead to social consequences.

**Interpretive repertoires**

The component of variation becomes the basis of a key step in the analysis of discourse. Potter and Wetherell use the term 'interpretive repertoires' to describe patterns revealed when discourse is analysed. Patterns are found in recurring instances of variability and consistency in the discourse. These include differences in content or form within and between accounts, as well as consistency of features shared by accounts. The notion of interpretive repertoires allows us to look at the way people use words or terms to accomplish a certain purpose. Attitudes, attributions and beliefs which are held to be relatively consistent over time, and are frequently the focus of empirical research, are terms traditionally understood to describe this phenomena. Alternatively a cognitive approach may describe this effect in terms of social representations or the result

of prototype formation or categorisation. The interpretative repertoire makes no assumptions about cognitive processes or ingrained cognitive systems but is simply a term used to describe patterns found, and from which identification of function and consequences follows.

This description of Potter and Wetherell's approach to discourse analysis is by no means comprehensive or complete, but rather aims to introduce the key components of their theory, (for a more detailed elaboration of the theory and practice of discourse analysis see Edwards and Potter (1992), Potter and Wetherell (1987, 1994), and Wetherell and Potter (1988). For the purpose of the present study, the above outline of the major elements of discourse analysis is considered adequate to provide an insight into the potential benefits of this approach when applied to natural language.

## ADVANTAGES AND DISADVANTAGES OF DISCOURSE ANALYSIS

Using discourse analysis as a research tool has a number of advantages and disadvantages compared with more traditional research methods. In social psychological research the aim is generally to produce or examine broad empirical laws. The process of discourse analysis can not achieve this, however as Wetherell and Potter (1988) point out, it is not designed to do so. They also recognise that further theoretical work is needed to fully develop the concepts on which the approach is based.

More theoretical work is not the only area of discourse analysis which could benefit from further development. Using this approach in research also has a number of difficulties. No clear guidelines exist as to the actual method of discourse analysis, although Potter and Wetherell (1987) do provide an outline of stages by which the process of discourse analysis can be conducted. They account for the lack of clear sequential steps in the process by describing how the nature of discourse analysis involves "a broad theoretical framework, which focuses attention on the constructive and functional dimensions of discourse, coupled with the reader's skill in identifying significant patterns of consistency and variation" (p. 169). This may be so, but is barely sufficient justification for the lack of clear guidelines to effect the analysis.

Discourse analysis makes no claims regarding objectivity, but rather recognises the subjective nature of the approach. However it is not only the subjectivity of research participants which needs to be considered. As with all psychological research the potential exists for researcher biases to influence the conduct of the study. Whereas traditional scientific methods actively impose conditions to eliminate or minimise researcher effects, the process of discourse analysis has no such safeguards. Particularly the actual analysis process is prone to any biases the researcher may have with regard to the topic of interest.

Although discourse analysis does not conform to the objective aims of empirical research it does constitute a systematic approach from which conclusions can be both evaluated and validated. Potter and Wetherell (1987) discuss a number of techniques by which this can occur. Because the process of analysis and the conclusions reached by the researcher are openly discussed, they are open to evaluation by any observer. No claim is made that the researchers interpretation of the discourse being studied is the only interpretation possible. Therefore interested parties are free not only to study the analysis and interpretations provided, but also to reach their own conclusions from the material presented.

For practical purposes discourse analysis has a number of advantages. Discourse analysis involves studying natural language in context. Because there is no attempt to quantify data, there is no need to limit participant responses into predetermined categories, or to code specific examples of talk into generated categories. The problems of restriction and gross categorisation are therefore eliminated. In interviews, while participants talk may be focused into particular topic areas, responses are not constrained in any way. The material available for analysis retains all the variances, doubts, and contradictions within the contexts that they occurred, including the influence of researcher input.

Categorisation is generally described, studied and explained from a cognitive perspective which assumes a prototype basis to the phenomenon. Social categorisation likewise assumes a particular social group has a number of defining characteristics. People categorised as belonging to a group are perceived to possess all the characteristics which define the group as a whole. However, on its own the cognitive approach does not fully explain all the implications of categorisation and resultant stereotyping, for example the influence of motivation on the information processing which occurs (Macrae & Hewstone, 1990). While the concepts of categorisation and stereotyping are

basic to an understanding of prejudice and stigmatisation, Billig (1985) points out that they fall short in accounting for exceptions to the rule. He proposes that particularization (accounting for individual exceptions to the category) must also be considered when studying how people maintain biases and prejudices. It is this approach of Billig's which signifies the value of discourse analysis in understanding the social implications of categorisations. Because discourse analysis is not concerned with the cognitive processes involved in categorisation, and looks instead at the functional application of category terms in everyday language, a clearer picture of social consequences is available.

Language forms the basis of almost all social interaction. Language therefore also forms the basis of interaction which is detrimental to social harmony. By providing an insight into the constructive and functional nature of language, and its social consequences, discourse analysis provides the means by which harmful linguistic practices can be recognised and understood. From this type of information steps can be taken to effect change.

# CHAPTER FOUR

# PROCESS

## INTRODUCTION

There is no single correct method for discourse analysis. The Potter and Wetherell approach is best conducted by way of a system that suits both the nature of the topic being investigated and the source of the discourse being analysed. In the present study the aim is to analyse what members of the public say about people with mental disorders living and being cared for in the community. Therefore the suggested stages for analysis described by Potter and Wetherell (1987, pp.158-176) were considered adequate, and appropriate to achieve the research aims. The system used follows these guidelines reasonably closely.

**Stages:**

The sequence of stages used is as follows:

- Research questions preparation;
- Sample selection;
- Interviews;
- Transcript preparation;
- Analysis.

## PREPARATION OF RESEARCH QUESTIONS

The preparation of research questions first involved making a decision about exactly what topics would be the focus of interest. Keeping in mind that the purpose of interviews was to obtain discourse for analysis it was necessary to ensure the number of relevant topics were a manageable amount. The final topic selection included;

- the policy of caring for people with mental disorders in the community;
- the rights of people with mental disorders;
- responsibility for people with mental disorders;
- care of people with mental disorders;
- knowledge about mental disorders.

**Interview format**

There are three main forms for interviewing in qualitative research. Patton (1987) describes these as 'informal conversational', 'interview guide', and 'standardised open-ended'. The most appropriate for the present study being the 'general interview guide' approach. This involves the formulation of a basic checklist of questions covering all topic areas to be explored during the interview. Even though the prepared list of questions may be formulated in topic areas, the sequencing of questions is of little importance during the interview. The flexible nature of this approach allows for probe questions to be introduced during the interview, as well as allowing a general conversational style of interviewing.

**Interview schedule**

The interview schedule followed a basic sequence with questions grouped into selected topic areas. To ensure the participants responded in their own words questions were open-ended. Probe indicators were included for use where necessary to make the interview challenging, and to follow up on points raised by participants. It was recognised that it could not be assumed participants would have any accurate knowledge in the general area of mental illness and community care. Therefore a brief opening statement was prepared. This statement provided information regarding the policy and effects of the New Zealand Mental Health Act, 1992. The opening statement and interview schedule is attached in Appendix A.

**Pilot Interview**

A pilot interview was conducted in order to assess the suitability of the prepared interview schedule. No major alterations were considered necessary, however five additional probe indicators were added. The pilot interview was conducted in the same manner as interviews with all other participants, details of which follow. Because no significant changes were made to the interview schedule the material collected in the pilot interview was included as part of the research data.

## SAMPLE SELECTION

In discourse analysis the focus is on language used rather than on the people from whom the language originates. Sample size only becomes relevant in terms of the nature of the research. For example a single text may be appropriate to demonstrate a particular commonly used linguistic phenomena, or a large number

of texts may be analysed to identify recurring patterns. Potter and Wetherell (1987) describe how an interesting range of phenomena, with considerable practical importance, can be found in material from only a few interviews. Regardless of the number or size of the source materials, if analysis results are to be of value, it is most important that the origins of the material are clearly stated, and the material being analysed is clear and described in detail.

Even though one interview would have been adequate to obtain material for analysis, this would only have allowed the identification of variation and consistency within the talk of the one person interviewed. Interviews with a number of people allow for them all to be questioned on the same topics, and comparisons made of their responses. It then becomes possible to identify whether there is any commonality in the way they construct their responses, and in the linguistic resources used.

Because the aims of the present study were to investigate what types of patterns would be generated in talk about mental illness and community care, it was considered that ten interviews would provide an ample base of source material from which to achieve this.

**Participants**

Participants were ten members of the public resident in the south-eastern suburbs of Wellington. All were aged between 25 and 60 years, and included were nine females and one male participant. Of the ten, two had Maori heritage, two with British backgrounds, and two Australian backgrounds. (Note: these features are identified for interest only. Participants were not selected on the basis of gender or ethnicity, neither was this information sought from them). Five participants were known to the researcher by infrequent casual acquaintance, the other five were acquaintances of the initial five. All participants were ordinary members of the public resident in the community.

Prospective participants were approached by the researcher and invited to participate in the study. They were each given an information sheet (Appendix B) detailing the purpose of the research, what their participation would involve, and their rights if they agreed to participate. All those approached agreed to participate.

## INTERVIEWS

After confirming their willingness to be interviewed appointments were made for a time and place suitable to both the interviewer and participant. Prior to the commencement of the interview all participants completed a consent form, (Appendix C).

Each interview took approximately one hour, and was recorded on audio-tape. At the completion of the interview participants were thanked for their contribution. They were reminded of their right of access to the audio-tape, and to the interview transcript which they could alter if they wished. None exercised the right to hear their tapes or alter their transcripts. One participant requested a copy of her interview transcript for personal reasons. This was provided.

## TRANSCRIPT PREPARATION

In keeping with the requirements of confidentiality all audio-tapes were allocated a pseudonym which then became the only reference used on the transcript of each interview.

When conducting discourse analysis on interview material the questions and other interviewer input form some of the functional context for the interviewee responses (Potter & Wetherell, 1987). It is therefore important to have a clear picture of **all** the dialogue which took place during the interview. Accordingly a full transcript was prepared from each audio-tape. Omissions in the transcripts occurred only on portions of the interview where a participant requested the talk be deleted. This occurred in two cases, and only minor portions of their transcripts were effected.

### Transcription information and symbols

The type of analysis being conducted determines the type and number of symbols included in the transcript. For the purpose of discourse analysis it is unnecessary to use the full range of transcript symbols, as long as an accurate and clear record is presented of everything said by both the interviewer and the interviewee. The symbols used in the present study are a limited selection from the transcription notation system developed by Jefferson, and described fully in Atkinson and Heritage (1984, pp.ix-xvi).

The symbols used in the present study represent features of talk such as silences, voice intonation, and laughter, but omit complex detail of these features. All symbols used are described on a list attached at Appendix D, and have been taken from a modified list of Jefferson's work described by Button and Lee (1987).

## CODING AND ANALYSIS

In this section only a brief discussion of the process of coding and analysis is given. Detail of the processes are discussed fully in Chapters Five, Six and Seven as part of the analysis discussion.

### Coding

The purpose of coding is to separate material from all transcripts into groups or categories relating to the topic areas of interest. As part of the coding operation all instances of talk relevant to specific topic areas were included, as well as sections of talk which appeared to be only vaguely related. The coding process (discussed more fully in Chapter Five) is a preliminary step taken prior to commencing the analysis, however during the course of the analysis the coding groups were added to, revised and refined.

### Analysis

The process of analysis initially involved careful reading of material, looking at what was actually said. Patterns of variability and consistency in the material were identified. The material was also examined in order to make out the function and consequences of the talk. From the patterns of talk a number of interpretive repertoires were revealed, and hypotheses developed regarding their functions and effects. These are discussed fully in Chapters Six and Seven.

## ETHICAL CONSIDERATIONS

A number of ethical considerations were addressed:

a. Informed consent - participants were informed about the nature and purpose of the study, their rights as participants, and their consent obtained.
b. Confidentiality - the identity of participants and their interview material was kept confidential. This was effected by allocating each participant a

pseudonym for use on audio-tapes and interview transcripts. A single key list linking names and pseudonyms, stored securely by the researcher, is to be destroyed when no longer required.

c. Sharing of information - Participants were advised about their right of access to interview material they provided.
d. Potential harm to participants - it was not anticipated that the study could cause harm to participants.
e. Use of information from the study - information from the study is intended for use in the researcher's MA Thesis, and may be offered for publication in scholarly journals. Participants were advised of this.

All aspects of the planned research conformed to the ethical guidelines of Massey University and the New Zealand Psychological Society. A detailed research proposal was submitted to the Human Ethics Committee at Massey University who granted approved for the research to proceed.

# CHAPTER FIVE

# ANALYSIS PRELIMINARIES

This section covers the process of coding and discussion of context. These do not constitute part of the analysis, however each is important in its contribution to the analysis.

## Coding

Coding of material from transcripts is done in order to divide the talk on particular topics into groups relative to the areas of interest generated by the interview schedule. This step, which is completed prior to analysis, allows for the analysis to concentrate on one topic at a time. Coding was therefore conducted under the broad headings of **policy**, **rights**, **responsibility**, **care**, and **knowledge**.

All passages of talk relating (even slightly) to each of these topics were included, a process which in many cases involved the same passages of talk being included under more than one heading. For example the phrase **'turning them out'** was included in four separate groups. The inclusive nature of coding is illustrated in Appendix E which shows actual words and phrases used by only one participant. Although the coding sample illustrated in Appendix E includes only single words or short phrases, the coding process involved the inclusion of the entire passage of talk in which each instance occurred. This process was conducted on the transcripts of all participants.

During the process of coding it became apparent that a substantial amount of overlap occurred between the topics of responsibility for, and care of people with disorders. For the sake of simplicity the two were incorporated into a single category of 'care'. It was also found that a large amount of dialogue occurred on the topic of location of residences for people with disorders. It was decided that this warranted inclusion as a separate area of interest, and coding was conducted accordingly.

At the completion of coding the topics of interest for analysis were;

- the policy of caring for people with mental disorders in the community;
- the rights of people with mental disorders;
- care of people with mental disorders;
- the location of residences for people with mental disorders
- knowledge about mental disorders.

## Context

One important component relevant in discourse analysis is context. Function, variation and construction are all affected by context. The functional, performative and intentional nature of language can only be clearly identified by discourse analysis when contextual information is taken into account. Context also is a significant element in the way talk is constructed and the variation which occurs.

Context exists in a number of forms. Passages of talk, when read in isolation from surrounding talk, are out of the context in which they occur. It is therefore often necessary to consider extended sequences of talk in order to better understand the context. Interaction between more than one speaker also contributes to context. For example an interviewer's questions or comments form part of the contextual basis for the talk which follows from an interviewee. Recognition of these factors which influence context is made in the examples used in the analysis discussion. These include interviewer input and / or comment on the context in which the statement was made, and where appropriate, extended sequences of talk.

Other factors also influence the way in which people functionally construct and vary their talk. One of these, considered particularly relevant to the current study, is the previous personal experience of participants. People often relate personal experiences in their talk on a variety of topics, and the way they are constructed depends on a number of factors. These include, how the experience was originally linguistically constructed by the individual to create their version of the experience, the purpose of relating the event, and the context in which the relating occurs. Less overt than actually talking about a personal experience is the influence of experience on talk on topics related to the experience. It is this

undisclosed influence of personal experience which is also considered relevant for inclusion as a factor contributing to context.

**Personal Experience Influence**

Interview transcripts revealed that a wide variety of personal experiences were related by participants, (experience in this context refers to the personal understanding people gain from reading, watching, listening and doing). Distinct differences were evident in the backgrounds of participants regarding their experience in the general area of mental disorders and community care. The following summaries show the wide range of source experiences revealed within the interviews. An overview of each participant's experience becomes particularly valuable when considered along with the transcript extracts used in the analysis discussion. For example they reveal how, in some cases, participants were selective in using their experience depending on the view they wanted to express. (Note: all names used are pseudonyms).

## SUE

Throughout her interview much of Sue's talk suggested she was calling on her experience with intellectually handicapped children mainstreamed in the school where she works. This occurred even though the interviewer drew her attention to distinguishing between intellectual handicaps and mental disorders. However she did use other source experiences when necessary to make a point. For example she referred to a person she knows who was in professional employment prior to suffering a burst aneurism in the brain, and who now works as a shop assistant. She also stated her belief that the general public would probably only know of mental disorders in terms of post-natal depression and nervous break-downs, however she made no other reference to these conditions in her interview.

## KIM

During her interview Kim related one personal experience involving a community residence being set up next to a kindergarten. Her reference to this experience was made in conjunction with statements she was making about sex offenders, or potentially dangerous disorders. On occasions during the interview she referred to things she had read, but gave no indication of any other source experiences.

## VAL

On four separate occasions during the interview Val talked about situations where extreme violence or dangerous behaviour occurred. The way she worded her statements suggest knowledge obtained through the media. The major part of Val's interview reflected her view that people with mental disorders are dangerous and unpredictable. However when necessary to make a particular point she made statements indicating personal experience contrary to this. She talked of a friend who is schizophrenic and who is excitable or calm depending on his medication. She also talked about people she knows from a local community residence, stating her belief that they are treated normally and cause no problems.

## TOM

Despite acknowledging the difference between intellectual handicaps and mental disorders most of Tom's interview reflected his experience with his intellectually handicapped teenage son, and his involvement with work in this area. Exceptions occurred when he cited specific personal experiences which were more likely to emphasise the point he was making. For example when he was adding conditionals to his view about a residence being set up in his street he cited his partners ex-husband who he referred to as dangerous and a lunatic. Tom also revealed that he was prone to claustrophobia.

## EVE

Throughout the interview Eve's discussion reflected her understanding of people with intellectual handicaps rather than those with mental disorders. When asked directly what she knew about schizophrenia she revealed personal experience with a lady who suffered from schizophrenia. Even though she had this personal involvement (which included visits to each others houses) her interview responses did not indicate she called on this experience except when asked directly.

## BEV

Bev referred to a variety of source experiences which she used selectively depending on her purpose to support opinions or add strength to arguments. These included newspaper articles, movies and books she had read. She also talked about a mental institution located in her village when she was a child and her interaction with patients, and her knowledge of her sister's work in a staffed residence for older people. Her experience has a teacher was twice referred to,

once regarding a pupil who developed schizophrenia causing his family difficulties, and once when talking about a class of young boys with very low intelligence who she used to teach. On one occasion Bev also referred a personal experience with private therapy.

## GAY

Gay frequently talked about her abusive ex-husband. This appeared to be her single most influential experience, referred to directly and indirectly throughout her interview. She also made reference to other source experiences when it suited the purpose of her argument. These included reading, television and her work with disadvantaged children.

## JOY

Media documentaries and news items were cited many times by Joy throughout her interview. From most of the comments made it appears that these formed the basis of her source experience. However she did refer to other personal experiences when she needed to make a particular point. These included a neighbour who she considered had a mental problem, people with intellectual impairment who work in a local shop, and a friend who suffers from chronic depression.

## LIZ

Liz made six specific references to television documentaries, newspaper and magazine articles. It appeared that most of her opinions were based on this source experience. Only on two instances did she reveal other personal experience. Once she referred to community residences that she had heard about, and once she talked about a friend who had a bipolar disorder.

## PAM

Pam disclosed a number of source experiences including the media; a friend's son who is on a sickness benefit but who, she believes, has nothing wrong with him; her involvement with the IHC; and two relatives who are mental health nurses. The experience she talked of most often, and which appeared to influence most of her opinions, was her personal experience with depression. She also used childhood experience of a mental institution and contact with patients as a basis for her views on a number of topics.

Demonstrating the different source experiences from which participants formulate their accounts and arguments serves three purposes. Firstly, it emphasises the fact that people have wide variety of different social experiences from which they build their own version of the world. Secondly, and more importantly for discourse analysis, it shows how people actively construct a linguistic version of these source experiences, for a particular purpose. Thirdly, it highlights the significance of the interpretative repertoires and use of linguistic devices which were a common feature in the talk from all participants, irrespective of their background knowledge and experience. Personal experience sources receive little mention in the analysis discussion (Chapters Six and Seven), however the influence of these becomes quite evident in many of the examples of talk provided.

# CHAPTER SIX

# ANALYSIS REPORT
# INTERPRETIVE REPERTOIRES

**Analysis procedure**

Performing the analysis involved studying the material in each topic area for the purpose of identifying patterns. This was achieved by looking at each extract of talk to find contradictions and / or consistency within and between statements from the same speaker. Each passage of talk was also studied to determine possible function and the effects arising from the way it was constructed. This process resulted in six interpretive repertoires being identified.

## REPERTOIRES

The repertoires identified were given titles which best described their nature. They were commonly used by all participants in their discourse across all topic areas. A description of the structure of each repertoire follows.

**rights repertoire:**

The rights repertoire contains words and phrases which indicate lawful or fair entitlement to consideration, opportunities, and treatment, and applies to people who do not have mental disorders as well as those who. When the rights repertoire was applied to those with mental disorders it was often indicated by phrases such as **"they have the right to ..."** , and almost always preceded or followed by conditions. When applied to people who do not have disorders, expressions were more direct and unconditional eg. **"that's my right"**. The use of the rights repertoire was not always as explicit as the above examples suggest. Statements such as **"if they are doing ....then they should have the opportunity to ..."** and **"I should be able to do ..... without being afraid of ....."** also come into this category.

**dual community repertoire:**

The dual community repertoire is shaped by patterns of discourse which distinguish a functioning healthy human community as being separate from mental illness. Although the physical community environment may be portrayed

as including people with disorders, phrases which indicate an us/them design form the basis of this repertoire.

**patronising repertoire:**
This repertoire relates to patronising talk. Terms and phrases which are condescending or domineering form the basis of this repertoire. Talk which describes people being **"put"** somewhere, or **"allowed"** to do something are examples. Also included in this repertoire are statements indicating the dependence of those with disorders on others. This repertoire enables the promotion of caring and support presented in a benevolent way. If this is criticised, the challenger can be seen as uncaring and unsupportive of people less fortunate.

**affiliation repertoire:**
The repertoire of affiliation expresses views of the equality of people on the simple basis of their belonging to the human race eg. **"we're all equal"**, or **"they're no different from us".** This repertoire differs from the 'rights repertoire' in that it always actively promotes equal treatment. However it is only used on occasions when it is to the advantage of the speaker.

**disorder repertoire:**
This repertoire occurs in a number of forms. It may involve direct reference to a specific disorder, or to the behaviour believed to be associated with a disorder. It may also be revealed in the form of talk about the seriousness or relative mildness of a disorder. In all cases a view is being expressed on a particular topic, and the disorder reference is made in support, eg. **"because they're incapable of ... they need ..."**. Using examples selectively, and appropriate to the particular point being made, gives credence to the view being expressed.

**solicitous control:**
The solicitous control repertoire enables people to express a view which incorporates a control element under the guise of a care statement. It allows statements to seem to be in the interests of a person with a mental disorder 'for their own good'. As in the patronising repertoire if this view is criticised the challenger may seem to be trying to deprive people with disorders from the best possible care they could have.

Although the basic structure of interpretive repertoires has been provided at the beginning of this discussion, it is relevant to note that these were identified during the process of analysis. A more detailed deliberation on the way repertoires were constructed, used, and their functional effects is conducted in the discussion which follows.

## USE OF INTERPRETIVE REPERTOIRES WITHIN TOPIC AREAS

This discussion is divided into the five major areas of interest which evolved from the coding process, i.e. policy, rights, care, residence location, and knowledge about mental disorders. This division serves three purposes. It reveals the functional nature of the repertoires relevant to specific topics, and how the same repertoires were used across a range of topics. It also exposes the similarities and variances in talk from each participant which occurred both within and between the different topic areas.

**Note:** All extracts are verbatim from interview transcripts. Each extract is numbered sequentially in order of presentation. Where interviewer input is included this is printed in italics and prefixed with either 'Interviewer' or 'Context' as appropriate.

### The policy to care for people with mental disorders in the community

The statement provided at the beginning of each interview gave a brief account of the current policy whereby the majority of people with mental disorders are being cared for in the community rather than in hospital. While it was apparent that some talk about the policy was based on information provided in this opening statement, it would be wrong to assume this statement formed the basis of all the comments made. For example, during the course of each interview the interviewer answered queries, and intervened if participants made incorrect assumptions about the policy. It is also relevant to note that in the weeks prior to the interviews being conducted there was considerable media publicity about the Pugmire case which focused attention on potentially dangerous psychiatric patients being released from hospital into the community.

Repertoires used in talk about the policy were also common to the other topic areas of interest. In the following examples it can be seen how the different repertoires were used on the subject of policy. These extracts from four interviews are indicative of those used by all participants on this topic.

> **Tom:** To care for them in the community as opposed to keeping them in a hospital ? (.) it depends on what sort of mental disorder they have, some people fit the community environment, and other people will never fit the community environment. [extract 1]

The key to this statement is the *disorder repertoire* **'it depends on what sort of mental disorder they have'**, which acts to suggest that the type of mental disorder is a determining factor when considering care in the community. However Tom goes on to use *dual community repertoire* **'some people fit...'** inferring that the **'community environment'** is about people who **'fit'** rather than the type of disorder they have. It is interesting that Tom refers to **'care'** in the community but **'keeping'** in the hospital. This distinction varies with the view he expresses in extract (2).

> **Tom:** ... we weren't brought up with seeing those people shut away, um we they were part of the community, sure they looked different and they acted differently and so on, um but a lot of this I think comes down to pretty much common sense, if somebody can survive in the community then they they are placed in the community, um forget about where the funding comes from, and some of the people have to be locked up for ever. [extract 2]

Here Tom talks of **'if somebody can survive ...'** being the determining factor regarding their placement in the community, whereas in extract (1) he talks of whether or not they **'fit the community environment'** . He uses a *patronising repertoire* when he talks about people with mental disorders being **'placed'** in the community, or where they **'have to be locked up ... '**. In this context this repertoire suggests the actions being taken with regard to people with disorders are in their own best interests, in that their survival may be at stake. A *dual community repertoire* is also evident here. People who do not have mental disorders are admitted to hospital if they become ill, but they remain part of the community while they receive hospital care, however people with mental disorders appear to be separated from the community if they become ill until a decision is made to place them in the community or lock them up for ever. Tom's statement that this is **'pretty much common sense'** implies that his view is sensible and would be seen as such by people who have common sense, while a contrary view could be seen as not sensible.

> **Joy:** I feel that they haven't thought it through, and they're not giving the resources to provide for that, they think that they are going to save a lot of money by putting people back into the community but they're not allocating the funds required to make sure that these people are still getting (.) um adequate protection and care, I mean I've just seen somewhere that they're just living in squalid conditions (.) and nobody's supervising the fact that they're still taking their medication. [extract 3]

On the face of it Joy appears to be supportive of people with mental disorders and is concerned that they are being treated unfairly by an unspecified **'they'** presumably the government or other authorities. However closer examination suggests that this is more a criticism of the policy rather than support for people with disorders. Joy talks of **'putting people back into the community'** which is *patronising,* inferring that action is being taken with regard to them by somebody else. This also has the function of suggesting that wherever they were prior to being put back into the community was not really part of the community, revealing a *dual community repertoire.*

In extract (3) Joy also criticises the policy by stating **'but they're not allocating the funds required to make sure that these people are still getting (.) um adequate protection and care, ...'** which suggests first, that they did get adequate protection and care before they were put back into the community, and second, that the funds are needed not only to provide adequate protection and care, but also to **'make sure that ..... '** such care is provided. When clarifying her meaning Joy uses a *disorder repertoire* **'they're just living in squalid conditions'**, inferring that the nature of mental disorders is such that a person who has a disorder can be expected to end up living in such conditions. This then supports her use of a *solicitous control repertoire* **'nobody's supervising the fact that they're still taking their medication'** which implies an issue of control rather than care. The inference from this statement is that living in squalid conditions is a probable consequence of not receiving appropriate supervision and medication.

> **Sue:** Could be difficult ((pause)) for some people may need extra care and that extra care may not be available (.) in the places that they need (.) needed. [extract 4]

Sue is talking about the policy to care for people with mental disorders in the community when she says **'could be difficult'**. To support her view she uses a *disorder repertoire* by referring to the people that **'may need extra care'**. However by elaborating on this statement in extract (5) she outlines the conditions under which the policy would be **'fine'**.

**Sue:** If ((pause)) people just need (.) daily supervision ((pause)) making sure they're okay in the morning (.) they get out, they get dressed, they go to work, and at night making sure they're okay they've got their meals (.) fine, they're no danger to anybody, to themselves or anybody else ((pause)) as long as its special care that needs perhaps one on one or one on two. [extract 5]

In stating the conditions under which the policy would be **'fine'** Sue uses a *solicitous control repertoire* **'just need (.) daily supervision'**, which has the effect of inferring insurance against a problem. This problem Sue indicates by using the *disorder repertoire* **'a danger to anybody'**. The inference being made in this statement is that if they do not get this **'daily supervision'** then they may become a **'danger'**. Sue's use of *solicitous control* is also justified by an *affiliation repertoire* **'themselves or anybody else'**. This has the effect of justifying her statement on the grounds that it is not only other people's safety that is of concern but also their own. Finally she adds the proviso that if it is **'special care'** that is needed, then that needs **'one on one or one on two'**. She does not explain what is meant by **'special care'**, however the inference which can be drawn from her previous comments is that she is referring to people who pose a potential threat to themselves or others.

**Context:** *about the policy to care for people with mental disorders in the community.*
**Kim:** Well I think you can look at if from two angles. You can look at it from their point of view and from the community's point of view. Now from the patients (.) you know (.) in quotes (.) point of view, obviously that's going to be a very positive step because obviously they need to be reintroduced back into society. [extract 6]

Kim introduces a *dual community repertoire* with her statement **'from their point of view and from the community's point of view'** by inferring that the two points of view will be quite different. Then by talking of **'the patients ... point of view'** being a **'very positive step'** she leads one to conclude that the **'community's point of view'** is not positive. She uses a *disorder repertoire* **'obviously they need to be reintroduced'** which has the effect of suggesting that their disorder obviously makes them strangers to society, and as such makes her use of the *dual community repertoire* **'back into society'** justified.

## Rights of people with mental disorders

Promoting human rights for all is not only 'politically correct' behaviour in modern western society, it is also in keeping with the New Zealand Human Rights Bill of February 1994. This Bill makes it illegal to discriminate against people on the grounds of disability, and this includes mental disability. However it was evident from material gathered in the interviews that many people were unaware of the law, or it's implications. The following example reveals a lack of knowledge which was mirrored by all participants in their talk about the rights of people with mental disorders.

> **Bev:** ..... do we discriminate against people with mental disorders or don't we, I can never keep up with what human rights we've got now in our bill of rights, I know you're not supposed to discriminate against gays any more ((laugh)) but I, is discrimination against people with a mental disorder now against the law or is it not ? [extract 7]

Within this question Bev seeks to clarify her understanding of the law. Her wording of the question **'do we discriminate against people with mental disorders or don't we, '** infers that the legal position regarding discrimination is a key factor in whether discrimination is acceptable or not.

Discrimination and restriction of human rights are different things. For example a number of factors influence the possession of specific rights, such as the right to vote or drink in a public bar which are restricted by age factors. Ideally, except for legislated restrictions, all people should have equal rights. The fact that this does not occur naturally is evident by the need for the Human Rights Bill which prohibits discrimination on grounds such as gender, race, age and disability.

When talking about rights people tend to relate the topic to what it means to them and what they believe they are entitled to. It could be assumed that the rights they ascribe to themselves are the same as they believe others should also have. If this was so then laws to prohibit discrimination would be unnecessary, leading to the conclusion that people apparently do not ascribe to others the same rights as pertain to themselves.

In discussions with participants about the rights of people with mental disorders it was evident they had either a lack of knowledge or understanding of the law, or that their views were contrary to the provision of the law. It was also apparent

that there was considerable variation within individual participant's talk on the topic of rights. The following three extracts show this effect:

> **Tom:** .... these people should live where they want to live. [extract 8]

This is a clear statement that people with mental disorders have the right to choose, and to live where they want to. Extract (9) appears to confirm this view, however it contains a subtle difference.

> **Tom:** I mean you don't live somewhere where you don't really want to live and if you do well then that's your that's you putting up with it, if you wanted to move, really wanted to move, then you would move on. So they should be given the same sort of situation. [extract 9]

In extract (8) there is a straight forward comment about the right to choice while extract (9) is more complex. Tom uses an example of a person who does not have a disorder and likens their situation to that of a person with a disorder. This *affiliation repertoire* has the effect of suggesting that a person with a disorder has the same options as anyone else. However he makes the point of the statement with a *patronising repertoire* **'they should be given'**. This has the effect of inferring it is not a matter of choice on the part of the person with the disorder, but rather something they are dependent on the benevolence of others for.

Another variation was revealed in Tom's transcript on the subject of rights.

> **Tom:** They have to earn the right, I mean they have to come out into society and show that they are, can cope to whatever level and then depending on the level they then have the right to say well I'd really like to go and live over there, and we have to be able to er accommodate them. [extract 10]

This time Tom indicates that choice of place or type of living is not a right for people with mental disorders. They must **'earn the right'**, and their level of rights is dependent on their level of coping, presumably judged by somebody else. He also states **'they have to come out into society'**, a *dual community repertoire* which infers that the person has been somewhere which is not actually part of society or the community.

The next three extracts from Bev's transcript reveal similar patterns of variation on the topic of rights;

**Context:** *about what sort of rights someone with a mental disorder should have.*
**Bev:** I suppose I'm not aware of, of how out of control of themselves they are when they're having an attack or whatever, um I don't know, I suppose a lot depends on ((pause)) on that, I suspect I would say they should have every right ((pause)) but um (.) again you see I don't, I don't know ((pause)) if (.) if it's hypothetical I mean cause I don't know, but if someone with a mental disorder were disposed not not to take medication and due to their refusal to take medication became a danger to themselves or to anybody else (.) then I think that, that has to override ((pause)) other basic human rights (.) I think (.) surely, but I don't know if that occurs, I don't know if there are people who who quite deliberately refuse, refuse medication and therefore can become a danger. ( ) not to refuse medication no I don't believe the refusal of medication, that's not a problem for me, but if the refusal of medication means that their behaviour then does become dangerous, I mean there may be some who can refuse medication and can cope or find some means of coping or who's illness does not lead them, to harm themselves or anybody else. [extract 11]

The overall content of extract (11) is a *rights repertoire*, revealed by Bev's statement **'I suspect I would say they should have every right'** which promotes the concept of rights for people with disorders. Adding comment about the potential for **'danger to themselves or to anybody else'** allows her to claim the rights of others to safety, and so justifies her inclusion of **'that has to override ((pause)) other basic human rights'**. While promoting the rights of someone with a disorder Bev imposes qualifications on those rights, a process in which she uses the *disorder repertoires* **'how out of control of themselves they are when ....'** and **'their behaviour then does become dangerous,'**. These repertoires focus attention on the potential for dangerous behaviour which could be a feature of mental disorders, and allow her to make their rights conditional, i.e. **'a lot depends on that'** .

In extract (11) Bev also uses a *dual community repertoire* where she talks of the potential for dangerous behaviour as a result of failure to take medication. Other members of the community have the potential for dangerous behaviour where their taking of medication is not an issue, for example alcoholics, gang members, or even feuding neighbours, but their rights are not curtailed or made conditional until they are convicted of dangerous behaviour. The *dual community repertoire* functions to distinguish people with disorders as different from other people in the community. Distinguishing particular groups of people as different not only stimulates prejudice, but also has the effect of justifying treating such people differently from others.

Although distinguishing people with mental disorders as different serves a particular function in some cases, for example making their rights conditional on their behaviour, the *dual community repertoire* is only used by people when it is to the speakers advantage. A different repertoire was commonly used in situations where advantage would more likely be gained by calling on similarities rather than differences. This *affiliation repertoire* which promotes the idea of equal treatment can be seen in extract (12).

> **Context:** *about what should be provided for people with mental disorders in terms of medical, financial, accommodation.*
> **Bev:** I suppose what I'm trying to say is, if if someone is in control of their own medication and can find a job, if they can find a job then I think they should find a job (.) and I don't think there should, if they can do it on, for themselves I don't think there's any necessity for anyone else to do it for them. I think simply because they may happen to have a mental disorder does not preclude them from doing a job, holding down a job. [extract 12]

The *affiliation repertoire* being used in extract (12) **' if they can find a job then I think they should find a job (.) and I don't think there should, if they can do it on, for themselves I don't think there's any necessity for anyone else to do it for them'** makes it clear that they should be treated the same as other members of the community. The inference being made is that they do not have the right to special consideration over anyone else.

Bev also states **'I think simply because they may happen to have a mental disorder does not preclude them from doing a job, holding down a job'**. In this *disorder repertoire* she talks of a mental disorder as if it were a minor inconvenience **'simply because'**, which is quite different from the *disorder repertoire she* used in extract (11) which focused on the potential for dangerous behaviour. By using the term **'simply because'** she minimises the significance of a disorder, which enables her to express the view that they should help themselves.

It is important to look at the different contexts which stimulated the difference in the terms used by Bev. First, in extract (11), the discussion was in relation to the rights of people with mental disorders, and second, extract (12) related to what should be provided for them. These two extracts show how the *dual community* and *affiliation* repertoires both function to serve the interests of the speaker, and how a *disorder repertoire* is used to form a basis for justification in both cases.

A final example of Bev's comments regarding the rights of people with mental disorders demonstrates the variance in her views;

> **Bev:** ... what do they want to do, I say they I mean they are all individual but I don't know what they would like, I mean do they want to have their own flat with a few other people and just be allowed to lead their lives, or do they want somebody to supervise them and help them with their their money and their food and their living arrangements, I don't know what they want, and I guess it differs from person to person.
> **Interviewer:** *So what the individual wants should be taken into consideration.*
> **Bev:** Yes ! Oh heavens above, isn't it ? don't they ? hopefully they do, no I can't believe we're still back in the middle ages when we just say this is what we think is right for you that's what you're getting, hopefully not.
> [extract 13]

Here Bev expresses marked indignation with the idea that the wishes of others are imposed upon people with mental disorders. This is at variance with extract (11) in which she specifies conditions under which the rights of people with mental disorders should be overridden. It also varies with extract (12) where she insists that **'they should find a job'** if they can, while in extract (13) she promotes the idea of lifestyle choice.

The above extracts are typical of the variation in opinions expressed by all participants depending on the function of their talk at the time. Even on occasions where rights were not specifically being discussed, analysis of the talk revealed repertoires which had the function of making the rights of people with mental disorders conditional, or secondary to the rights of other members of the community. The next four extracts from different participants illustrate this commonality;

> **Context:** *about the right to vote, move about freely in the community, have choices, applied to a hypothetical example of a schizophrenic.*
> **Joy:** Well I don't think, I don't think he should have many of those rights then.
> **Interviewer:** *Why ?*
> **Joy:** Because (.) it's the rational thought (.) side of it, being responsible for your thoughts and actions. [extract 14]

Joy states that the schizophrenic (example) should not have many of the rights mentioned. Her use of a *disorder repertoire* **'rational thought'** and **'being responsible for your thoughts and actions'** infers that the schizophrenic example would not have these attributes, and by which she sets a criteria for entitlement to the rights mentioned. Overall the statement reveals a *dual community repertoire* in that members of the community who do not have mental

disorders do not have their rights diminished or challenged whether or not they have demonstrated dubious rationality or irresponsibility in their thoughts and actions. A similar *dual community repertoire* is used by Sue in extract (15).

> **Interviewer:** *What rights do you believe someone with a mental disorder should have in terms of freedom to participate in the same things as other people do?)*
> **Sue:** Oh absolutely ((pause)) if they can (.) cope or interact (.) within the norms (.) that they don't um overreact um ((pause)) yeah they can they can just interact with people on a reasonable level, with the people they are interacting with having a little bit more tolerance than normal to help or guide or as long as those people can can can do that. [extract 15]

Sue includes a number of conditions to her statement that people with mental disorders should **'absolutely'** have the same rights as others. The conditions **'if they can ...'** include **'cope or interact (.) within the norms'** infer that the norms are set by people in the community who do not have mental disorders. The *dual community repertoire* used in this statement occurs in her application of conditions which people with mental disorders must satisfy before they can have the same rights as others, conditions which are not applied to others.

> **Context:** *about whether or not a person with a mental disorder should be allowed to leave hospital contrary to the advice of health professionals.*
> **Gay:** You get into then, ah the problem of um, oh what do they call it, um there is another law um (.) you know the human rights side, um what one's that?
> **Interviewer:** *Human rights.*
> **Gay:** What ever they call it here, but I can only think of it as the human rights law, there you're taking away the rights of that individual. You <u>may</u> be taking away the rights of that individual and that person sees it, but then again they may not be able to see their their <u>rights</u> properly for themselves, and then certainly there're <u>NO</u> rights for the people in the family. You've just taken away the rights of the family (.) if that person comes back in and continues to be a harm to themselves and to the family.
> **Interviewer:** *If they're going back into the family situation.*
> **Gay:** That's right, if they go back into the family situation and you are allowing them out because of their own rights you are then not considering the rights of the family.
> **Interviewer:** *What rights do you think someone with a mental disorder should have ?*
> **Gay:** It depends on the mental disorder, and it depends on the degree of the mental disorder (.) um if you are talking about chronic, and they are, I see it as they are either a threat to themselves and their family or they are not a threat to themselves and their family. If they are <u>not</u> a threat to themselves or their family I think that they have a fairly high degree of personal rights, of human rights. If they are not able to care for themselves properly, I believe then that their rights are diminished (.) and there should be a degree, a phasing of of rights. [extract 16]

In extract (16) Gay avoids answering the question until prompted. She uses a *rights repertoire* to identify a problem of conflicting rights between the **'rights of that individual'** and the **'rights of the family'**, and justifies her inference that family rights should be paramount by employing *disorder repertoires* - **'harm to themselves and to the family'** and **'they may not be able to see their rights properly'**. Her use of *disorder repertoires* allow her to make the rights of a person with a mental disorder conditional **'it depends on'**. Gay also uses a *dual community repertoire* by applying the conditions of **'not being a threat to themselves and their family'** and being **'able to care for themselves properly'**. Other members of the community often do not meet these conditions without having their rights challenged or diminished.

> **Context:** *about the right to refuse to see a doctor.*
> **Val:** Mmmm cause there's that civil yes there's that mmm civil rights thing ((pause)) oh boy ((pause)) that's a difficult one (.) I would, I (.) try to put myself in that position, if it's something I don't want to take I really wouldn't want to take it (.) but (.) oh boy.
> **Interviewer:** *We get a clash of rights here.*
> **Val:** We certainly do.
> **Interviewer:** *So whose rights do you think (.)*
> **Val:** I would like to say the patient but no, the patient is in a state which a lot of them do not understand or can not cope so therefore no. Yeah I have to put it that if the if (.) they are not quite with us, they're in another sort of planet ((laughing)) I'd say, no they would not be able to reason, to think, you can not reason with them, no, I'm afraid not, I think, yes you would have to come down to the the officer in charge, the the medical officer who ever, doctor yeah. But the doctor must be able be, if they're in a state you can not communicate terribly well with a patient like that, so I think after three or four days back on the medication THEN I think it's down and let's have a talk. None of this 'here take this you've got take it' and no explanation nothing, so you'd have to wait for them for that medication to rework itself again into, stabilise them, and I think it still maintains that that doctor patient relationship and it's got to be an honest one. Talk to them not down to them, and give them reasons, because at that stage they do want reasons, they must do. [extract 17]

Even though the initial question was about the right to refuse to see a doctor Val continues on a theme of medication raised in an earlier question **'if it's something I don't want to take I really wouldn't want to take it'.** She uses an *affiliation repertoire* here by comparing her own situation with that of people with mental disorders, and resists answering by indicating her quandary **'but (.) oh boy'**. When prompted Val uses the *disorder repertoires* **'in a state ...'** and **'they're in another sort of planet'**. These function to justify her decision that the rights of people with mental disorders are subject to someone else's approval, in this case **'the officer in charge'.**

Overall extract (17) is an example of a *patronising repertoire* demonstrating action taken with regard to people with disorders for their own good, providing a lengthy explanation of how this should occur **'But the doctor must ....'** , and **'None of this ....'** . It should also be noted that this is a contradiction of an earlier response to a question about the rights a person with a disorder should have, where Val stated;

> **Val:** I should, basically the same rights, I can't see any difference (.) ah unless they're chronic cases. [extract 18]

## Care of people with mental disorders

The concept of care being discussed in this section involves care of people with mental disorders who are living in the community, often referred to as 'community care'. The term 'community care' is widely used particularly by health professionals, policy makers and the media when discussing or promoting alternatives to hospital care (Potter & Collie, 1989). Without consideration of the practical implications of community care, but by simply focusing on the rhetorical nature of the term itself, Potter and Collie showed how it generated more positive responses than other terms, when used with regard to moving people with mental disorders out of confinement. They suggest the term is a powerful rhetoric for advocates of community care by providing "effective and appropriate support for a policy which amounts to a dramatic enhancement of the quality of life of people with mental handicap" (p 62). At the same time it becomes difficult for opposition to such a policy because each time the term is used the positive implications of the term undermine their criticisms.

It may be that the term is used deliberately because of its rhetorical strength, or may be it is simply a convenient descriptive term to describe an alternative to restricted hospitalisation, but whatever the reasons behind the use of the term it continues to be used by professionals, policy makers and the media. It might be fair to assume that the general public would also use the term 'community care' when discussing care for people with mental disorders in the community. However this was not found to be the case in the present study. Only two participants used the term, and then only one time after it had been used by the interviewer. Perhaps the power of the rhetoric remains within the area of public debate on the topic.

Quality of life may be the most important component of community care for people with mental disorders, however from the perspective of other members of the community their own quality of life often remains of paramount concern to them. It is not easy to reconcile the potentially conflicting view points. On one hand most people consider it right for people with mental disorders to be cared for in the community, and on the other hand they are apprehensive about the impact that the situation could have on their lives (Dear & Taylor, 1982; Patten, 1992).

The conflicting perspectives formed the basis of some interesting discourse on the topic of caring for people with mental disorders in the community. Participants commonly expressed favourable views regarding care in the community, however they also used a range of repertoires which functioned to protect their own interests. Patterns of talk showed that they regularly used the same interpretative repertoires as they did when discussing rights, and frequently used the repertoire of *solicitous control.*

Examples of patterns of talk common to all participants are demonstrated in the following extracts from Bev's transcript. These show her use of repertoires and illustrate the way her talk varied as the context and the function of her talk changed. The first three extracts (62,63 and 64) show the variance in Bev's views about institutions;

> **Context:** *about the policy to care for people with mental disorders in the community.*
> **Bev:** I'm not sure (.) um I suspect that I don't think it's a good idea unless um there is such a lot of back up (.) for the people let out, I I suspect, from what I glean from papers, news and so on that what has happened that people have been let out and they've been put in circumstances in the community where they're not capable of looking after themselves, as as you or I might quite comfortably do, and they need a large amount of help to do this, if they're not given that help I think (.) I think I think they're better off in an institution, if that help is not available. [extract 19]

Bev starts out with three distinct expressions of doubt **'I'm not sure'**, **'I suspect that'** , and **'I don't think...'**, a tentative framework which enables her to express an opinion on matters about which she has little knowledge, (this type of linguistic device is discussed more fully in Chapter Seven). She concludes her statement with what may be an unacceptable view using a *patronising repertoire* **'they're better off in an institution'**. Use of this repertoire enables her to present a view which appears to be in the best interests of people with disorders, however by preceding it with uncertainty **' I think (.) I think I think they're....**

Bev indicates that she is open to revise her view. Other *patronising repertoires* **'the people let out'** , **'the people have been let out'**, and **'they've been put in'**, are all phrases indicating action taken with regard to people with mental disorders by some other person. **'Let out'** indicates that they had to wait until an authority allowed them to leave, and **'put in'** indicates that they had no choice but to be placed in a position of someone else's choosing. The indication is that people with mental disorders had no choice in respect of the actions taken.

Bev also uses a *dual community repertoire* **'they've been put in circumstances in the community where they're not capable of looking after themselves, as as you or I might ...'** which functions to justify her stated need for them to have **'a large amount of help'**. By using the words **'you or I'** Bev infers that a person's ability to look after themselves could fairly be measured against that of the interviewer or herself. Clearly the lifestyle and capabilities of other members of the community could compare unfavourably against herself and the interviewer. However her use of this repertoire enables her to suggest that people with mental disorders may be **'better off in an institution'** if they do not get the **'large amount of help'** she believes they need. Other members of the community are not subject to institutionalisation if they do not measure up favourably to her standards of capability in looking after themselves.

Her view of an institution being suitable for people with mental disorders under some circumstances is confirmed in extract (20).

> **Bev:** Okay, well if I can come back then to the, to what I mean about the institutions, I don't have (.) a fierce hatred of institutions as I think some people do, because I think they can have value, if if they are treated in the right way ((pause)) I think what I'm trying to say is that somebody with a mental disorder (.) who is allowed, who is out in the community with no support and help (.) I don't I don't think that is right I think they should be back in an institution I think it is safer for them..... [extract 20]

Here Bev again uses a *patronising repertoire* **'somebody with a mental disorder (.) who is allowed'**, inferring that permission had to be sought and obtained, however she does correct her use of the word '**allowed**' indicating that either she feels the connotations of '**allowed**' are unacceptable or that she made an error in using the term. To justify her view that **'they should be back in an institution'** Bev suggests that the safety of people with mental disorders is the major consideration. This indicates a *dual community repertoire* similar to that used in extract (19), in that other members of the community who may need, but

do not get, support and help are not considered for placement in an institution for their own safety.

In both extracts (19) and (20) Bev justifies her suggestions that people with mental disorders may be better off in an institution. First, in extract (19) her justification is based on if the person with the disorder is unable to get the **'large amount of help'** she considers is necessary, and second, in extract (20) her justification is based on the safety of the person with the disorder. Overall she justifies her suggestions of institutions on the basis that they **'can have value , if if they are treated in the right way'**. These comments were made in the context of talk about what Bev thought of the policy for community care.

When the context changed so also did Bev's view about institutional care. Extract (21) was in the context of the best system of care for people with disorders who were not able to function satisfactorily most of the time, and here she contradicts her earlier view.

> **Interviewer:** *Okay, so with people who are not able to function satisfactorily most of the time, the best system ?*
> **Bev:** Is some form of residential care where there'd be a little sort of flatette in a complex or something like that, I don't much care for the idea of the old style of hospital, I think they were grim. [extract 21]

Bev refers to the **'old style of hospital'** as **'grim'** and that she does not **'much care for the idea'** which varies with views expressed when talking about policy in extracts (19) and (20). Here in the context of care, issues of safety and support raised earlier appear to have been either ignored, or satisfactorily addressed by the nature of a residential care environment. Her criticism of the **'old style of hospital'** has the function of inferring that with regard to care she considers the environment to be important.

In the next two extracts Bev is discussing provision of medical treatment for people with mental disorders. In this new context Bev's views vary again from those expressed in earlier extracts..

> **Bev:** .... leave aside the disability, and I think all medication should be paid for (.) I don't see them in any different light from the way I see people who are in very strained circumstances (.) I think if you are going to do one for the mentally disabled then you've got to do it for the very poor and very disadvantaged. [extract 22]

**Bev:** I don't make them special any more than an asthmatic child or any any, I would put them on exactly the same basis as that. I think if they have got an ongoing chronic disability which requires therapy, medication or whatever, that should be paid for by the state, yeah out of taxation. [extract 23]

In both these extracts Bev uses *affiliation repertoires* **'I don't see them in any different light from....'** and **'I don't make them special any more than .... I would put them on exactly the same basis'.** The use of this repertoire functions to promote equality of treatment for everybody whether they have a mental disorder or not. While this may seem to be an open and generous view it also has the effect of inferring that people with mental disorders should not receive any special consideration or treatment which is not available to other members of the community. Bèv does not only infer this, she actually states it **'if you are going to do one for the mentally disabled then you've got to do it for the very poor and very disadvantaged'**.

It is interesting that from her opening statement in extract (22) Bev moves from a position of **'all medication should be paid for'** to the inference that she intends this to apply to people who are **'very poor and very disadvantaged'**. This affiliating of people with mental disorders to those who are **'very poor.....'** has the effect of aligning them with the **'very'** low socioeconomic groups of society.

Overall the function of both extracts (22) and (23) is to affiliate people with disorders with other people, achieved by drawing similarities with particular groups of society. In both cases the way Bev talks about people with disorders is quite different from the way she talks of them in earlier extracts, where she emphasises their differences - by talking of their need for **'a large amount of help'** (extract 19) and **'support and help'** for their own safety (extract 20).

The final two extracts (24 and 25) from Bev's transcript show again how variance occurs as context changes. These two extracts illustrate how the apparent simplicity of a statement (extract 24) becomes quite complex when considered in the context of the extended sequence in which it occurred (extract 25).

**Context:** *about who should be responsible for caring for people with mental disorders.*
**Bev:** If they're within the community I guess we have to pay for people to supervise them, be there to help them, look after them. [extract 24]

Firstly Bev contradicts the views expressed in extracts (22) and (23). She reluctantly agrees (**'I guess we have to...'**) that people with mental disorders may need to be treated differently from other people. In so doing her overall statement becomes a *dual community repertoire* by emphasising what **'we have to'** provide for these people **'if they're within the community'**. This functions to separate people with mental disorders from other members of the community who do not need these things provided for them.

Although Bev uses the terms '**supervise**', **'help'**, and **'look after'** as three separate components, they function together in terms of what she believes **'we have to pay for'**, and on the face of it this appears to be a benevolent approach. However her inclusion of **'supervise'** reveals a *solicitous control repertoire* which has the effect of including an element of control over people with mental disorders. Overall the three components in this statement indicate a *disorder repertoire* by inferring that people with disorders are unable to supervise, help or look after themselves, which in turn functions to justify her view that **'we'** as a community **'have to pay.....'** .

Extract (24) makes a completely different impact however when looked at in the context of the whole statement from which it was taken;

> **Interviewer:** *In your opinion who should be responsible for caring for people with mental disorders.)*
> **Bev:** Ah, oh this is a really really hard one (.) isn't it ? ((pause)) this is where it gets really difficult (.) because I don't believe it should be an ongoing continual burden for the family because they can't always cope. I have heaps of sympathy, I think for families who find themselves in this situation, and don't quite know where to turn. I guess it's depressing enough for the person who's got the disability, but even worse I would think for parents um trying to cope with it and other er normal children alongside (.) okay so whose responsibility is it? ((pause)) I suppose if families can't then the community must ((pause)) but quite what is the best way to to care for people like that I don't know, as you said in the past it's always been done in an institution which is nice and easy, put them away, somebody looked after them all the day and all the night and all was well and you could forget them. If they're within the community I guess we have to pay for people to supervise them, be there to help them, look after them.
> **Interviewer:** *So when you say the community must, by the community you mean?*
> **Bev:** I guess I'm duck shoving here (.) because I don't mean me (.) by the community do I (.) if I'm being honest (.) I mean somebody (else) the system paying for (would) fund. [extract 25]

Within extract (25) Bev uses the *disorder repertoire* **'continual burden'**, to justify her view that she doesn't believe the families should have to cope. She also employs a *patronising repertoire* - **'parents um trying to cope with it and other er normal children alongside(.)'** - by projecting the impression that the

person with the disorder is childlike, and thus has similar needs to children. These two repertoires enable Bev to justify her statement **'I suppose if families can't then the community must'**. A *dual community repertoire* is revealed here as Bev infers that for the community this care becomes an obligation rather than a responsibility, and also if the person with the disorder was being cared for by their family then the community did not have any obligation to become involved. At the end of the extract Bev clarifies what she meant by the **'community must'**. In order for her to make the admission that she did not mean herself **'I don't mean me'** Bev seems to find it necessary not to impose the responsibility for caring for people with mental disorders on to other members of the community. This leads her to add **'I guess we have to pay for people to....'**, effectively inferring that the community's obligation is involved with funding for care rather than being involved with care.

Bev refers to care for people with mental disorders as having previously been **'done in an institution'** which she sees as **'nice and easy'** because they became somebody else's responsibility **'all was well and you could forget them'**. She uses the word '**you**' when she talks of forgetting them which serves a function of suggesting other people rather than herself. Whereas if she had used the word **we**, she would have been including herself in the potentially offensive **'could forget them'**.

Talk from all participants on the subject of care for people with mental disorders showed similar patterns to those identified in extracts from Bev's transcript. Variation occurred as the context of the discussion changed and as the function of the talk changed. All participants used the same repertoires in their talk about care, illustrated in the following extracts from four different participants.

> **Context:** *about the best system of care for people with mental disorders. (Note: Pam has previously stated that she thinks care by the family is best - the following comment is Pam's view if the family can not provide the care)*
> **Pam:** Home environment where there may be ten people that's working on the same support system, where they're working, each person will be given their own sort of responsibilities, an area of responsibility. I think it's all about you've got you know if you expect some thing of somebody then you'll get something back in return (.) and if people are of a like mind, in a like situation ((pause)) then you can't say 'well I can't do that because I'm sick' because everybody else is sick too ((pause)) that's probably the ideal way, but then there must be able to be (.) some degree, you've got to have some sort of self support systems, so I mean even if they, say they dig the vegetables in the garden or something like that. We used to have a patient from Coney Hatch that used to come up and do our garden (.) but he lived at Coney Hatch because he was so, institutionalised that he couldn't um get out of it ((pause)) you know he was he couldn't get out in the world ((pause)) but

> he had the job of coming out and doing the garden. So I think you've got to do that, somebody, everybody has to have their own pride and their own degree of independence, perhaps that's the way of doing it. [extract 26]

Pam uses a *patronising repertoire* **'each person will be given their own sort of responsibilities'** which infers that they are unable to take the responsibilities on for themselves, so this is done for them by someone in the **'support system'**, and is justified by returns on expectations. She explains the benefits of having a group of **'maybe ten people'** together as being that no one person can claim their illness as a reason for not doing something because **'everyone else is sick too'**. This *disorder repertoire* promotes the idea that people with mental disorders tend to use their disorder as a reason for not doing things or taking responsibility. To justify her suggestion that they should have **'some sort of self support systems'** she uses an *affiliation repertoire* **'everyone has to have their own pride ....'** which likens them to everyone else who take pride in their work by supporting themselves, and infers they should be self supporting as much as possible.

> **Context:** *about who should be responsible for meeting the financial costs of providing care for people with mental disorders.*
> **Gay:** Again, if if you're saying that the person hasn't got the means themself um then I would go back to say the government (.) now the government is the community (.) so the community is really the ones that are responsible for it, and I see that if you work hard at the community to get people back into normality, in other words that person is out working, they've got themselves through their illness and they are out now living a normal life, then the process of the return dollars because they're out in the work force has got to be um considered, you can't look at just the now and say well they can't afford anything they're not going to be, you know they're always going to be a burden on the community, they're not, you've got to work them through the process as you know, um so I think it's that the community has to look after it's own when they can't look after themselves. [extract 27]

Gay open with the phrase **'if the person hasn't got the means'** indicating that she believes people with mental disorders should be means tested, and pay for their own treatment and care if they can afford to, (this was established earlier.) She then introduces *dual community repertoires* by saying **'the government is the community (.) so the community is really the ones...'** and then later **'they've got themselves through their illness and they are out now living a normal life'**. This repertoire functions to distinguish between the community and those with disorders, who, when they are **'living a normal life'** become part of the community by **'the process of the return dollars'** (tax from their income). Gay also uses an *affiliation repertoire* **'the community has to look after it's own when they can't look after themselves**, suggesting a single community which contrasts with her earlier use of the dual community repertoire. The

affiliation repertoire functions to identify the advantage to the community where - if people with disorders are looked after when they are ill then **'they're not...always going to be a burden on they community'**. Overall the *disorder repertoire* of this extract infers that people with mental disorders will eventually become well and cease being a **'burden on the community'**. The use of this repertoire functions to justify her suggestion of funding to assist with their care.

> **Context:** *about the policy to care for people with mental disorders in the community.*
> **Sue:** I think they need more than that (.) that's probably looking on it from the community centred view that they (.) they probably don't like to see these people out (.) without supervision or, depends what they're like you know it depends what sort of what's their problem. [extract 28]

In extract (28) Sue talks of what she thinks is needed for people with mental disorders beyond what the current law provides. She starts with her own opinion **'I think'** then obscures her place as part of the community by describing her view as **'probably'** being a **'community centred view'**. By talking of **'they'** Sue is able to state a view which if attributed to herself alone may make her seem intolerant towards people with mental disorders -**'they probably don't like to see these people out (.) without supervision'**. Her use of the word **'supervision'** indicates a *solicitous control repertoire*, which has the effect of placing supervision or control above care with regards to people with disorders in the community. Overall the extract uses a *dual community repertoire*. Where she talks of how the community **'probably don't like'**, Sue again separates herself from the community view, but this also functions to separate people with mental disorders from the community. Her talk about these people being **'out'**, either means **out** in the community or **out** of some place that the community was happy for them to be, perhaps a hospital or an institution. Using a *disorder repertoire* **'depends...what's their problem'** makes her earlier statement seem considered and reasonable. Finally the term **'you know'** functions to reinforce her consideration **'depends'**, and infers that her point is not only reasonable but is understood by the interviewer.

> **Context:** *about people with mental disorders in a community residence who have the freedom to come and go in the community.*
> **Val:** All right ((pause)) I think they still, yes I, yeah you don't lock them up, but they've got to be worked back into the community, there's no problem there. It's the lack of back up when there is a problem, or when there's, before a problem. They've still got to be (.) checked. Because it's it's a medication thing, once they go on that off that medication there's a problem. There's problems, they're standing out screaming, the neighbourhood starts getting upset. [extract 29]

Although Val concedes **'you don't lock them up'** she uses a *dual community repertoire* by talking of them having to **'be worked back into the community**. This distinguishes them from the rest of the community by inferring two things; first, that they have somehow been out of, or not considered part of the community, and second, that something about people with disorders requires that they need to be **'worked back'** before they can become fully fledged members of the community again. Val then presents her doubts such as **'lack of back up when ... or ... before a problem'** which justifies her using *solicitous control* **'they've still got to be checked'**. In order to account for introducing a control element she employs a *disorder repertoire* based on medication and unacceptable behaviour **'once they go ...off that medication ... they're standing out screaming'**.

## Location of residences for people with mental disorders

One of the most commonly reported findings of surveys and research into public attitudes towards people with mental disorders living in the community has been that people generally do not welcome the idea of residences being set up in their neighbourhood, and that resistance increases the closer the residence is to home, school or kindergarten, (Dear and Taylor, 1982; Patten, 1992; Rabkin, 1974; Hall, 1985; Segal, 1978; Cree and Curson, 1985).

It could be expected that as community residences for people with mental disorders become more common, an understanding would develop that resistance to such houses was unwarranted. However this does not occur, and Hall (1985) reports that tolerance is diminishing with the increased numbers of people with disorders living in the community. Undoubtably media revelations of incidents involving people with mental disorders who cause harm to children or other members of the public have stimulated some community resistance. Even so, it is unlikely that people are influenced by negative media reports to such an extent that they are incapable of forming a realistic picture for themselves.

There is clearly some dynamic at work which constructs the commonly found resistance to community residences for people with mental disorders. Discourse analysts propose that people construct their own reality by the way they talk. By

taking this approach it is possible to unravel how people talk about community residences for people with mental disorders, and how their resistance is maintained and strengthened. Extracts from participant interviews reveal how this occurs, and as with other topic areas of interest the same interpretative repertoires are evident.

Three extracts have been used from Val's transcript to show how consistency and variation occurred both within and between statements.

> **Interviewer:** *How do you feel about one of these community residences being set up next door to you.)*
> **Val:** I wouldn't mind, I wouldn't mind.
> **Interviewer:** *Why?)*
> They've they've got to be somewhere and there's always that nobody wants something next door (.) but it's got to be set, it's got, they <u>have</u> to be set up, as long as they're staffed (.) maintained (.) yeah, if there's a problem I think that's who, the organisation who's in charge of that that area, they must um communicate with the neighbourhood (.) they can not dismiss if there's anything or if someone has complained about something it must be dealt with. None of this 'oh well we've got the rights'. You know some of them there's this attitude that we've got the right to be here. I think they've got to approach, those people who are setting up those sort of things <u>must</u> approach the neighbourhood itself. [extract 30]

Taken on its own Val's initial response **'I wouldn't mind'** seems to be a straightforward and open response, and is contrary to what previous research has found about resistance. However when prompted Val provides more information. She uses an *affiliation repertoire* **'they've got to be somewhere and there's always that nobody wants something next door (.) '** which has a dual effect. It recognises that people with disorders, like everyone else, have to live somewhere, and it also recognises that many people resist having a residence next to them. Then having made herself seem more open and generous than others, she perhaps feels justified in imposing a number of conditions to her view **'but it's got to be ...'** and **'as long as'**. Her conditions include staffing, property maintenance, and problem resolving with the neighbourhood. Her use of the word **'staffed'** could be read as provision of care however in this case it is a *solicitous control repertoire* involving control more than care. This becomes more evident when read in conjunction with extracts (31) and (32) which emphasise potential problems with community residences. **'maintained'** is an example of a *dual community repertoire*, where a condition applies to a residence for people with disorders but not to other members of the community, a number of whom fail to maintain their properties in keeping with their neighbourhood standard. Her inclusion of **'problem'** resolution reveals a *disorder repertoire*

which contains the inference that problems will arise simply because the residents have mental disorders.

In extract (30) Val also contradicts an earlier statement that people with mental disorders should have **'basically the same rights'** as other people, (see extract 18, p.48). Here in the context of the right to live where they wish Val uses a *rights repertoire* by declaring **'None of this 'oh well we've got the rights'**, inferring that **'neighbourhood'** rights are more important than the rights of those with mental disorders. A *dual community repertoire* is also revealed by her statement that the neighbourhood **'must'** be approached by the **'people who are setting up those sort of things'**. Such approaches are not required by other members of the community who move into the neighbourhood.

As the interview progressed on this topic (see extracts (31) and (32) Val confirms her view that the neighbourhood must be consulted prior to the planning for a residence, and uses the potential for violence to support her case.

> **Context:** *about when Val thinks the organisers should approach the neighbours)*
> **Val:** Bef I think before they set up because that's when it sets in. People get sort of [raised both hands level with her head] before it even arrives ((pause)) they don't know much about it.
> **Interviewer:** *Do you think they have the right to know.*
> **Val:** Yeah I think they do (.) definitely.
> **Interviewer:** *Why do you think they have a right to know.*
> **Val:** Why (.) um (.) well going on for instance, one or two things that have happened up in Auckland with the community um sort of housing um there's been problems where ah um violence has broken out. [extract 31]

Val uses two types of justification to support her inference that the neighbours 'right to know' supersedes the rights of those with disorders to privacy or to live where they choose. First she mentions peace of mind **'People get sort of ...'**, then a *disorder repertoire* **'problems where ah um violence has broken out'**.

> **Context:** *about what she would want to know from the organisers of a community residence)*
> **Val:** What would I want to know ((pause)) about the number of people in the property itself, um is the property going to be maintained to the of the street, cause people do, if it's maintained, property places should not fall around the ears as far as price goes, valuation. If it's maintained, BUT supervision comes into it. It does (.) there's got to be back ups, people are going to be frightened if they know there's a bunch of people there and the fact is they don't know which one is going to (.) you know, go berserk. It's not always the case, but this is what goes in peoples minds (.) and they don't want police cars going in there every five minutes or something or other.
> ***Interviewer:*** *So you'd want to know*
> I would like somebody who was going to <u>live</u> there (.) more like a family

> home there's the person of the household and these are the people living, boarding or whatever you may like to call it. So they would be have to be somebody really special because they would have to um help the community too, in the factor of accepting them, it's their, they've got to be diplomatic, there's a special person has to be involved in that sort of thing. They've got to maintain their relationship with the neighbourhood on a friendly, but you know any problems um be there um that's another thing. [extract 32]

The same repertoires are evident in extract (32) as occurred in her previous statements. She talks about the property being **'maintained'** *(dual community)*, **'supervision'** *(solicitous control)*, somebody going **'berserk'** *(disorder theme)*, and **'more like a family home'** *(affiliation)*. The functions of these repertoires have all been discussed in the comments about extracts (30) and (31), revealing consistency in both the construction and function of Val's talk about community residences.

An interesting feature of Val's talk is the way in which she changes from the first person **'I'** to the second person **'they', 'people', 'the neighbourhood'**, all of which enable her to ascribe views which may not be socially acceptable to other people. This type of language use was common throughout all interviews, and is discussed in greater depth in Chapter Seven.

Although content analysis is not one of the objectives of discourse analysis the responses obtained from most participants revealed similar views on the topic of location for community residences for people with mental disorders. By analysis of the discourse however it also became evident that all used the same repertoires when discussing the topic. The following extracts show different participants' use of the same repertoires as identified in Val's transcript.

> **Context:** *Tom was asked what action he thought he would take if a residence for people with mental disorders was planned to be established next door to him.*
> **Tom:** I would simply want to know what controls would be put er in place to to er to dictate who moves in there and lives there, and if the people were to be er not violent or whatever I would take no further action, if they were, they'd have trouble. [extract 33]

A *patronising repertoire* is clearly evident in extract (33) where Tom talks about **'controls'** which would **'dictate who moves in'**. This inference that people with mental disorders to not have the right to choose whether to live there or not varies with what he said earlier (see extract 8, p.42), and is more consistent with what he said in extract (10, p.42). By his statement **'I would simply want to know'** Tom infers such knowledge to be his right, and so reveals a *dual*

*community repertoire*, in that this right is not assumed when an unknown prospective neighbour plans to move next door. To justify his inference that people with mental disorders are not welcome to live next door to him unless they have passed his criteria for suitability, Tom uses a *disorder repertoire* **'not violent or whatever'**, which has the effect of making his seeking knowledge about prospective residents seem reasonable.

> **Interviewer:** *What sort of things would make it something that you didn't want, after you'd written and tried to find out about it, and had meetings.)*
> **Joy:** Umm (.) the level of maintenance on the building, that it wasn't just going to go run down because nobody was caring for it (.) umm the prob situation of people that would be in it (.) and um basically the situation of people that were in it and what um what level of supervision, even if it was somebody calling around once a month to see that it was running okay.
> **Interviewer:** *If it was to be a staffed place, fully staffed?*
> **Joy:** Umm I guess that would be more acceptable but (.) that comes under the level of supervision mmm. [extract 34]

Joy talks of things about a community residence that she would not want. She talks of **'maintenance'** *(dual community)*, **'the prob situation of people that would be in it'** *(disorder repertoire)*, **'what level of supervision'** *(solicitous control)*. Joy also infers she has the right to know about these things and object if she does not approve, which together indicate a *dual community*. Knowledge of this nature is neither sought or expected with regard to other prospective neighbours.

> **Context:** *Gay has previously spoken about the best location for a residence for people with mental disorders being in a rural environment. The interviewer then asked her to consider if such a location was suitable for residents who might want to look for jobs.*
> **Gay:** If you're back to the ( ) of getting to jobs then you'd be in the city, but you're way past the part of, it depends on your levels, see when you first are I think in a in a (.) a really deep problem area still and you're diagnosed that you need a lot of help, I think the quieter, but then you've got to bring them introduce them back into more of society, you don't want to move them a dozen times, so your rural area can be, not really rural, it can be on um on a acre somewhere near the near the city, you know so that hey can commute fairly easily, and I mean let's face it, in New Zealand you can commute anywhere in half an hour, it's lovely, I think that's wonderful. So they can commute just down the road. [extract 35]

By using *disorder repertoires* **'depends on your levels'** and **'you're diagnosed that you need a lot of help'** Gay justifies her view that a rural environment is best for a residence for people with mental disorders. *Patronising repertoires* **'you've got to bring them'**, and **'you don't want to move them a dozen times'** describe action taken on individuals with disorders, for their own good.

**'introduce them back into more of society** reveals *dual community* where they have to be introduced to society rather than be considered part of it, and this only occurs after they are past being in a **'really deep problem area'** - *(disorder repertoire).* Finally Gay uses an *affiliation repertoire* **'you can commute anywhere in half an hour,'** which promotes the idea that commuting to work is fairly easy for everybody. This then functions to justify her suggestion that the best location for a residence is **'on a acre somewhere near the city'**, which in turn supports her view that a semi-rural environment is best for a residence.

The final two extracts in this section show how Pam avoided making a direct statement of resistance to a residence being located in her street.

> **Context:** *Explaining her statement that she would feel 'ambivalent' about a residence being set up in her street.*
> **Pam:** Well because why shall you know why shouldn't it be here n rather than anybody else. I well quite frankly I don't think there's enough room in this street, anyone, you'd need something with a bit more greenery around you, um but that's not the argument um (.) I mean anybody that was living in this street full time all day and all night would probably would go psycho completely ((laugh)) (.) given enough room I don't think it should be a major problem. [extract 36]

Pam gives an indirect answer in the form of a question **'why shouldn't it be here ...'** inferring that there is no reason why such a residence should not be in her street. She then proceeds to provide reasons why her street is not suitable, **'you'd need ... more greenery'** and includes the *affiliation* repertoire **'anybody that was living in this street full time ... would go psycho...'.** Twice she indicates that the suitability of a place for a residence is dependent on **'enough room'** which she does not consider to be the case in her street. *(Note: Pam lives in a standard suburban street with medium density housing).*

After Pam had expressed reservations about the suitability of her street for a residence, the interviewer asked her about other options, such as a day centre.

> **Pam:** Well I wouldn't be so keen on that because this is a residential neighbourhood that's people coming and going all the time, that should be near a medical centre or by a bus route or something like that, that would be bloody stupid putting it out here, or putting it in a street like this, that's ludicrous. [extract 37]

Pam's opening words **'I wouldn't be so keen on that'** infer that she was **'keen'** on the idea of a residential house in her street, contrary to her earlier inference in extract (36). She then uses a *dual community repertoire* where she provides a

number of reasons to justify her reservations. (*Note: a large community medical centre, library, shops, community facilities and major bus route are all located at the end of Pam's street, within a quarter of a mile).* Pam's words **'that would be bloody stupid'** and **'that's ludicrous'** function to suggest that sensible people, presumably those who decide where residences are to be established, make sound decisions and accordingly would consider, as she does, that her street would be unsuitable.

## Knowledge about mental disorders.

People accumulate knowledge about mental disorders from a variety of sources. These sources include personal experience and personal exposure, academic learning or reading, fictional literature, media information, and talk with others such as family, friends, or other people. With such a variety of input sources it is reasonable to expect that knowledge about mental disorders will often be expressed in views which are conflicting, inaccurate or stereotypical.

Through a discourse analysis approach it becomes possible to achieve more than simply gain an understanding of knowledge people have about mental disorders. Analysis of their talk reveals the versions they created for themselves, and how these are selectively used depending on the function of their talk.

The following examples reveal diverse views about mental disorders and behaviour believed to be associated with disorders. This diversity of opinion occurs naturally between participants, often reflecting their personal experiences (detailed in Chapter Five). It also occurs within talk from individual participants, the variability generally being driven by context and the function of the talk.

Three examples from Gay's transcript demonstrate the different ways she talks about mental disorders. In extract (38) she refers to acting out (which might occur with schizophrenia) as being behaviour which could be expected as 'normal' from other people. In extract (39) when faced with an example of people with disorders participating in normal community activities she has difficulty reconciling this with them living in a residence with twenty four hour staff. Finally in extract (40) she is adamant that people with disorders should be treated differently from her because she does not have a disorder.

The variability in the way Gay discussed mental disorders can be attributed to both the different topic context and to the function of her talk. However the repertoires used, consistent in all three extracts, reveal a pattern in how she constructs her talk, and the effects of her talk about people with disorders.

> **Context:** *about how she might expect a schizophrenic to behave.*
> **Gay:** Well I mean if their medication, with is is stabilising them I'd expect to see no, probably more um them acting out of the normal circumstance than somebody with inverted commas normal. We all get grumpy, we all do sorts of things, we all get into a rage at times, we all do something stupid, that person should be allowed to be normal too and do those sorts of things, a person doesn't have to be perfect all the time to be considered to be normal, because if they are they're not. [extract 38]

In this extract Gay uses the *disorder repertoire* **'if their medication.....is stabilising them'** suggesting her belief that without medication a schizophrenic could be expected to be unstable, evidenced by **'acting out'**. In the event of them being stabilised by medication Gay employs the *affiliation repertoire* **'we all do'**, which leads into a combination of *patronising and dual community repertoires* **'that person should be allowed to be normal too'.** Here she infers that because normal people do not need permission to act out they should therefore allow some acting out from someone with schizophrenia..

> **Context:** *about residents in a [named] community residence who have cars, easy access to bus transport, and who move freely around the community, belong to the library, do their own shopping, and go to the local community centre.*
> **Gay:** Well they're able to do that, well then they should be able to do that, and they should be in a place where they can, but they're obviously not in a place where they need um ((pause))
> **Interviewer:** *They have twenty four hour staff there.*
> **Gay:** Hmm, mmm I mean that's a personal thing, I don't know. [extract 39]

In extract (39) Gay has difficulty accounting for people with mental disorders who are free to come and go as they please in the community. She uses a *disorder repertoire* **'but they're obviously not in a place where they need'** to make the assumption that they are not in need of supervision or staff. When advised that their residence has twenty four hour staffing she uses a disclaimer **'that's a personal thing, I don't know**.

> **Context:** *about the people next door not knowing who was moving in to Gay's house when she moved in.*
> **Gay:** Yeah but that's different. I'm not considered to be needed to be looked after twenty four hours a day or whatever, all right, so I am a person considered to be without an illness, a mental illness. I'm sane, considered to be sane. [extract 40]

Here Gay talks about the difference between her right to prior knowledge about a person with a mental disorder moving in next door, and the situation when she moved into her house and her neighbours right to prior knowledge about her. She justifies her statement of difference by using a *disorder repertoire* **'needed to be looked after twenty four hours a day or whatever'** implying that people with mental disorders, unlike her, need constant care. She also employs a *dual community repertoire* **'I'm not considered to be ...'** which has the effect of distinguishing people with disorders as different from others like herself who are considered to be sane. Using these repertoires justifies claiming the right to prior knowledge about prospective (mentally disordered) neighbours.

Variability both within and between contexts is also evident in the following four extracts from Joy's interview. Extracts (41) and (42) are on the topic of things being provided for those with disorders, while extracts (43) and (44) relate to their behaviour.

> **Context:** *(about what should be provided for people with mental disorders)*
> **Joy:** Well depending on their capabilities they should be encouraged to get a job (.) for the sort of fulfilment reasons. [extract 41]

By using a *disorder repertoire* in the conditional term **'depending on their capabilities'**, Joy implies that some mental disorders do not effect a person to such an extent that they would be unable to work. This justifies her view that **'they should be encouraged to get a job'**, a view quite different from that expressed in extract (42).

> **Context:** *about who should be responsible for financing the care for people with mental disorders.*
> **Joy:** Well it can't be the people concerned because they can't earn any money, so the government has to either abandon them or foot the bill for giving them adequate care, not over the top and not inadequate otherwise they might as well not offer anything. [extract 42]

The *disorder repertoire* **'they can't earn any money'** in this extract infers that having a mental disorder means that a person is unable to work, contrary to the conditional statement in extract (41). The repertoire in this case functions to justify her conclusion that the **'government has to either abandon them or foot the bill'**. A *dual community repertoire* is evident by the reasoning that people with mental disorders have to be either abandoned or supported by the government, a situation which does not apply to other people in the community.

This statement infers that no one other than the government would provide the care needed, and functions to emphasise the dependence of those with disorders.

> **Context:** *what Joy thinks children need defending from.*
> **Joy:** People that go 'baah' at you and stuff like that.
> **Interviewer:** *Do you think that that's likely to happen.*
> **Joy:** No idea ((laughing)) this is why that's why this is so hard because it's generalising and that's why we, we HOPE that we've got enough faith in the health professionals that they are (.) um are vetting people that they are putting back into the community. [extract 43]

After using an emotive (humourous) *disorder repertoire* **'people that go 'baah' at you....'** to account for an earlier statement about defending her children, Joy concedes that she has **'no idea'** if that is likely to happen. However this repertoire functions to support her use of the *patronising repertoire* **'vetting people that they are putting'**, which infers the right of **'health professionals'** to act on and make decisions about people with disorders.

> **Context:** *about how she thinks people with mental disorders generally behave.*
> **Joy:** I just find that their um behaviour to be unpredictable (.) because it's not something that I'm used to dealing with, it's sort of erratic ((pause)) I'd, all you know (.) yeah unpredictable from my point of view I don't know how they're going to react in different situations because (.) to my mind they don't follow the norm normal behaviour of society. [extract 44]

Even though in extract (43) Joy stated she has **'no idea'** about the likelihood of unpredictable behaviour, in extract (44) she express more certainty in her view. She employs the *disorder themes* **'unpredictable'** and **'sort of erratic'** to support her applying a *dual community* **'they don't follow the norm normal behaviour of society**. This has the effect of suggesting that people without disorders have predictable behaviour across different situations, and this predictability is **'normal'**. The inference being made is that those with disorders do not behave as predictably as others.

Quite a lot of variability occurred in the way people talk about behaviour believed to be common among people with mental disorders. This variability is shown in the following three extracts from Bev's transcript. Again, the change of context and the function of the talk are key factors in this variability. First, in extract (45) Bev is responding to a question asking if she thought a community residence in her street would affect property values.

> **Bev:** ...., the fact that they can look and behave oddly and strangely doesn't personally worry me at all. I would obviously be concerned from the violence thing but but as I said before I would need to know I'd need to satisfy myself

> somehow that that the danger was minimal of any of the residents actually becoming violent (.) but yes I'm sure it would actually depress the property market, because people don't like this kind of thing, people want a nice little street with a nice little house, nice little neighbours, and nobody steps out of line and they all you know behave well and and I think that's a chronic shame. These people have to live somewhere, and why not next door to me. [extract 45]

Bev states a **'fact'** to describe people with mental disorders. This *disorder repertoire* **'they can look and behave oddly and strangely'**, along with her comments on violence and danger, serve to justify her view **' but yes I'm sure it would actually depress the property market....'**. By using disclaimers **'doesn't personally worry me at all'** and **'I think that's a chronic shame'** Bev effectively separates herself from things that other **'people want'**.

Bev also uses a *dual community repertoire* in extract (45) by inferring that people with disorders are not compatible with **'a nice little street with a nice little house, nice little neighbours, and nobody steps out of line and they all you know behave well'**. This functions to suggest that people with disorders do not fit this criteria of what **'people want'**, and also suggests they somehow do not qualify to have these things for themselves.

The views expressed in extract (45) are quite different from those in extracts (46) and (47) where the context changes. These two statements are responses to a direct question asking Bev how she thinks people with mental disorders generally behave.

> **Bev:** I suppose one tends to think of them as being rather unhappy and behaving in rather a depressed way, as sort of looking rather forlorn and lonely and miserable, ... [extract 46]

> **Bev:** .... how do they behave? well I don't know, I suppose I suppose I thought of somebody with a mental disorder as actually most of the time behaving quite normally, just like me really (.) but I suppose if I think of them as being under the er er having an attack I suppose I think of them as being chronically depressed (.) but otherwise, otherwise normal. I suppose in the back of my mind there is also the thought that I I'm aware that some of them can become violent, maybe, maybe I see them sort of throwing things around, I'm not sure. [extract 47]

By **'normally'** Bev declares that she means like herself **'just like me really'**. This *affiliation repertoire* is restricted to **'most of the time'**, that is unless they are **'having an attack'**, inferring her view that the behavioural effects of a mental disorder occur only infrequently. The behaviour Bev believes to be associated with **'an attack'** is described using the *disorder repertoires* **'depressed'** and **'violent'**. Although the potential for violent behaviour was also raised in extract

(45) on that occasion mention was also made of people behaving **'oddly and strangely'**, behaviour not raised in the two extracts above. Overall it is difficult to reconcile Bev's view that most of the time they behave **'normally'** with the range of behaviours she describes to support her views on different topics.

Bev was not alone with contradictions of this nature. When participants were asked directly about the sort of behaviour they would expect from people with mental disorders all responded with descriptions incompatible with other statements made during their interviews. Two extracts from Sue's transcript show this effect.

> **Sue:** Generally behave ((pause)) mm (.) well I can't really answer that fully cause I've only come across a few people (.) probably slightly different sometimes. [extract 48]

As Bev said in extract (47) **'most of the time ... quite normally'**, here Sue responds similarly with the *disorder repertoire* **'probably slightly different sometimes'**. This suggests a *dual community repertoire* by the inference that the behaviour which probably occurs is different from the behaviour of other people. The opening of her statement with the disclaimer **'I can't really answer that fully cause....'** followed by an understated view, suggests a lack of knowledge prevents Sue from providing a more detailed response. However this impression is not evident in extract (49) where she comments on the usefulness of information given to locals prior to a community residence being set up in her suburb a few years ago.

> **Sue:** I don't care what they say I mean there still may have been absolutely nothing happen, but only <u>one</u> thing could go wrong, and if someone was hurt or injured whether it be the resident, or a person involved, or a fright, and I mean <u>nobody</u> should be exposed to that, no matter whether they're part of the residence, or part of the community (.) but it hasn't, I don't think. [extract 49]

In this extract Sue uses *disorder repertoires* with terms such as **'go wrong ... if someone was hurt or injured ... or a fright'** to support her view that prior information about the community residence was inadequate. In so doing she actually says that nothing they could have said at that time would have been acceptable **'I don't care what they say'**. She uses the *affiliation repertoire* **'nobody should be exposed ...'** which suggests equal concern for residents and non-residents, and justifies her inclusion of the *disorder repertoires*. She would be unable to make her point here if she used the same *disorder repertoire* **'slightly different'** as she did in extract (48). Finally she reveals a *dual*

*community repertoire* when she talks of people being **'part of the residence, or part of the community'**. This effectively distinguishes between those who are **'part of the residence'** and those who are **'part of the community'**, and carries the inference that if people belong to the residence then they are not actually part of the community.

## Conclusion - Topic Areas and Interpretive Repertoires

The analysis discussed so far has focused on interpretive repertoires, and their use within the separate topic areas of interest. Before providing a summary of this analysis, and discussing the social consequences arising from use of these repertoires, it is relevant to discuss some of the linguistic devices used by participants. Although some linguistic devices were mentioned briefly in during the discussion of interpretive repertoires a more comprehensive analysis of these is warranted.

# CHAPTER SEVEN

# ANALYSIS REPORT
# LINGUISTIC DEVICES

## Introduction

Linguistic devices can be found in natural talk on any topic, and many have been evident in the extracts presented. Although this discussion of linguistic devices is presented separately from that of interpretive repertoires as used within topic areas, it is important to note that they constitute an integral part of discourse as a whole.

There are two reasons why linguistic devices are being discussed separately. Firstly, a number of particular types of linguistic devices were found to be used frequently by all participants, forming part of the construction and contributing to the functional effects of their discourse. A close analysis of these devices reveals how participants use them and the resulting effects, an aspect which seemed to warrant special attention. Secondly, to have discussed linguistic devices earlier would have resulted in complicated and lengthy discussions which may have detracted from the significance of the interpretive repertoires.

Three commonly used forms of talk have been included in this discussion of linguistic devices. These will be discussed separately, and include;

* opinion presentation
* singular and multiple references
* consensus devices

## Opinion Presentation

Although the knowledge people have on any given topic varies from considerable depth to virtually nil, when involved in discussions people generally contribute opinions. The nature of the discussion will dictate the type of talk, and depending on who is involved in the discussion this may range from polite contributions of accurate knowledge to ill-informed arguments. In an interview where people may be asked to comment on a topic about which they have little knowledge, they often feel obliged to venture an opinion, or take steps to avoid doing so.

Analysis of interview transcripts in the present research revealed five different ways participants achieved this. These opinion types commonly used by participants enabled them to respond to questions, make a point, avoid making statements which may be socially unacceptable, or simply to evade comment.

Opinion types fit easily into five groups;

- hesitant
- confident
- impersonal
- elusive
- conditional

The following discussion describes the nature of the different types of opinion presentation, how they are constructed, and their function. Examples demonstrate their use.

## Hesitant opinions

Statements indicating the speaker has given some consideration to the topic before expressing an opinion fall into this category. Unfamiliarity with the topic resulted in these opinions being presented with some hesitancy. They are generally preceded with terms such as **'I think'** or **'I'm not sure but'**, or may be followed with a disclaimer such as **'I don't know'**. Sometimes they may be incorporated into the statement by way of a term like **'as ( ...) said'** . Using this type of device allows a point to be made. It enables people to express an opinion or personal belief which need not be accurate, and is freely open to correction.

> **Bev:** I'm not sure (.) um I suspect that I don't think it's a good idea unless um there is such a lot of back up (.) for the people let out, ... [extract 50]

This example of an hesitant opinion shows how Bev is able to state that she does not think the policy of caring for people with mental disorders in the community is a good idea unless adequate backup is provided for them. Her statement allows room for her to be advised about the amount of back up provided.

> **Interviewer:** *Can you see any advantages to having a staffed residence?*
> **Joy:** I think ah you need somebody that's looking out for their overall well being, because in an unstaffed thing it's all very much every man for himself, and so so people can have these crises like er you know somebody suddenly hearing voices inside their head, and the person who's there to help them

> doesn't feel like talking to anybody today (.) so the situation can get worse. Whereas if there's somebody there who is prepared to to listen and offer the guidance that's needed at the time (.) I don't know I don't know much about this stuff ((laugh)). [extract 51]

Joy opens her statement by indicating she has given some thought to the question prior to venturing an opinion **'I think'**. She then has the freedom to make her point and provide an example to support her point. Closing with a disclaimer **'.... I don't know much about this stuff'** provides her with an excuse if what she said was incorrect or unacceptable.

## Confident opinions

Completely opposite to the hesitant opinion a confident opinion represents a persons firm view on the topic. Expressed with conviction this type of opinion indicates the view may have been formulated prior to the current discussion. That is not to say the statement issued is necessarily accurate, only that it harbours no doubt in the speakers mind. This is demonstrated in the following extract from Gay's interview.

> **Gay:** Forget it, you're gone, you're out there in the field by yourself that's terrible! there that is absolutely of no benefit to the families that have got to care for that person with the mental illness, ah and that is fraught with um unbelievable potential problems to the family (.) unbelievable. [extract 52]

This opinion from Gay was expressed following the opening statement of the interview. During the course of the interview it became apparent that this opinion had probably been formulated prior to the interview. It was not so much objection to the policy which stimulated Gay's response, but the potential for problems for the family, a theme which was evident throughout her interview.

## Impersonal opinions

By using impersonal opinions people are able to respond to a question or participate in a discussion without actually expressing an opinion of their own. Instead they credit the views they express to the majority of others, eg. **'people think'** or **'the public don't want'**. Opinions expressed in this way may indicate a view held by the speaker but not necessarily so, and often no comment is made to clarify this point.

**Interviewer:** *How do you feel about your property values if there was a place next to you.*
**Gay:** Again ((pause)) well I don't like to get, I'm a factual person, and I don't like to get into a um er theoretical or a (.) airy fairy can't think of the word, to me that's er airy fairy ideas, but (.) society I believe has got to face up to what is in society, and I don't see why the value of my home should go down because I have next to me a known group of people who are moving and doing well in society, are trying to get from one level to another level. WHO do I know I've got right now? But society is so busy seeing what they think they see as opposed to fact, let's get on and see the facts. [extract 53]

Gay was asked how she felt about her property values, however her opinion on that subject is expressed in an extremely impersonal way, if at all. Identifying her actual answer from this statement requires guess work. It seems that what she is saying is firstly, the value of her home would or might go down, secondly, that society has unrealistic attitudes about living next to people with disorders, and thirdly, that she does not agree with society.

**Elusive opinions**

Claiming lack of knowledge in order to avoid responding to a question is characteristic of an elusive opinion. The most obvious form this takes is **'I don't know'**. It may also include a change of subject either directly, or indirectly by way of a question which is irrelevant to the subject. This differs from a 'hesitant opinion' where a speaker uses the term 'I don't know' before or after a genuine attempt to respond. Recognising that all participants were intelligent adults, and that probe questions generally resulted in a response, elusive opinions indicate avoidance of the question posed.

**Interviewer:** *What do you think should be provided for people with mental disorders in terms of things like medical, financial,*
**Pam:** Well I don't know, I mean any question I am going to answer I'm going to give to you that question, it's tempered with the fact that New Zealanders' can't afford it, with you know, it's this bottomless pit of money which we can't afford we just haven't got it,.... [extract 54]

Pam begins her response with **'I don't know'** then proceeds to talk about **'the fact that New Zealanders' can't afford it ...'**. While the question asked about what she thought should be provided, Pam uses an elusive opinion by talking of New Zealander's inability to afford anything. It could be assumed that she is saying that nothing should be provided on the ground of cost, however as probe questions revealed later in the interview this interpretation is not correct. What

Pam made quite clear throughout her interview was her view that taxes are high enough without increasing them in order to provide more support for people in unfortunate circumstances. With this information it becomes clearer how Pam has expressed herself using an elusive opinion in this extract.

A more blatant form of elusive opinions is an outright avoidance as illustrated in extract (55).

> **Interviewer:** *Do you think they have the right to decide whether or not they take their medication ((pause)) you have the right to decide whether or not to take medication prescribed for yourself.*
> **Val:** Well if they, gosh it's very hard to get into somebody's brain to sort of work our why, how they're thinking at times because they can be very devious people. [extract 55]

**Conditional opinion**

Conditional opinions occur in most forms of discourse. These allow the speaker or writer to express a view which best suits their purpose. The conditional opinions which occur most frequently are indicated by;

- 'it depends on ...'
- individual considerations
- provisional statements

Often the opinion being expressed is preceded by the conditional term **'it depends on ... '**, however this may be embedded in the statement or added at the end. The conditional allows for a view to be expressed which otherwise may be seen as biased or politically incorrect. By including a conditional term the opinion becomes difficult to challenge. On some occasions when the conditional term is used on its own with no following statement (**'it depends.'**) it functions the same as an elusive opinion. When this occurs clarification must be sought by the interviewer. The speaker then responds to the request for clarification, and so avoids expressing a view on the original subject. The following two extracts illustrate different ways the term 'depends on' is used.

> **Interviewer:** *How do you feel about a residence for people with mental disorders being set up in your street.*
> **Liz:** Depends on the disorder ((pause)) as I said I've got no problem with like people with schizophrenia, um (.) bipolar whatever (.) the only, THAT I have no problems with. [extract 56]

By stating that it **'depends on the disorder'** Liz is able to suggest that she has **'no problems'** with a residence being set up in her street, however by specifying two specific disorders the inference is that she would have problems if the residents were to have other unmentioned disorders.

> **Interviewer:** *What rights do you think someone with a mental disorder has, in terms of freedom to participate in the same things that you and I might.*
> **Pam:** Well, yes of course it's all dependent isn't it.
> **Interviewer:** *On?*
> **Pam:** Their degree of (.) ability to (.) partake in the community probably isn't it, but then how do you say whether they are (.) capable or not .....[extract 57]

By requiring the interviewer to seek clarification as to what she meant with the term **'it's all dependent ...'** Pam is able to respond to the clarification question and avoid responding to the original question.

Individual considerations are sometimes included in a 'depends on ' consideration. This type of device has the same function as 'depends on ...' but generally occurs at the end of a statement. The speaker is therefore able to get a point across, then temper it with individual considerations, making the view appear considered and therefore reasonable.

> **Tom:** I don't think you can have a a clear policy that says one way or the other, it comes down to the individual.
> **Interviewer:** *Okay so you look at an individual case basis.*
> **Tom:** Well it is the only way to do it (.) we treat all of us are individuals so to treat those people any other way would be crazy. [extract 58]

Tom uses individual considerations to justify why he does not think it is possible to have **'a clear policy ... '** . His comparison with **'all of us'** disregards the many policies which apply to everybody and include consideration of individual circumstance. Nevertheless his use of individual considerations make his opinion appear to be thoughtful and reasonable.

The final type of commonly used conditional opinion is where people add provisions to their statements. Examples include **'as long as'**, **'but if '**, **'provided that'**, and **'if.....then'**. The use of these types of conditional opinions enable people to make a statement which is socially acceptable, but which probably would not have been made if it had to stand alone. Extracts (59) and (60) show how provisos are added, and conditions applied to an initial statement.

> **Interviewer:** *Do you think it would effect your property values to have a place on your street.*

**Kim:** Ohhh um ((pause)) I don't think so no ((Pause)) um (.) no I don't (.) I don't that wouldn't worry me at all, no, I don't think it would. Um provided that that, that the property that these people had was neat and tidy and well looked after, no problem. [extract 59]

**Bev:** ..., but if someone with a mental disorder were disposed not not to take medication and due to their refusal to take medication became a danger to themselves or to anybody else (.) then I think that, that has to override ((pause)) other basic human rights (.) ... [extract 60]

## Singular and Multiple References

How closely people involve themselves in their talk on a particular topic is often revealed in the way they construct their accounts. The interview style used in the present study invited participants to comment on their feelings and thoughts. It would therefore be reasonable to expect that participants giving such subjective views would align themselves fairly closely with what they were saying. However analysis of interview transcripts revealed that participants commonly and frequently used linguistic devices which functioned to distance themselves from their views.

One such device already discussed is the 'impersonal opinion', where people talk about what others want or do. Less obvious, but serving a similar function is the use of pronouns. When divided into three groups, personal, collective personal, and impersonal, pronouns have quite different functions. These are first described, then their function and effect is demonstrated in examples.

### Personal

In this category are the words **I**, **me** and **my**. Clearly the use of these words align the speaker closely with what is being said. By using personal terms speakers are able to express views which they clearly claim as their own. This has the effect of giving the impression that the opinion expressed has been carefully considered.

**Liz:** I think in the general run of the mill, such a schizophrenia or something like that I think they have the same rights as we have that don't have a mental illness, but if it's someone that's actually classed as dangerous, and once again I'm going back on what I've read in the newspapers or articles and things, I can't honestly say I'm keen on that. I would like, I don't want to take away their rights but I also don't want to take away mine or other peoples safety. [extract 61]

In this extract Liz expresses a view which she claims as her own **'I think they have the same rights as we have ... '**, and she also declares her own reservations **'I can't honestly say I'm keen on that'**. This type of statement gives the impression of a well thought out response, which has the effect of strengthening her view for herself and has the potential to influence others.

**Collective personal**

Collective words such as **we, us** and **our** come into this category.
Where these words are used people include themselves and others as being involved with what they are talking about. This enables them to express a view which they do not claim to be solely their own. The benefit of using collective terms is that the speaker is able to either claim direct alliance with the view being expressed, or alternatively can not be held personally responsible for it. The following two extracts demonstrate the use of these terms, and how they function to involve the recipient of the talk into the view being stated.

> **Bev:** ... I can't believe we're still back in the middle ages when we just say this is what we think is right for you that's what you're getting, hopefully not. [extract 62]

Bev uses the word **'we'** to talk about a situation of dominance over people with mental disorders which she finds distasteful. This has the effect of including other people into her statement which criticises what the collective did in the past. Use of this type of discourse has the effect of aligning herself with the recipients of her opinion. It also has the potential to shape their views to match her own.

> **Context:** *about who should pay to provide for people with mental disorders.*
> **Pam:** Well if they can afford it then they should pay for it really I suppose. I mean we just can't afford it (.) [extract 63]

In extract (63) Pam uses the collective **'we'**, inferring that she is expressing the view of other people in general. If the opinion expressed was to be attributed to her alone, then she may be subject to reproach for being unsupportive of people with disorders. However by talking collectively she not only infers that others have the same opinion, it also has the potential to influence others to her way of thinking.

## Impersonal

This category includes 'collective' words such as **they,** and 'direct' words like **you** or **your**, which refer to the person being addressed and / or other people in general. The use of these words indicates that the speaker is not associated with the substance of what is being said, except as the agent for the words.

### Collective: (they - them)

The most common impersonal terms used, particularly when discussing a group of people, are the collective **they** or **them**. All participants used these terms frequently throughout their interviews, as well as other terms such as **'those people'**. These collective words are primarily used for efficiency. However they also enable the speaker to make gross categorisations, or depending on the purpose of the opinion being expressed, can be modified with particular individual examples (Billig, 1985). The use of these terms is illustrated in the extracts (64) and (65).

> **Context:** *about what level of understanding the public should have about mental disorders)*
> **Gay:** Very high, ((laugh)) short answers ! (.) they should be made aware, more and more and more, of what our society is made up of. .... and they should be shown what real life in a community is all about, don't hide it. [extract 64]

Even though she is a member of the public Gay uses the word **'they'** in her talk. This has the effect of separating herself from those who **'should be made aware'**, and infers that she has the awareness she talks about.

> **Context:** *about what should be provided for people with mental disorders.*
> **Val:** Everything because they're incapable, often incapable, .... [extract 65]

Val uses the word **'they're'** in reference to people with mental disorders. This functions to categorise them all as being **'incapable, often incapable'**. By using this gross categorisation Val is able to justify her opinion that everything should be provided for them.

### Direct: (you or your)

Use of **you** or **your** generally indicate a more direct reference to the person being addressed. Talk which includes these terms carries the inference that the statement being made does not apply to the speaker.

**Context:** *about where Joy would prefer to live if she had a mental disorder.*
**Joy:** Well I just like the idea of sort of people in similar situations helping each other (.) so then you'd want to be in in some kind of halfway house, but that's before you do feel that you can go out and get a flat on your own or with other people, but off your own bat you'd choose to be where you'd want to live. [extract 66]

Even though Joy was specifically asked about her preferences if she had a disorder, throughout her response she talks of **you**. This has the effect of directing attention away from herself, and in this case functions to distinguish her separateness from those with disorders.

The use of **you** words also often function to make directives or accusations, placing the recipient in a position of accountability.

**Kim:** I guess it depends a lot too on the type of illness that they have, and how the community perceive them too (.) I think you've got to look at each individual (.) you can't just say there's a group of patients who have had some form of mental disorder, ok let's put them back into society, you've got to look at each individual person ..... [extract 67]

In this extract Kim talks of things **'you've got to'** do and things **'you can't'** do. Her use of these terms keep herself and the community separate from the **'you'** she refers to, enabling her to state what she thinks someone else should be responsible for.

**Combinations of singular and multiple terms.**

**Tom**: Well that's crazy, that is crazy. I mean there is nothing like, they're just similar to children you turn children out on their own they wouldn't survive either, we've we've got to have (.) er more um (.) not control but more responsibility than just casting them adrift and saying 'well we've we've done our bit, we've had them in here and we've looked after them, done all we can' and they open the doors and they pop out into the community and our responsibility finishes, it it's not like that at all. There needs to be an ongoing system whereby they are supported. [extract 68]

In this extract Tom uses a combination of collective personal and impersonal words in the construction of his argument. Saying **'they're just similar to children'** functions to place all people with disorders in this category. Then Tom states **'you turn them out'**, describing an uncaring act from which he distances himself by his use of the word **'you'**. This is followed by a number of references about what **'we've got to'** do. Here his use of the terms **'we've'** and **'our'** have the effect of involving others in his statement which talks of

**'responsibility'** and things which the collective **'we'** should not do. Finally, by using the term **'there needs to be'** which is completely impersonal Tom separates himself from involvement with what needs to be done. This has the effect of placing the responsibility for doing things properly on to **'an ongoing system'**.

It is interesting to note that when asked how he thought we could best conduct a system to meet what he said was needed, Tom avoided committing himself.

> **Tom:** I I really don't know enough about all the individuals that you're talking about that fall into this category, .... [extract 69]

Even though it suited his purpose in extract (68) to categorise all people with disorders as **'just similar to children'**, here he uses individual considerations to avoid elaborating on what he meant when he talked of **'an ongoing system'** being needed.

## Consensus

The act of claiming consensus within a statement is an effective way to strengthen the validity of the view being expressed. Edwards and Potter (1992) describe two of the major types of linguistic devices used in accounts to promote consensus. These are claiming the assent of reliable witnesses and stressing the independence of those who are can corroborate the account being offered. Analysis of the interview transcripts in the present research revealed that participants all made statements using consensus devices.

### Verifiable examples

Participants employed specific verifiable examples to make their opinion valid. Particularly on occasions where an expressed view had been questioned or corrected by the interviewer, consensus devices were used. Most often participants acknowledged and agreed with the interviewer, then they made reference to a corroborative example which supported their original opinion. The following two extracts illustrate how participants used these types of consensus devices.

> **Interviewer:** *Well if they are decreed by the authorities to be dangerous they are confined. When they are no longer determined as dangerous*

*they are released into the community.*
**Liz:** Yeah but that's not quite right either, because what I've read in the newspapers etcetera of the 1992 Mental Health Act there are people being let out of Lake Alice that are classed by the staff that work with them and by psychologists and psychiatrists as dangerous, and yet under the new rules they are still being put out into the community. [extract 70]

In extract (70) Liz first acknowledges what the interviewer said, then makes reference to **'what I've read in the newspapers ...'.** Without challenging the accuracy of the actual newspaper reports she refers to, it is difficult to refute her opinion. This device functions to present her opinion as validated, strengthening her own view and adding to the potential influence on others.

**Interviewer:** *They actually have a lot of sound ideas, and treatments.*
**Bev:** Do they really ! (.) yes I, I mean obviously they're a lot better than they were, I think of Janet Frame, but um, I mean so many mistakes have been made in the past, and it's not the too distant past really when you think about it. [extract 71]

Bev also states agreement with the interviewer but adds the verifiable example of **'Janet Frame'**. Even though she uses a single individual example, this functions to provide support for her view that mistakes in diagnosis and treatment of people with disorders are common.

## Generalisation

Another type of consensus device occurs with generalisations which refer to what 'everybody, most people, or nobody' knows or does. Participants commonly and frequently used this device, generally in the form of talking about what people, the community, or the public think, want or do .

**Val:** ... BUT supervision comes into it. It does (.) there's got to be back ups, people are going to be frightened if they know there's a bunch of people there and the fact is they don't know which one is going to (.) you know, go berserk. It's not always the case, but this is what goes in people's minds (.) and they don't want police cars going in there every five minutes or something or other. [extract 72]

In extract (72) Val talks of how **'people are going to be frightened'**, and **'this is what goes on in people's minds'**. By referring to 'people' she presents a far stronger case than would have been made if she had credited these factors to herself alone. It is also difficult to challenge her generalisation which is presented with an emotive example of someone perhaps going berserk. Talking of 'people'

in this way has the effect of suggesting wide support for Val's statement that supervision is necessary in a community residence for people with disorders.

**'You know'**

The final type of consensus device often used by participants was the term **'you know'**. Because this term seems to have become widely used in general conversation, it may be viewed as a type of token confirmation seeking device, with little real meaning. It can be used in lieu of the question 'do you know what I am saying?' or as a challenge ' you do know what I am saying'. In neither situation is a response invited or expected, and in both situations its use infers that the recipient understands and agrees with the speaker.

The use of 'you know' as a consensus device can have the effect of adding power to an opinion or argument. This is demonstrated in the following extracts.

> **Kim:** Yeah you send your child to kindy, now I mean that that's almost like saying that the kindergarten teacher has got no con you know is is not looking after your children, that's not what's meant by you know I mean anything can happen. [extract 73]

This extract comes at the beginning of a lengthy statement about why Kim would have less problems with a residence in her street than she would if it was next to the local kindergarten. Twice she uses the term 'you know'. First, **'that's almost like saying that the kindergarten teacher .....you know is not looking after your children'** invites the interviewer to agree with her interpretation of what it is **'almost like saying'**. Then she clarifies the point she intended to make - **'you know I mean anything can happen'**. This states a fact which she implies is not only known by herself but also by the interviewer. Claiming the interviewer's corroboration of her view that **'anything can happen'** functions to add strength to her argument.

> **Pam:** I think that a lot of GP's are far too free with medication (.) and um you've got anti-depressant syndrome you know 'poor woman' you know 'you're frustrated' you know 'you're what are you, you haven't got a man, oh god yes you're depressed because you're feeling tired', or 'oh you'd better have some Valium [name]' I mean we've <u>all</u> had it (.) ... [extract 74]

In her description of how GP's treat people Pam freely intersperses her example with **'you know'**, inferring that the interviewer has a clear and supportive understanding of what she is talking about. Finally she uses a generalisation

**'we've <u>all</u> had it'** to add emphasis to her point that **'a lot of GP's are far too free with medication'**. The use of these consensus devices to strengthen her point function to support the case she goes on to make - GP's need educating because they prescribe medication too freely, people become dependent on prescription drugs, and finally that people should get rid of their medication and rely more on self help and self determination.

## Conclusion - Linguistic Devices

The linguistic devices discussed in this section were the ones most commonly and frequently used by participants. Most of these occur naturally in talk, with their function being overlooked unless the talk is closely analysed. By discussing the most commonly used linguistic devices separately from interpretive repertoires, it has been possible to demonstrate more clearly how they were used by participants in the construction and function of their discourse.

# CHAPTER EIGHT

# SUMMARY DISCUSSION

## SUMMARY OF THE ANALYSIS REPORT

A casual reading of the interview transcripts would lead one to conclude that most of the views expressed were supportive of people with mental disorders. Indeed it would be difficult to describe any of the participants as being opposed to the concept of community care. However it is not the purpose of discourse analysis to reflect on the motives behind what people say, but rather to investigate the social consequences of the structure and function of the particular discourse used.

### Interpretive Repertoires

The analysis of discourse from participants on topics relating to mental health care in the community revealed the common and frequent use of a number of discursive practices and patterns of talk. Analysis resulted in the identification of six interpretive repertoires. It has been demonstrated how each repertoire contains content reflecting a considered and thoughtful outlook, often based on the concept equality and caring for those less fortunate. However they were also constructed in such a way as to promote and protect the interests of the speaker.

The repertoire of 'human rights promotion' advances the ideal of equal rights for all. When talking about rights it is reasonable to expect that people will focus on the particular rights relevant to the discussion. If the purpose of the discussion is to talk about rights in general terms, promoting the equality of rights for all is the legally and socially acceptable thing to do. Talking of rights as they apply to people with mental disorders adds another dimension to the discussion. People are confronted with the idea that people with mental disorders are the same as themselves, with the same legal and social rights. However a quandary arises when they do not consider the rights of people with disorders to be absolutely the same as their own. Talk about denying the rights of any group of people has the potential to raise issues of discrimination. It is easier to promote the concept of equal rights for all, and claim the entitlement to protection of those rights. This allows people to add conditions and provisos to the rights of people with disorders, in order to preserve their own rights.

The word community carries with it a wide variety of assumptions and implications. The 'dual community' repertoire identified from the analysis is concerned with the way participants discussed the community in relation to people with mental disorders. There is no dispute that people with disorders are living in the community, therefore to talk about them as if they did not belong would create the impression that the speaker is unaccepting and unsupportive. One way of warding off this impression is to make the content of the talk appear favourable towards integrating people with disorders into the community. This type of talk allows speakers to state views which appear to be supportive, while at the same time preserving the division between themselves and those with disorders. The question to be addressed is 'what community does the person with the disorder need to be integrated into when they already belong to the community ?' The dual community repertoire carries the inference that while people with disorders may be part of the physical community, they are not so readily accepted as part of the more personal human community.

Talking to people in a patronising way often has the effect of generating an irate response. However talking about people in a patronising way often appears to be socially acceptable, particularly when concerned with the care and support for people considered unable to care for themselves. The patronising repertoire enables the speakers to present benevolent views which if criticised make the challenger seem uncaring and unsupportive of those less fortunate than themselves. Because it also depicts people with disorders as dependent on others, the use of the patronising repertoire makes it seem reasonable for the speaker to assume an entitlement of dominance over them.

A repertoire of affiliation promotes the concept of the equality of people on the simple basis of their belonging to the human race. Using affiliation advances the idea that everybody should be treated the same, recognising no difference between people with disorders and anybody else. Such a concept is difficult to criticise without appearing to promote the idea that people with disorders do not warrant the same treatment as everybody else. Although this type of talk may appear to be advantageous to those with disorders, it has the effect of disregarding any special circumstances which may need to be taken into consideration. The analysis revealed that the affiliation repertoire was only used on occasions when the consequences of what was said was to the speakers advantage.

The disorder repertoire involves the use of talk about specific disorders and behaviour which may be associated with a particular disorder in order to make a point. General statements or examples of disorders, are incorporated into talk on the subject under discussion, providing what appears to be a well reasoned and thoughtful statement. The disorder repertoire also has another primary function. It enables the speaker to magnify or minimise the seriousness of a disorder, or to select a specific disorder or potential for behaviour as an example appropriate to justify the opinion being offered.

Talk about the care of people with disorders most often involved the use of a solicitous control repertoire. On the face of it this repertoire gives the impression that the interests of people with mental disorders are paramount. If the view being presented is criticised it may be seen as an attempt to deprive them of the best possible care they could have. However, in a way similar to the patronising repertoire, talk which depicts people with disorders as needing care 'for their own good' makes it reasonable for the speaker to incorporate a control element into the statement.

## Linguistic Devices

The topic of caring for people with mental disorders in the community is not one which many people would give much attention unless it affected them directly in some way. Therefore it makes sense to look at how participants were able to make statements on the subject, while avoiding the risk of appearing ignorant or ill-informed. Linguistic devices perform this function, enabling people to express an opinion while protecting them from criticism on the grounds of inaccuracy. The analysis revealed that the most common devices used in this respect were the opinion repertoires which allowed participants to express hesitancy and doubt at the same time as making their point. The use of these devices ensure that if a view is challenged, there is room for manoeuvre.

Also commonly used were singular and multiple references. Devices such as these indicate the extent of personal commitment to what is being said. For example, while a personal reference to self suggests complete alliance with the account being given, collective personal references allowed both a direct alliance and some space between the view being expressed and their own association with

it. At the other end of commitment is the use of impersonal devices, allowing an opinion to be offered without involving the speaker to any extent at all.

When discussing a topic about which they are uncertain, people commonly use a consensus device to add strength to the validity of the account being given. The analysis revealed that claiming consensus occurred often throughout all interviews. This was frequently achieved by relating specific verifiable examples to the point being made. Generalisations in the form of what people, the community, or the public think or do, were also used as consensus devices. These devices are hard to refute without statistical evidence to justify the challenge. The final consensus device found to be common was the term 'you know' used in a way which infers that the recipient of the statement understands or agrees with the view being expressed.

## SOCIAL CONSEQUENCES OF TALK ABOUT PEOPLE WITH MENTAL DISORDERS

The dominant repertoires and linguistic devices discussed were seldom used in isolation. Most of the time they were used in combinations which indicate an active and careful construction of the view being expressed. This construction functions to produce a convincing version which is designed to have a particular effect. The analysis of participant's talk about community care for people with mental disorders, revealed a number of effects or consequences.

Each time a person articulates an account or version of an event they construct it in a way which suits their purpose at the time. The version which is so produced becomes part of their own reality, strengthened by the telling of it. In turn, the narration provides material for others who also create their own versions from the discourse they receive. One likely outcome from this sequence of social interaction is that people can become confident of the reasonableness of their views, an impression which can subsequently be passed on to others via discourse.

Talk which states outright, or infers that the rights of people with disorders are subordinate to the rights of others has the potential to become a discursive reality. People with disorders may come to accept this as fact, or be reluctant to oppose what they see as a majority who accept this as fact. Because the discourse

occurring naturally within the social arena creates the impression that people's rights would be breached if those with disorders had absolutely the same rights as themselves, it is an unfortunate consequence that those with disorders who may be inclined to claim their own rights are unlikely to receive wider social support.

People with disorders, regardless of their residential circumstances, are part of the community. Talk which carries a contrary inference has the effect of maintaining a division between those with disorders and those without. Many minority groups live in the community. Some of these groups, for example gangs or street kids may be looked on by the community as socially undesirable, but there is no suggestion that they are not actually part of the community. Discourse which preserves the separateness of those with disorders also serves to justify the treatment of these people as different. Consequently they retain their place on the fringes of the community, and the rightness of this situation becomes confirmed for other members of the community.

There is little dispute that some people with mental disorders need constant care. However the extent of incapacitation resulting from mental illness varies considerably depending on a number of things such as the severity of the condition or the effectiveness of treatment. Patronising discourse which functions to position people with disorders as subordinate to others has a number of consequences. Firstly, those with disorders can come to accept their place as dependent and inferior, and accordingly accept the inference that those who do not have disorders are somehow better than themselves. Secondly, it enables people without disorders to assume an air of superiority, which conveys an entitlement of dominance over those with disorders. Finally, by inferring responsibility over and for people with disorders, others depict themselves as considerate and noble. It should be noted that gross generalisations often accompany patronising talk. This has the added consequence of targeting all people with disorders with the consequences of such talk, irrespective of their ability to take responsibility for themselves.

It would seem that the major effect resulting from the way people talk about those with disorders is to maintain the social distance between the two groups. Discourse which has the effect of promoting affiliation should therefore be a positive step towards correcting this situation. However affiliation discourse has quite harmful consequences. The idea of equality should be welcomed by those with disorders, therefore making it difficult for them to reject. By accepting that

they are equal with others they also, by default, accept that they are not entitled to any special treatment ahead or over others. As noted earlier, affiliation discourse is used on occasions when advantageous to the user. Such discourse ignores the special circumstances and needs of some people with disorders, and places them in a position of being unable to request special consideration without registering themselves as different.

The term mental disorders conjures up a wide variety of other terms frequently used by both professionals and lay people. Such terms seldom incorporate any indication of the severity or mildness of the disorder. However discourse based on disorder themes has the primary function of focusing attention on this aspect in order to justify the view being expressed. Often discourse which involves a minor disorder, or one which has the least severe effects, functions to justify a point being made about their abilities, while discourse involving more severe disorders justify a point made regarding inabilities. Consequently people with disorders which have no relevance to the talk become either included due to the general nature of the talk, or invisible because of the specificity of the talk. Another significant consequence is the creation or maintenance of an image of people with disorders being distinctly different from other people.

The amount and type of care needed varies considerably depending on the nature and severity of the disorder involved. Some people function perfectly well with only minor intervention, while at the other end of the scale others may require permanent hospitalisation. Ensuring that people get the care they need is commendable, and discourse on this topic gives the impression of advancing this notion. One consequence of this type of talk is the potential it has to influence those with disorders towards accepting that it is in their own best interests to subject themselves to the care thought by others to be best for them. However discourse used by participants about care often focused on 'ensuring'. Sometimes embedded into a statement, often overt, and at times only inferred, was the concept of supervision and or control. Talk of this type has two main consequences. Firstly, people with disorders may accept this as part of what is considered to be being best for them, or believing in their own dependent status accept this to be what they need. Secondly, it maintains the impression that those with disorders are subordinate to other people. It also instils the idea that something is amiss unless people with disorders are controlled or supervised. The naturally occurring flow on effect is the preservation of the division between themselves and those with disorders.

To presume that people are aware of the consequential nature of discourse would lead to the conclusion that their talk is deliberately constructed for the purpose of maintaining a division between those with disorders and other members of the community. However speculation about the psychological motivations behind the use of particular discursive forms falls outside the realm of discourse analysis. Rather it is the social processes which occur as a result of the functional way talk is constructed which are identified from analysis of that talk.

The most obvious social consequence originating from discourse is the continued stigma which remains attached to mental illness. Goffman (1965) discussed how people were generally reluctant to associate too closely with those who had disorders, and how people who had received some form of therapy or treatment were often hesitant about discussing it. This situation does not appear to be much changed three decades later, although personal disclosures about mental illness and therapy seem to be occurring more frequently on television and in the media. While this might suggest a more enlightened and accepting approach towards those with mental disorders, in many contexts it remains socially acceptable to denigrate mental illness. This often occurs by way of humour using terms such as 'looney', or with fear using words like 'psycho' or 'mad'. Television comedies continue to use mental illness as source for generating mockery, demonstrated blatantly in programmes often by focusing on the lives and trials of psychiatrists. Television dramas direct their attention to creating fear in their audience based on the horrific antics of a psychologically disturbed offender. Unfortunately there appears to be little resistance to the portrayal of people with mental disorders in this manner. Whether it be the result of ignorance or apathy this situation needs to change, and this can only occur when people are made aware of the harmful effects which arise from their discourse on the topic.

## LIMITATIONS OF THE CURRENT STUDY

The very nature of discourse analysis imposes a significant limitation on the current study. The process which involves in-depth analysis of everything said by each participant, makes it necessary to ensure the material being analysed is kept to manageable proportions. Accordingly the number of subjects was limited to ten. Subjects were specifically selected on the basis of their being ordinary people resident in a suburban community. The way they talk about people with

mental disorders and community care may not be the same as the way other members of the public talk on the subject. Therefore the results of the current study can not be generalised.

Discourse analysis, particularly when conducted by only one person as occurred in the present study, is subject to the limited perspective of the researcher. Having found patterns of talk, then focused on the particular interpretive repertoires identified, it is possible that other more complex patterns indicating other repertoires are overlooked. Unfortunately the analysis report discusses only those repertoires identified, with examples of talk which support the discussion. Other samples of talk which may reveal different patterns are omitted, making it difficult for readers to draw their own conclusions or perhaps to identify repertoires not considered by the researcher. This limitation would be resolved to some extent if the analysis was to be conducted by more than one person, thus allowing consultation, challenge, and a wider perspective to be brought to the analysis.

Discourse analysis is not concerned with the motives which may influence the way people talk. In fact discourse analysts have traditionally avoided the problems associated with consideration of motive and intentions. However it may seem that an incomplete picture is provided when motives are disregarded. For example, the dual community repertoire is identified from talk about people with mental disorders being somehow separate and different from other members of the community. This might be deliberate, or it might be quite unintentional. It could be argued that the motives behind talk have an effect on the structure and nature of that talk, however this issue can not be addressed by means of discourse analysis. The focus remains on identifying the effects and social consequences of talk and, depending on the purpose of analysis, may provide information on which changes to harmful social practices can be based.

# CHAPTER NINE

# THE WAY AHEAD

## POTENTIAL USE OF FINDINGS

It took many decades and ongoing pressure from feminist groups to convince both men and women that depicting women in a subservient role was unacceptable. Even though this practice has not been eliminated, people have become more aware of an increasing lack of tolerance for denigrating and patronising talk about women. These changes are occurring as a result of education about the effects and consequences of the way in which women were talked about and to. Institutional recognition and implementation of gender neutral language in official documentation has also contributed to public awareness of the unacceptability of talk biased against women. The same type of changes are needed, and can be achieved by educating people about the effects and consequences of they way they depict and talk about those with mental disorders.

Changing the way people talk about those with mental disorders and community care has the potential to resolve some of the dilemmas which currently exist. One such dilemma arises from affiliation talk which promotes equal treatment of people with disorders making it difficult for them to request special consideration without marking their difference. Understanding how discourse contributes to this dilemma provides an insight into how it can be resolved. For example, people with disorders should be treated equally to others, however in order for them to actualise that equality they may need assistance. Just as a paraplegic is assisted with mobility and accessways without loss of dignity through the fact that these things have been specially provided, so also can assistance be given to those with disorders. The special considerations need to be talked of as the bridge to equality rather than something extra that others are not entitled to.

The same applies to the dilemma which arises when people are apprehensive about the impact on their quality of life which may occur when a community care residence is established in their neighbourhood. While they accept community care may enhance the quality of life for those with disorders, their resistance is based on the potentially negative effects it may have on themselves. When a dilemma of this nature is examined it can become evident that a different

approach may enhance the quality of life of both groups. For example, talk about factors which may result in community care being a negative experience for those with disorders has the potential to stimulate action to minimise those negative effects. Likewise, talk which is focused on the positive impact a community care residence may have in a neighbourhood may generate acceptance and support from other members of the community. Because it is the way in which people construct discourse which creates and reflects their own reality, it follows that their reality can change if the way they talk about things is changed.

Discourse takes many forms. Conversations, written material, and media presentations, are possibly the most pervasive forms of discourse from which people develop an understanding of their social world. Accordingly it is predominantly these areas which must initiate change in the way people with mental disorders are portrayed. It is not intended to suggest that most people are unsympathetic towards those with disorders. Indeed most people appear to be supportive and well-meaning, however they appear to be completely unaware of the effects arising from their discourse on the topic. To become aware people need to understand the constructive and functional nature of discourse, and so enable themselves to take a more critical view of written and media material. Stimulating change in such areas can only occur when people understand how they are being influenced and how they perpetuate the situation by their discursive influence on others.

A number of groups in society have the credibility to promote the changes necessary. These include mental health professional boards, the Mental Health Foundation and associated groups such as the Schizophrenia Fellowship, and the ministerial departments of Health, Social Welfare, Education, and Broadcasting. Others with a vested interest such as those with mental disorders, their friends and members of their families are also in a position to lobby for change. However first, awareness must be raised as to the type of discourse which has a negative impact on community mental health, which initially needs to be discouraged and eventually eliminated, and second, they must be aware of the type of discourse which can have a positive impact, which needs to be promoted. Further research using discourse analysis can continue to provide reliable information about discursive practices in the area of community mental health, information which can be used as the stimulus for change.

## FURTHER RESEARCH

When discussing the findings of his research investigating public attitudes towards mental illness Patten (1992) reported that "mental illness is viewed negatively by New Zealanders and that there are many misconceptions about it" (pp30). He pointed to a number of areas which would benefit from further research and amongst these included investigation into how attitudes could be changed. The Potter and Wetherell (1987) approach to discourse analysis highlights the problems inherent in attitude research, particularly the assumption that attitudes are enduring across different situations. However a discourse analysis approach may well achieve some of the research objectives which Patten identified as being needed. The results of the present study provide a useful insight into the way talk is actively constructed about people with mental disorders, and about the community association with them. It also reveals the potential effects and consequences such discourse has on those who have disorders and those who do not. Challenging the discursive practices which influence individuals, and by which they in turn influence others, may be the first step towards preventing the escalation of a dissatisfying relationship between those with mental disorders and others.

In order to gain an insight into why a people continue to maintain a separateness between themselves and those with disorders, further research using a discourse analysis approach would be useful in the following areas;

a. the government development of policy regarding community mental health;
b. public promotion of policy regarding community mental health;
c. the way in which all forms of media, including fictional presentations, represent and discuss people with mental disorders and community mental health;
d. how mental health professionals and field workers talk about those with disorders and community care;
e. the way people with mental disorders talk about themselves and others;
f. how literature (both fact and fiction) presents people with mental disorders and their relationships with others.

## CONCLUSION

The number of people with mental disorders living in the community has increased over recent years, and further increases are likely to continue. If community care for people with disorders in New Zealand is to avoid becoming like the social failure experienced in the United States (Hall, 1985), every possible effort must be made to ensure that those with disorders are accepted as part of the community. Being part of the community involves changes on the part of both those have disorders and those who do not. Because the social reality which people create for themselves is predominantly discursive, it is through discursive means that changes are most likely to occur. Understanding how people use discourse to construct their own versions of the situation involving people with mental disorders living in the community provides a firm ground on which to formulate a strategy for change.

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# Appendix A

## Interview Schedule

**Statement**

In New Zealand the Mental Health Act 1992 restricts compulsory treatment for people with mental disorders to those with a clearly defined 'need'. Hospitalisation for people with mental disorders is now focused on emergency care and treatment, and chronic cases. Outside of these provisions people with mental disorders must be cared for in the community. I am going to ask you to talk about the significance for you of this situation. There are no right or wrong answers. I want your opinions and feelings.

**Interview Schedule**

What do you think of the policy to care for people with mental disorders in the community ?

What rights do you believe someone with a mental disorder should have in terms of freedom to participate in the same things as other people do ?

What do you think should be provided for people with mental disorders?
**Probes:** medical / financial / accommodation / therapy or treatment.

In your opinion who should be responsible for caring for people with mental disorders?

Who do you think should be responsible for meeting the financial costs to society for the care of people with mental disorders ?

What do you feel is the best system for caring for people with mental disorders?
**Probes:** Why ? -- What if their disorder is such that they are (able / not able) to function satisfactorily most of the time ? -- What if the person with the disorder was yourself or a member of your family ?

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How do you feel about a residence for people with mental disorders being set up in your street or neighbourhood ?
**Probes**: Why ? -- What if - interaction with children - proximity to kindergartens / schools - property values - personal and family safety.

Where do you think a residence for people with mental disorders should be located?
**Probes**: Why ?

How do you feel about a non- residential facility for people with a mental disorders being established in your neighbourhood/ street/ next door. (for example, a drop in centre, a work shop etc.)
**Probes:** Why ? -- What if - encounters on public transport - movement of people in and around the neighbourhood.

Where do you think such a facility should be located ?
**Probes**: Why ?

If a residence for people with mental disorders was planned to be established in your street, what action to you think you would take ?
**Probes:**

How do you think people with mental disorders generally behave ?
**Probes:**

How would you feel if someone behaved like that around you/your children ?

What do you think you would do ?

What would you tell your children ?

Describe how you think you would feel if someone (say in a bus or a shop) began - talking aloud to themselves, - crying, - said things such as "get away from me", "leave me alone" ?
**Probes:** What do you think you would do ?

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Try to imagine yourself as someone who was suffering a form of mental disorder.

How do you imagine you would feel about being in places with people you did not know around you ?

Where do you think you would prefer to live / be cared for ?

How do you think you would like people to behave towards you ?

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What sort of understanding of mental disorders do you think ordinary members of the public have ?
**Probes**: Where do you think they get their ideas from?

What sort of understanding of mental disorders do you think ordinary members of the public should have ?
**Probes:** Why ?

What advantages or disadvantages do you think would result from a public education programme on mental illness ?

Is there anything you think is important on the topic of mental disorders or care for people with mental disorders that you would like to add ?

**Interview completed**

# Appendix B

## Information Sheet

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**COMMUNITY MENTAL HEALTH IN NEW ZEALAND**
**WHAT THE PUBLIC SAY**

**INFORMATION SHEET**

**The purpose of this research**

The aim of this research is to find out what members of the public say about mental illness and community care for the mentally ill. The research is being done by Jo Danks as a thesis for her Master of Arts under supervision in the Psychology department at Massey University.

**Participant involvement**

If you are interested in this research you are requested to contact the researcher within a week or so to confirm your willingness to participate. You would then be interviewed (which could take up to one hour). Your interview will be conducted either in your own home, or at a place suitable to both yourself and the researcher. The interview would be recorded on audio-tape. The interview would be aimed to get your views on mental illness and community care for people with mental disorders.

**Participant rights**

If you agree to take part in this research:

* you would have the right to refuse to answer any question, and to withdraw from the study at any time,
* you may ask any questions about the study that you wish,
* you are assured that any information you provide is completely confidential to the researcher. All audio-tapes and transcripts made from the tapes will be identified only by a pseudonym, and it will not be possible to identify you in any reports that result from the research,
* you will have access to your own audio-tape and transcripts during the course of the study,
* you will have the right to review your transcript, and change anything you said during the interview,
* if you request you will be given a summary of the findings of the research when it is completed.

If you have any further questions about this research you can contact me on Wellington Ph: 388-6572.

Jo Danks

# Appendix C

## Consent Form

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**COMMUNITY MENTAL HEALTH IN NEW ZEALAND**
**WHAT THE PUBLIC SAY**

**CONSENT FORM**

I have read the information sheet for this study and have had the details explained to me. My questions about the research have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I understand that I may refuse to answer any questions, and that I am free to withdraw my participation in the research at any time. I agree to provide information to the researcher on the understanding that it is completely confidential, and will not be used for any purpose other than for this research.

I agree to the researcher audio-taping the interviews with me, and that direct quotations from the interview may be used in the research report, provided these do not identify me in any way.

I wish to participate in this research under the conditions set out in the information sheet.

Signed: ----------
Name: ----------
Date: ----------
Researcher: ----------

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# Appendix D

## Transcript Symbols

The following transcript symbols are a limited selection of those developed by Gail Jefferson, from a modified list produced by Button and Lee (1987).

**(.)** - a short pause between words

**((pause))** - a discernible interval in the dialogue, noticeably longer than reflected by (.) a short pause.

**.** - a full stop indicates a fall in intonation, and is used both within and at the end of a passage of talk. It does not necessarily reflect the grammatical end of a sentence.

**,** - a comma indicates a continuing intonation within a passage of talk, not necessarily occurring between clauses of sentences. Its use is not a grammatical form.

**?** - a question mark indicates rising intonation, and may or may not mark a question.

**!** - an exclamation mark indicates an animated tone.

**CAPITALS** - reflects talk that is spoken louder than the surrounding talk.

**((laugh))** - reflects laughter within the dialogue

**((description))** - reflects a description of the talk, eg. ((whispered)).

**word underlined** - a word , words, or parts of words underlined reflect talk which is clearly emphasised or stressed.

**( )** - parenthesis enclosing a blank space reflects talk which occurred but was inaudible and unable to be transcribed. The length of the space indicates the length of inaudible talk.

**(doubt)** - parenthesis enclosing a word is an indication of doubt as to the transcription accuracy of the word within the brackets.

**[word]** - the use of square brackets indicates talk which has been deliberately omitted from the transcript, and/or may include information for clarification purposes, eg. [name].

# Appendix E

## Coding Sample

The following lists show actual words or phrases used by one participant. Listed are single words and short phrases, each indicating a section of talk in which the instance occurred. Numbers in brackets indicate the number of times a passage of talk was identified which included the word or phrase.

**policy**

fires everyone into
getting them out (2)
abandoned
turning them out
advocates (9)
guardian (2)
diagnose them
government (14)
social welfare
politicians (4)
public (3)
pop out into the community
casting them adrift
open the doors
assessment (3)
judgement (4)
protected
policy (2)
means test (2)
system
welfare benefit
family (2)
locked up (3)
constantly look after
put them in a system
probation
control (2)
responsibility
funding (3)
hand out
Mental Health Act
society (4)

**rights**

at risk
need (2)
what they want
locked up (3)
handle people
interpret for
advocates (9)
control (2)
guardian (2)
obligation
institution (6)
Mental Health Act
organisations (3)
fires everyone into
rights (4)
choice (2)
assessment (3)
constantly look after
put them in a system
judgement (4)
supervisor
protected
free speech
means test (2)
welfare benefit
society (4)
turning them out
suitability
have to earn the right
severe conditions (1)
decision making (3)
probation
keeping an eye on
assistance (2)
responsibility
shut away
social welfare
community (6)
public (5)

**responsibility**

abandoned
pop out into the community
ability (3)
mentally capable (2)
need (2)
assessment (3)
constantly look after
looking after (2)
probation
keeping an eye on
assistance (2)
responsibility
not socially acceptable
understanding
organisations (2)
professionally qualified (2)
institution (4)
turning them out
open the doors
capable (7)
cope (2)
help
handle people
decision making (3)
put them in a system
advocates (9)
control (2)
guardian (2)
incapable
responsibility for
compassion
mothers / fathers (2)
specialist care groups (2)
social welfare
casting them adrift
capacity
handling themselves (2)
support (5)
locked up (3)
staff member
interpret for
lives in
judgement (4)
case worker
protected
their situation (2)
obligation
community (10)
public (3)
family (3)
system

**care**

at risk
turning them out
ability (3)
mentally capable (2)
support (5)
locked up (3)
staff member
interpret for
advocates (6)
control (2)
assistance (2)
responsibility
problem (3)
mental problem
something wrong
obligation
fear (3)
mothers /fathers (2)
professionally qualifies
hospital (2)
finding (3)
danger
casting them adrift
capable (6)
cope (2)
need (2)
assessment (3)
constantly look after
looking after (2)
judgement (4)
supervisor
guardian (2)
their condition
incapable
their situation
feel inadequate
understanding
community (8)
society (4)
specialist care groups (2)
shut away
social welfare
abandoned
capacity
handling themselves (2)
medication
help
handle people
decision making (3)
lives in
keeping an eye on
case worker
protected
those people
mental illness
diagnose them
responsibility for
compassion
organisations (3)
public
family (3)
institution (5)

**knowledge**

violence (3)
threat (2)
disturbance
ability (3)
cope (2)
suitability
interpret for
control
mental disorder (5)
their condition
problem (3)
look different (2)
diagnose them
schizophrenia
not socially acceptable
need social behaviour skills
normal (3)
media
criminal
menace
danger
capable (5)
medication
severe conditions
looking after
assistance
mentally disturbed
mental problem
incapable
act different
mad man
something wrong
embarrassed
society (2)
institution
corrupt
at risk
abusing
mentally capable
need (2)
constantly look after
probation
protected
disorder (6)
those people (5)
mental illness
their situation (2)
moods swing (2)
behaviour
fear (3)
public (4)
television (2)