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REACTIONS TO INSANITY:
A STUDY OF STIGMA, DISCRIMINATION AND LABELLING IN RELATION TO PRESENT AND FORMER PSYCHIATRIC PATIENTS

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Abstract

The thesis is organised around an empirical investigation of the relationship between residents of a Hertfordshire village and people who are, or who have been, patients at a nearby psychiatric hospital, some of whom regularly venture into the village to use local facilities.

The research employs the method of participant observation and draws upon the discourse analytic approach of Potter and Wetherell, together with the rhetorical perspective of Michael Billig. In particular, the research focuses upon the discursive practices of local people, practices which function to sustain, amplify or minimise difference between themselves and others who are patients. The critical theory of Jürgen Habermas is drawn upon to complement and extend the discourse analysis approach, which receives critical evaluation.

In addition, the time-geography of Alan Pred is employed as an heuristic for the representation of journeys of patients in the village. The historical dimension of the relationship between village and hospital is addressed by drawing upon Parish Council minutes and local newspaper reports.

The thesis contains a conceptual investigation of public anxieties concerning mental disorder, an overview and discussion of the contemporary relevance of the labelling perspective, and a review of relevant literature. In addition it provides an exploration of methodological and textual issues involved in social research.

Contents

Chapter 14: Contd.

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I am especially grateful to my two supervisors, Gabriel Newfield and Judy Heather for putting up with my often inarticulate expressions of occasionally bizarre ideas and reflexive navel gazing over many years; for their support and encouragement.

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This project could not have been carried out without the support, involvement and forbearance of Jan and Ben. I am grateful that they have not divorced me in spite of my sometimes[1] singleminded preoccupation with this thesis. To borrow a phrase from Coleridge, I trust that this has not had time to intrude upon the 'strange dream of obscure yet happy sensations' of baby Joel.

I would also like to say "thank you" to those Shenley villagers and patients, as well as Shenley Hospital staff, who helped to make this research possible. There are too many people to name them all, but in particular the assistance of Steve, a village resident, was indispensable.

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1 Jan: I think you should delete 'sometimes'.

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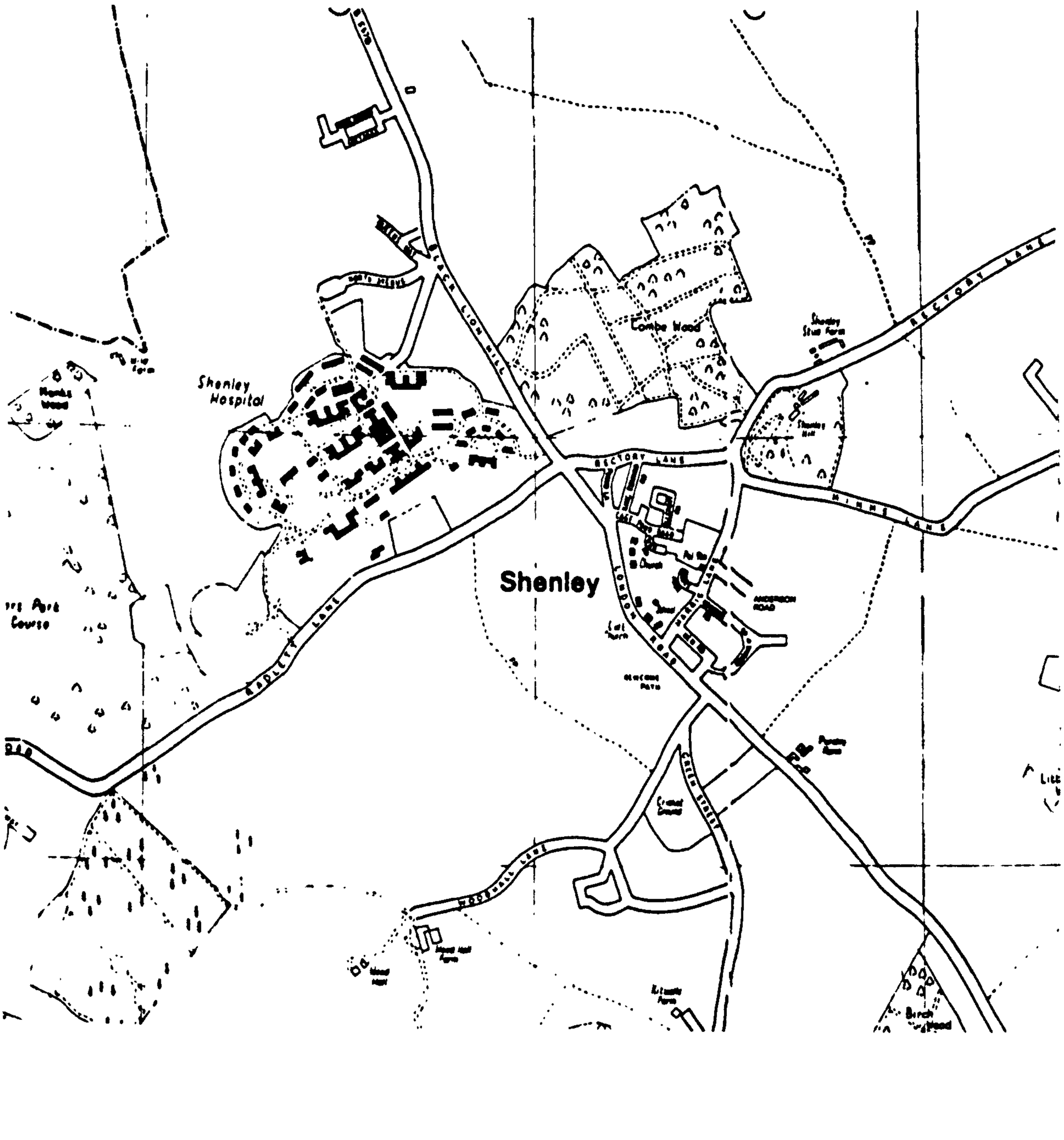
Finally, I am grateful to the late Dr John Auld of Middlesex Polytechnic for directing me onto the research path, together with Dr Lester Sireling, Richard Mitchell and staff of the Barnet Psychiatric Unit Social Work Department, for their encouragement. Corinne Mountford has provided invaluable practical and moral support, and Mike Eades kindly undertook some of the photographic work. Thanks also to Peter Cronin, Mike Eades and Dr Janice Morgan for reading and commenting on my work.

List of Illustrations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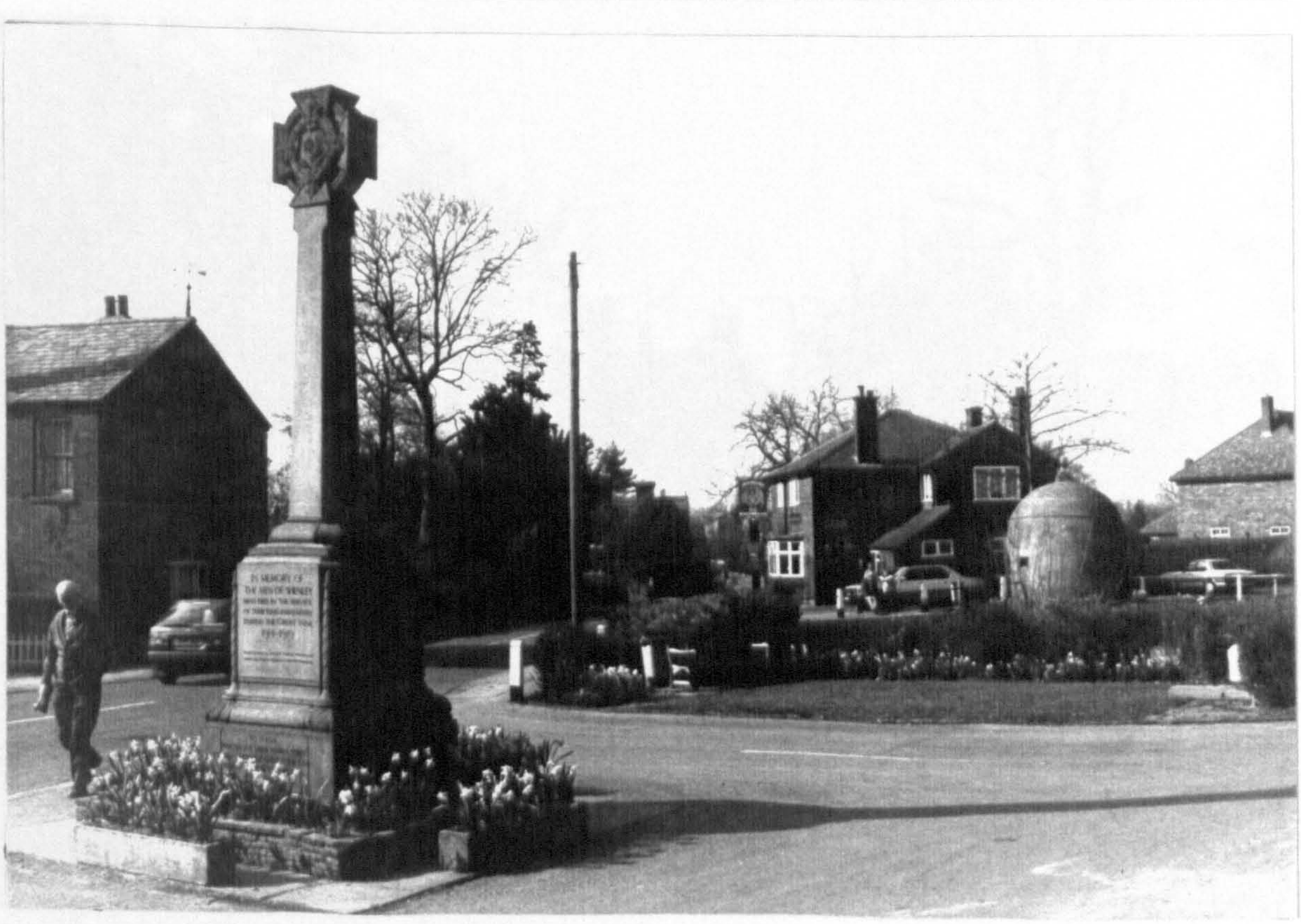

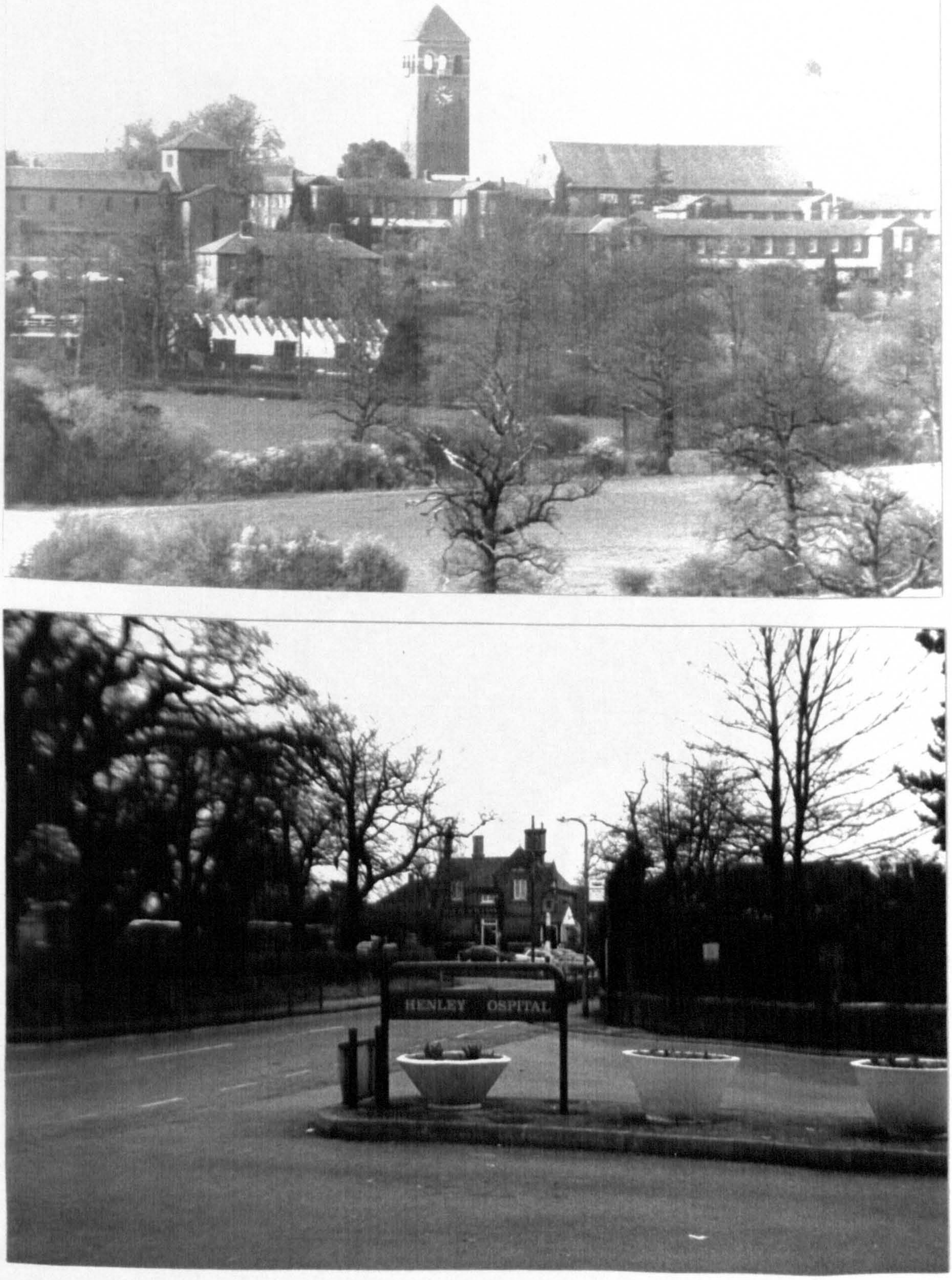
HENLEY OSPITAL

PART ONE

Chapter 1

The Career of a Research Project

Alice Schroeder, going out of her kitchen door to hang some laundry on the line, was surprised to see two strange men standing in her garden, apparently absorbed in looking at the roses. Having set her basket down, she was approaching them to ask what they wanted, when they turned towards her, and she screamed. 'Eddie! - Eddie, come *down*!' And she ran toward the house. Alice Schroeder knew mental cases when she saw them. (Patricia Highsmith, 1987 p68; *Tales of Natural and Unnatural Catastrophes*)

Background and Rationale

This study sets out to examine the nature of public reactions to people who are, or who have been, patients in a psychiatric hospital[1]. It concerns a particular place, Shenley village, and its mental hospital.

The general rationale for this project has derived from a number of related paths of interest and concern which have come

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[1] A note concerning categories: The terms 'patient', 'village' and 'villager' which are used in this thesis are terms which are used by residents of Shenley village themselves independently of discussions with me, although their meanings vary according to the argumentative context of their use. This can be clearly seen in Part Two below in my analysis of public debates, and in Appendices B and C. However my concern about the possibility of reinforcing stereotypical reactions has also led me to speak here of 'people who are patients', as well as 'patients'.

to intersect, as it were, at a particular place. They have been both theoretical and practical. Employed for some fifteen years as a social worker in a North-London Department of Psychiatry which has operated a community and crisis intervention service, I have spent many hours attempting to divert people away from psychiatric hospital admission in the belief that such admissions are not always in the best interest of the prospective patient. This service grew largely out of the work and energy of the psychiatrist R.D.Scott (see e.g. Scott 1973a, 1973b, 1974, 1975, 1979, 1980, 1990[2]. See also Baruch and Treacher 1978, Cohen 1988 and Johnstone 1989 for references to Scott's work) but also drew momentum from the 'anti-psychiatry' movement as a whole.

One of Scott's fundamental premises was that psychiatric hospitalization could result in what he called the 'closure' of highly charged emotional issues for the patient and his or her family. The conflicts which gave rise or contributed to the emotional distress would become buried on admission to hospital under the symbolic baggage of 'mental illness'. Such an approach has hinged upon a particular view of public knowledge and ideas about mental disorder, and public responses to psychiatric hospitalisation, while Scott's notion of the discourse of 'psychiatric space' might be said to have coincided, albeit unsystematically and perhaps unconsciously, with some of the 'post-modern' considerations of space and place (see Scott 1979, Foucault 1977, 1980, Soja 1989, and ch 8 of this thesis). From Scott's perspective the implication for practice entails challenging wherever possible the instantiation of stereotypical ideas by reframing the problem in non-illness terms. This practice has kept alive to some

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[2] For details of some of Scott's collaborative works see the bibliography.

extent the memory of an early provocative labelling perspective (e.g. Scheff 1966, Rosenhan 1973).

The second impetus has come more directly from sociology via the work of Thomas Scheff, David Rosenhan and Erving Goffman. In particular the audacity of Rosenhan's (1973) celebrated research stimulated the methodological imagination, although he was not the first to utilize the 'pseudo-patient' method (see e.g. Caudill et al 1952, Deane 1961, Goldman et al 1970, Lofland and Lejeune 1960), while Scheff provided clear proposals for further studies. To some extent this project can be seen as being concerned with a critical examination of Scheff's seventh proposition, that 'Labeled deviants are punished when they attempt the return to conventional roles' (1966, p87), although it draws upon a very different philosophical and social-theoretical background[3]. Goffman of course was the author of seminal works on stigma and the mental hospital and has written widely on the 'situational improprieties' of mental disorder.

The study of public reactions to people who are or who have been patients in a psychiatric hospital appears to be particularly relevant in an historical climate in which far reaching decisions are being made about *where* many such people should be living. In spite of opposition (Bartlett 1989, Dobson 1990, MIND 1989, Morris 1988, The Times 1987), the closure of the old Victorian mental hospitals continues, with consequences which may be no less significant than the iconographic and emblematic event of Pinel's striking of the chains from the prisoner-patients of Bicêtre, or the redesignation of the leprosaria, in Foucault's scheme of things. The 'public', it

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[3] I do not view this research as a 'test' of Scheff's proposition, as in more positivistic social science. That the issues here are complex will be shown below.

seems, is destined to have more contact with people who are, or who have been, designated as mentally disordered, and this study sets out to contribute to an understanding of the reception faced by people who are former patients in the community. At the same time it may be seen as akin to an anthropological study of an imminently extinct culture, focusing as it does on a village where the nearby psychiatric hospital is on the verge of being dismantled and its land sold off for redevelopment.

Fourthly my concern rests with an interest in the philosophical discourses of modernity, to use Habermas' phrase, as they pertain in particular to the methods of the social sciences, and how these discourses articulate in certain respects with madness. I have drawn throughout the thesis upon the work of Habermas in an effort to examine how his theory of communicative action and rationality may relate to madness, empirical research and social scientific methodology[4].

Finally, I must admit to an interest in the socio-psychiatric reality of a particular place established over many years of commuting through it and by the occasional use of its public houses. One day when seated quietly in a pub I was asked jokingly by men at a nearby table whether I was 'one of them' from the hospital. I subsequently came to think of the hospital-village as constituting an interface between madness and sanity and became interested to know how villagers and patients inter-related; how villagers told the difference between patients and others, and whether this was an important issue for them. At the same time I have seen this research

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[4] This is difficult not least because as Habermas makes clear (e.g. 1982 pxiv preface to *On the Logic of the Social Sciences*, 1970/1988, and cf. 1986b p152), he does not view his theory of communicative action as a continuation of methodology.

project as an opportunity to pursue a number of theoretical issues and challenge my own professional prejudice, language and practice[5]. The more specific aims of the project are set out below.

Early Days, Different Designs

> The Heisenberg principle applied to research activities.. states that money, time and suitable themes for research can never be present at the same time...(Sartorius 1977 p179.)

The current project began its life in a different form, with a different design. The first protocol had the objective of focusing solely upon audience responses to *former* psychiatric patients who displayed no behavioural or other signs which could be construed as indicative of mental disorder. Initially it was intended to recruit a research assistant to play the part of a pseudo-patient. The plan was that the researcher and assistant would independently join a local social club and that after a three month period a disclosure would be made to members of the club to the effect that the research assistant had been a patient in a psychiatric hospital. The role of the researcher was to monitor preceding and subsequent events and later to carry out in-depth interviews with club members, with the aim of investigating responses and the reasons for such responses towards a person who carried a psychiatric label. To this end the researcher conducted a limited pilot study by disclosing himself as a 'former psychiatric patient' to the secretary of a political party of which he was a member and for which he was due to stand as a prospective candidate at a forthcoming local election.

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[5] See Edelman's (1974) astute article concerning the political nature of psychiatric professional discourse.

This initial research design was finally abandoned following the failure to procure sufficient funding to pay for a suitable research assistant, coupled with increasing misgivings about the ethics of a program of deception (for discussion concerning such issues see e.g. Bulmer 1982, Duster et al 1979, Homan 1980, 1991). It was subsequently decided to pursue a broadly similar idea but by employing someone who had actually been a patient in a psychiatric hospital, rather than a pseudo-patient, and by offering expenses rather than a salary; deception would thereby be reduced substantially. The position was advertised in the local press, Time Out and City Limits, and a number of responses were obtained mainly from local people. The researcher then met the selected candidate regularly over a period of several months when the anticipated stressful nature[6] of the task was discussed and plans were finally drawn up to begin the fieldwork. The prospective research assistant was interviewed by a psychiatrist to gain a further opinion as to the extent of her vulnerability and it was decided that it might also be helpful to introduce her to the researcher's principal supervisor. This design then proceeded more or less according to plan until the point of engaging in fieldwork when the research assistant unexpectedly dropped out of the project. As a result the design was then abandoned. After almost a year of preparation and hard work

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[6] The literature warns that fieldwork is a stressful endeavour (see e.g. Clarke 1975, Hammersley and Atkinson 1983, Johnson 1975, Lofland and Lofland 1971/1984, Shaffir et al 1980). Indeed sociological fieldwork and mental disorder have been directly linked in a causal sense by virtue of the inherent ambiguity of the role of participant-observer. Clarke (1975) provides an account of how sociologist J.R.Seeley underwent psychoanalysis as a result of a research project and quotes anecdotal evidence of the psychiatric hospitalisation of an anthropologist during fieldwork. As Clarke points out, Lurie's (1967/1987) fictional account of sociological fieldwork, in which the researcher goes mad, may indeed be not always so far from fact.

this was inevitably dispiriting for the researcher who was faced with the task of reformulating the entire project.

The third and final design is different in many respects to the first two and to some extent addresses different questions. Fundamentally there has been a shift in focus away from an analysis of responses to a 'former psychiatric patient', who displayed no symptomatology, to a study of a particular social and geographical location in which people who are both former and extant psychiatric patients come into regular contact with members of the public[7]. However, in lieu of previous obstacles, new hurdles appeared to take their place, including an exceptionally slow and cautious Health Authority Ethics Committee[8]. Some of these difficulties will be discussed below.

Before moving on to consider the precise design and its problems in more detail, the sociological 'problem' which this project sets out to address and the context of the problem are set out briefly here.

Aims and Present Design

In its broadest sense the present study was initially organised around a critical examination of the proposition that people who are or who have been patients in a psychiatric hospital are

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[7] In addition, the present project did not depend upon procuring the services of a research assistant nor upon obtaining funding for such a post, although I have gratefully received some financial and material support from the Social Workers' Educational Trust, Hatfield Polytechnic, and Napsbury Hospital. Such assistance has been welcome not least because of my change to the status of part-time employee in order to pursue the research.

[8] It took me approximately one year to gain Parkside Health Authority Ethics Committee approval to interview people who were patients at Shenley hospital. I also had to gain the consent of the Polytechnic Ethics Committee for the project as a whole.

discriminated against and stigmatised by others; that they are excluded, devalued, and discredited.

Organised in part around a participant-observation study of the relationships in a local community between people who have been, or still are, patients in a nearby psychiatric hospital who regularly go into the local village for various reasons, and other local people, it has some loose similarities to the programmes carried out by Roosens (1979) and colleagues in Geel, Belgium, and especially Jodelet (1991[9], and cf. Cumming and Cumming 1957, Estroff 1981a, Kielhofner 1981, Scheper-Hughes 1987, Stoneall and Schmitt 1984).

The principal aim of the project has therefore been to provide a critical description[10] of the local practices of villagers in relation to people who were patients at the nearby hospital. To what extent, I wished to know, were patients discriminated against by the local population? What were the discursive and

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9 I only came across Jodelet's work recently (late 1991). Some of its content and description bear quite a remarkable resemblance to my own although her analytic methods are not the same and her theoretical base is essentially Durkheimian. The focus in social psychology upon 'social representations' (see e.g. Farr and Moscovici 1984, Herzlich 1973) has received critique from Potter and Wetherell (1987) and Billig (1991) amongst others.

10 The research is primarily descriptive, although not in a simple sense. I do not directly provide a causal analysis of those factors which predispose villagers to respond in one way rather than another, although causal links may be implicit in Part Two. A substantial part of the project however concerns those often delicate and dilemmatic themes which run through villagers' talk, and which I suggest illuminate areas where villagers' practices in relation to patients may be highlighted and opened out in further debate. In this sense the research is a critical project. At the same time I also subscribe to the notion that all description has a critical moment and all interpretation is an intervention of sorts (cf. Giddens 1984 p338, Habermas 1984, Thompson 1984 p141). However my use of the term 'critical' will be further elaborated below.

extra-discursive practices used by local people to either sustain, amplify or minimise difference between themselves and those others who were psychiatric patients?

At the same time however I set out to find out how people who were patients went about describing and accounting for the responses of the village residents. To this end I conducted semi-structured interviews with a number of patients who were identified by staff and villagers as frequenting the village, although I also met with many of these patients on numerous other occasions.

My aim has therefore been to thematise stigma and discrimination; to look at what it might mean to try to identify it in this place, to look at what might possibly count as discrimination; and to open up and extend the discourse and debate about mental disorder, psychiatry and stigma. In addition the research project has documented the impact upon the local community of the closure of its hospital. The land is in the process of being sold. Buildings have already been demolished, road layouts altered, and new pavements laid.

To achieve these aims I set out over an eighteen month period to take part (on a part-time basis) in local activities. Attending jumble sales, bazaars, school and village fêtes, shopping at the local store, drinking in the pubs, attending Parish Council and village society meetings etc; these activities were supplemented with more formal semi-structured interviews with villagers which were tape-recorded, drawing upon my experiences within the village to stimulate discussion and debate[11]. In addition I collected a large amount of documentary material from local newspapers and village

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[11] Details of the number of villagers interviewed are provided in chapter 13.

magazines, Parish Council minutes, hospital Management Committee minutes, and other information contained in the hospital archives (and see chapter 6 below).

Partly to assist me in an initial assumption deriving from studies of racial prejudice (e.g. Billig, Condor, Edwards, Gane, Middleton and Radley 1988, Gumperz (ed) 1982, van Dijk 1984) that discrimination may be a largely 'hidden process' (Jupp et al 1982) and have an often subtle linguistic dimension which may reinforce or alleviate social difference and distance, I have drawn upon a particular form of discourse analysis advocated by, *inter alios*, Potter and Wetherell (1987), and Gilbert and Mulkay (1982, 1983, 1984) (and see also Billig 1987, 1989, Billig et al 1988, Mulkay and Gilbert 1982, Potter and Reicher 1987, Wetherell and Potter 1988, 1989). In the following pages I shall outline this particular approach and demonstrate how it might be drawn upon productively as a complement to ethnographic work. I shall also consider briefly some of the theoretical and methodological problems of combining this form of discourse analysis with ethnography.

It may be prudent at this point to be explicit about what the research is *not* about. The focus is upon the village and villagers' reactions, both discursive and extra-discursive, to patients. It is not *primarily* about the quality of life of patients, their hopes and fears, the appropriateness or otherwise of community care, patients needs and health and so on, although it touches upon all of these[12]. As part of the

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12 The literature on these issues is extensive. For overviews and discussions see e.g. Brown (1985), Busfield (1986), Estroff (1981a, 1981b), Test and Stein (1978, 1980), Tomlinson (1991), Tudor (1990/1). For research of the views, experiences, quality of life and health of former patients in Britain see e.g. Abrahamson and Brenner (1982), Barham and Hayward (1991), Goldie (1988), Leff (1990), Petch (1990), Prior (1991). For an account of the Maudsley study of a community based approach to 'serious mental illness'

research method I have asked people who are patients for their experiences of, and views about, the village. But the focus nevertheless remains upon the responses of villagers, although Appendix D provides some space for the presentation of patients' views[13].

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see Marks and Connolly (1988). Knapp et al (1990) discuss the financial costs of community care.

13 For a description of the structure of Parts Two and Three of the thesis, and Appendix D, see chapter 6 below, especially pages 130-133.

Chapter 2

Changing Times: Re-establishing a Dialogue with Madness

Explorations

I set out in this chapter to provide a short introduction to ways of thinking about madness[1]. In the process I attempt to set the scene for an exploration of what it might be in practice about madness and the idea of madness in our society which is both unsettling and intriguing.

Madness and its synonyms is of perennial and enduring interest to mankind. Its themes, specifications and particulars are to be found not only in comparatively recent form in the annals of psychiatry but in the popular and local press, cinema, television, literature and drama (see e.g. Adlam 1990, Doherty and Young 1978, Domino 1983, Feder 1980, Felman 1985, Gardner 1982, Gerbner 1980, Janik and Kubickova 1975, 1976, Schneider 1977, Stumme 1973, Wahl and Roth 1982, Welsford 1935, Winick 1978, 1982, as well as Nunnally 1961 and Scheff 1966). Its figures have recurred in historical debate and philosophical argument, in intellectual and practical life from antiquity to the present (see especially Rosen 1968, also Bynum et al (eds) 1985, Clarke 1975, Doerner 1981, MacDonald 1981, Scull 1979,

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[1] In other words I do not attempt to offer here a comprehensive overview of models of madness. I am concerned here less with psychiatric-scientific models than with philosophical, sociological and historical approaches.

Skultans 1979). The histories of madness are not smooth however but often replete with competing images which are bound to competing philosophies, models of human nature and theories of history itself. The iconoclasm of Foucault (1961/1971) and later the work of Scull (1977, 1979) dealt a blow to uncritical, 'triumphalist' histories (Ingleby 1985 p81, Pilgrim 1990). Foucault's ideas concerning the relationship between a nascent Reason and its 'other' have had wide currency. For Foucault it was as if Newtonian physics and Cartesian rationalism required the sole sovereignty of reason and the 'consequent expulsion of anything that constituted a threat to its rule as a necessary condition of their birth' (Sheridan 1980 p13)[2]. The themes here are of subjugation and the end of a dialectical conception of madness (Cohen 1978). For Foucault (1961/1971 p68), 'Classicism felt a shame in the presence of the inhuman that the Renaissance had never experienced.' The Age of Reason in this version ushered in the end of men's communication and dialogue with madness as *déraison*, unreason (Radden 1985 p53). Where the madman in the 'preclassical' period once reminded each man of his truth (Foucault 1961/1971 p14), the language of psychiatry, a monologue of reason about madness, has become established on the basis of a broken dialogue, upon silence (ibid pxi, p262).

In recent years Foucault's version of events has been challenged[3]. Sedgwick (1982a) has pointed not just to the myth of the 'Narrenschiffen' but to a large variety of medieval

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[2] Compare Peter Ackroyd's (1986) brooding novel about Nicholas Hawksmoor, buried incidentally at Shenley, in which he portrays the sense of disjunction between the incipient rationalism of experiment, demonstration and calculus, and the mysteries and madness.

[3] Although as Boyne (1990 p5) points out, the force of Foucault's demonstration that our understanding of madness is shaped by a variety of social, political, economic and epistemological factors cannot be disputed.

sources which suggest that the mentally afflicted were regarded as 'ill' within a medical framework and had been confined in custody or therapy in pre-rationalist Europe for centuries before the 'Great Confinement' (Sedgwick 1982a p134. See also Jones and Fowles 1984, Merquior 1985, Midelfort 1980, Porter 1987/1990 ch 1). From Sedgwick's perspective the notion of a dialogue with madness may be a useful counterpart to our modern ways of dismissing mad people, but is unlikely to encounter much historical evidence other than that of 'an intelligentsia which has always preferred to toy with 'madness' as a literary or artistic spectacle rather than to re-arrange society's dealings with the common insane who live outside the safe distance of a poem, a tract, or a painting' (1982a p136).

That the issues here can be complex is shown by Skultans (1979) who has argued that beliefs about madness in any historical period may be contradictory and often conflict with practice. She traces the dual structure or 'double aspect' of madness in Elizabethan England, the contradictory opposition of bestiality, a fearful and incomprehensible force to be kept in subjection by physical brutality, with reconstituted Aristotelian notions of melancholic madness as poetic inspiration and wit (ibid ch 2). MacDonald (1981) has argued that early seventeenth century explanations and treatments were marked by a 'traditional mingling of magical, religious and scientific concepts' (p7). And if Horwitz (1982 p19) is correct, most societies distinguish two major categories of mental disorder: nonviolent eccentricities and violent forms of madness, although the precise form which these categories take varies culturally and historically (and cf. Marsella and White (eds) 1982/1989, Rosen 1968, Scull 1979 p64 *ff*, Platt and Diamond 1965).

Returning to the present day, the somewhat disembodied and abstract characterisation of madness which Foucault offers has been explicitly countered by Giddens who opposes the notion of a 'living, voluble and anxious madness'[4] with a model based on the chronicity and predictability of everyday routines. These maintain the essential ontological security of actors and at the same time underlie the constitution of structure and institution. It is therefore in the disruption of routine (cf. Bury 1980) that an indication and potential understanding of madness lies; in the disruption of the socialised responses associated with the security of the management of the body and a predictable framework of life. The mad person is portrayed as either lacking the social skills needed to manage everyday unmotivated life, or as challenging everyday routines[5]. In contradistinction to Foucault, and drawing upon the work of Goffman, Giddens identifies an understanding of madness not in terms of the 'other face of reason', not in the extravagance of delusion or visions of other worlds, but in '...much more mundane features of bodily and gestural impropriety. Social disability, not a mysterious access to a lost continent of unreason may express its real nature' (1984 p158). On this reading mental disorder can be seen as a kind of social grit in the wheels of chronic and routine interaction.

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[4] Although Foucault is intent upon detailing the way in which madness is a social 'construction' there is a arguably a residue in *Madness and Civilization* in which he attempts to evoke some sense of the 'ultimate truth' or the 'underlying reality' of madness (Bernauer 1987, Gutting 1989 p265, Boyne 1990 and Appendix D). In the following pages it becomes clear that what is often at issue is the 'universal' 'nature' of madness. In this thesis I attempt to locate a 'grounding' for critique in formal pragmatics.

[5] Compare Garfinkel's (1967) students, who disturbed the sense of ontological security of their subjects by undermining the intelligibility of discourse, intelligibility anchored in the routinisation of practices.

Madness, then, is as much at home in the front room as it is in the formalised schema and battles for reason (cf. Ford 1975 ch8). In a mundane sense madness returns in the routines of everyday life. This impression of the undistinguished and commonplace is portrayed in the work of a number of other authors who share a common concern with the intelligibility of action, such as MacIntyre (1981), Horwitz (1982), Coulter (1973, 1979), Ingleby (1982, 1985) and Morgan (1975). I have said more about this debate elsewhere (Southgate 1992c), but for now will briefly track the arguments of Horwitz (1982) for the light they may later shed upon empirical research.

For Horwitz (1982 p19) there is an inevitable association between incomprehensibility and unpredictability, and between the latter and dangerousness. If we cannot understand another, the argument goes, then we cannot predict the other's behaviour and this poses a fundamental threat to our security. There exists a link here with the notion of routinisation as grounding the ontological security of actors which I have identified in the work of Giddens. From this overall perspective we can see that the idea of mad people as dangerous, although often reinforced by media accounts, may not achieve its credibility from such accounts alone, but from the disruption of the very structures of language and social action which madness may entail.

This argument initially appears to have merit. But on closer inspection the sequence 'incomprehensibility, unpredictability, dangerousness' turns out to be too simple. It is for example quite possible to imagine someone who appears on the surface to be unintelligible in terms of their behaviour or language but whom we may nevertheless come to see as quite predictable; someone for example who refuses to leave their bed or venture outdoors. Similarly unpredictability may be of such a minor

nature that it poses no threat at all. At the same time Alisdair MacIntyre (1981 ch8) has argued that both predictability and unpredictability are necessary if life is to have meaning (and compare Shotter 1989). Whereas predictability is associated with the coordination of social action, the construction of plans and projects, unpredictability is related to our desire to be in possession of ourselves, to preserve our independence, freedom and creativity, to be not merely the creations of the projects or intentions of others. We are, he argues, therefore involved in a world in which we are simultaneously trying to render the rest of society predictable and ourselves unpredictable (ibid p104)[6]. Unpredictability then can be seen as generative of power in relationships and an ordinary and acknowledged feature of human life. Mental disorder it seems cannot therefore be readily reduced to unpredictability, although the latter may be rendered as one aspect of it[7].

Throughout the preceding admittedly bald outline of interests in madness a particular theme continually resurfaces. This is the sense in which madness is portrayed as partaking of something which is less (or more, e.g. Connor 1982/89, Screech

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[6] The use of unpredictability can be explicitly found in the realm of psychiatric therapy. By rendering one's actions systematically unpredictable it is arguably possible for the therapist to gain power in an ostensibly therapeutic situation in which the impetus has been lost to the patient (see e.g. Birch 1985).

[7] Alternatively we may say that although unpredictability is a necessary and ubiquitous feature of everyday life, with positive and creative features, that of the mentally disordered is of a particular type which is generally unacceptable to others. In other words issues of normative rightness surround '(un)predictability' as an identifying concept for mental disorder. As an empirical issue the alleged dangerousness of people who are considered to be mentally disordered has received attention both in terms of the amount of reported violent activity and in terms of people's opinions and attitudes towards present and former patients. This research is discussed below.

1985) than human, as sinking below the human horizon. The fashions of viewing the insane, we might say, are linked to the moral temper of the particular age, so that the description of an *illness* often incorporates characteristics opposed to those of the contemporary human ideal (Jahoda 1958, Porter 1987, Sedgwick 1982a, Skultans 1979 p140). The view of the insane as less than human can be traced as I have shown in the accounts of antiquity but also in more recent writings. The identification of madness with unintelligibility for example may tend to reduce and push mad people to an uncomfortable position on the edge of a common humanity (cf. Barham 1984 p199, Barham and Hayward 1991 ch3). And there is a link here perhaps between the criterion of unintelligibility and the cessation of dialogue with madness of which Foucault writes, for dialogue depends it seems upon a comprehensibility, lying somewhere between speaker and listener.

In a recent book Roy Porter (1987) addresses the issue of a colloquy with madness. Although he is intent here upon encouraging dialogue by providing accounts of what mad people have had to say, rather than 'explaining away' what they said, Porter appears uninterested in looking at the implications for any future discourse of contemporary policies of deinstitutionalisation. For Cohen (1978) on the other hand, the latter provides an important opportunity to reconsider the dialectic between madness and sanity, to explore the potential benefits of a communication with madness and to begin to recognise once more that people whom we consider to be mentally disordered have social value (and see Barham and Hayward 1991, Doyle 1989, Lewis et al 1989, Tudor 1990/91). Peter Barham (1984) has pointed to the way that 'chronic' psychiatric

patients may focus the question of the 'bounds of community'[8], but as much as the patient it is arguably the whole complex process of deinstitutionalisation which is of vital importance.

The Bounds of Community

A certain nostalgia for 'community', an iconography of Gemeinschaft, has been a recurring theme in human history (Cohen 1985/1987 p118, Ignatieff 1984). This picture of the 'genuine' community contains images of sharing, commitment, intimacy, stability, mutual aid and a sense of belonging. One irony here as Gordon (1987, and see also Rosenblatt and Mayer 1974) has pointed out is that for many psychiatric patients and also staff this is just what the old asylum has been providing. The process of decarceration may for many mean the loss of a sense of 'community'. Whatever the reasons for this process of closure, whether it is best analysable in terms of political-economy and its critique, humanitarian reform, or medico-scientific progress or hegemony, it seems unlikely that it is the result of greater acceptance or toleration by the public (cf. Scull 1977 and Unsworth 1987 for an account of the involvement of MIND in mental health reform).

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[8] Barham (1984 p199) cleverly describes the place of the 'chronic schizophrenic patient' by drawing out the multi-faceted nature of the phrase, 'the edge of the common': 'The schizophrenic, it may be said, resides at the edge of the common. Common refers in one form of usage to the life that we may think of ourselves as holding in common, to (as is sometimes said) the common conditions of our lives; yet also in an opposing sense 'the common' is the effect of a history of division and enclosure, the residue of a common estate over which we all of us have rights but that is at the same time 'wasteland'; and common finally is seen as the low and the vulgar, as the converse of the civilised. The edge of the common is stipulated not only because, in the various senses of common, that is where the schizophrenic has so often been put, but also because he focuses sharply the whole question of the bounds of community.'

In *Museums of Madness,* Scull makes the point that from the moment of their existence asylums reduced people's tolerance for deviance, that people became less willing to put up with inconvenience and troublesome relatives (p240). As a corollary we might ask whether, with the demise of the asylum, people will consequently become more tolerant of mentally disordered people. Clearly however 'toleration' cannot simply be measured from hospital in-patient statistics. We are just as likely to see rejection, exclusion and exploitation, the latter being linked in the present economic and political conditions to the increasing privatisation and commodification of problems and people (Brindle 1990, Cohen 1985/1987 p63, Kovel 1981, Scull 1981, Spitzer 1980, Shadish 1989)[9].

But in addition to the process of decarceration, the historical canvas may be filled out by the much broader strokes of political economy. One argument which makes a certain amount of intuitive sense is that public tolerance of marginal groups is likely to increase during periods of economic expansion (cf. Scott 1969, 1984 p101). The suggestion is that due to the overall decrease in the surplus labour force, employers are more willing to accept the labour of erstwhile castouts and that as a direct consequence their social value increases along with public acceptance and toleration. Although hedged with conditions, Brenner's (1973) work implicates community intolerance as a factor in the high correlation between the state of the (U.S.) economy as measured by employment levels and rates of psychiatric hospitalisation. However, Brenner's ideas have been overtaken by reality in that Britain has witnessed massive *increases* in unemployment coupled with

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[9] Whorley (1978) discusses pathways to community acceptance of psychiatric patients but in the process utilises a framework of 'social profitableness' which is consistent we might say with the formal rationality of a 'disenchanted world', although perhaps fitting for Britain at the end of the millennium.

dramatic *decreases* in psychiatric hospital populations including decreases in psychiatric first admission rates (Central Statistics Office 1987, DHSS 1985).

Community tolerance cannot therefore be read off in any deterministic sense from either in-patient statistics or economic indicators. Similarly with changing policies concerning hospital admission, decreased in-patient admission rates lose any claim to represent overall rates of emotional or psychiatric distress in society.

In the following portrayal of a Hertfordshire village community, I attempt wherever possible to depict the interrelation between action and structure, lifeworld and system. I show that the relationship between village and hospital has changed over time especially in the recent context of the hospital's planned demise. Many villagers have opposed the closure of the hospital and yet at the same time retain an ambivalence towards people who are patients. For these villagers the bounds of community are indeed being tested, not now by an influx of patients but by their loss, or perhaps more precisely the loss of the hospital, and a proposed massive influx of housing estate residents. The presence of both hospital and patients has arguably contributed to a sense of local identity, to that which has made Shenley a 'special place' for its residents, in addition to its rural nature and proximity to the capital. I will show how this is reflected in the way that some villager talk displays a corporate identity in which hospital and village become merged. And in Part Three I also track the parameters of the dilemmatic nature of villagers' responses in relation to the interpretative repertoires and discursive methods which they use to talk about people who are patients. Several themes of the above debates concerning the nature of mental disorder re-emerge here. In

Appendix D the issues raised above concerning a dialogue with madness meet head on with a dialogic orientation to social research.

Chapter 3

The Place of Stigma and Labelling

Whither Labelling?

As I have suggested above, the labelling perspective in psychiatry depends upon an assumption of negative public responses to patients, responses which provide the basis for a symbolic reorganisation of self and a stabilised patient career (e.g. Lemert 1951, Goffman 1961/68, Scheff 1966[1]). As I will go on to show in a review of the literature (chapter 4), the available empirical evidence is equivocal with regard to public reactions to people who are, or who have been, psychiatric patients and that evidence which does exist is predominantly American and based upon sometimes questionable methods.

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1 The clear, systematic and propositional work of Scheff (1966, 1975) achieved respect (Matza 1968, Pearson 1975) and also notoriety. Allegations of a host of '-isms' have now all but buried Scheff's prototypical version; from decontextualism (Coulter 1973, Warren and Johnson 1972) and abstractionism (Taylor et al 1973, 1974), to reductionism (Matza 1968), positivism and determinism (Plummer 1974, 1979) not to mention immanent logical inconsistency (Mankoff 1971) and a disregard for self-labelling and 'emotional deviance' (Mankoff 1971, Pugliesi 1987, Thoits 1985 and cf. Rotenberg 1974). In the early form presented by Scheff (1966) the labelling perspective appears largely untenable (see Southgate 1982b for further discussion of Scheff's work). However this does not mean that labelling is irrelevant. I suggest following Plummer (1974, 1979) that the labelling position is most usefully conceived of as a perspective rather than a theory, the core problems of which concern the nature, emergence, application and consequences of labels. The work of Emerson and Messinger (1977) has been drawn upon in chapter 9 below.

However, this project is not directly concerned with the whole labelling process, nor with the initial construction of patient identities, although it has implications for both. The patients in this study are already in-patients, already abstracted from home or family, or else they have been discharged into a mental health community care resource close to the village.

On the other hand it is a tenet of this project that public responses to patients and former patients are likely to be an important factor in the successful 'rehabilitation' of such people. From my position, people who are long-stay patients (and others) may in the right circumstances be able, to a significant degree, to throw off their symptomatology and their patient identities. Cross-cultural studies focusing on psychotic conditions, in particular schizophrenia[2], have shown that the presence or absence of stigmatising responses and imagery may be significant factors here (Ciompi 1980, Horwitz 1982, Kirmayer 1989, Lefley 1985, Murphy and Raman 1971, Warner 1985 ch 7, Waxler 1974, 1979[3] and cf. Prudo and Blum 1987, Sartorius et al 1986, W.H.O. 1979), while many psychiatrists acknowledge the importance of 'environmental' and social factors in the alleviation of positive and negative symptoms of schizophrenia (see e.g. Kendell and Zealley 1973/83, Strauss et al 1989, Wing 1989)[4].

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[2] I continue to be unhappy about the use of the concept 'schizophrenia'. For some of the debates see Bannister (1968), Ciompi (1984), Coulter (1973), Harvey (1987), Hill (1983), and more recently Bentall et al (1988), and Bentall (ed) 1990.

[3] For a contrasting view see Murphy (1976), and for criticisms of her work see White (1982 p72).

[4] See also Southgate (1982a) for an account of the rather positivistic work on 'expressed emotion' and relapse in schizophrenia, and Falloon (1988) for an overview of the literature. Greenley (1986) has theorised 'expressed emotion' in terms of familial social control.

In the more local terms of this project, the possibility cannot be ruled out that some patient behaviours may arise as a response to audience reactions, so that exclusion by villagers might for example contribute to social withdrawal or a show of disdain or anger by the patient, which might then serve to confirm to the audience that their original grounds for exclusion were legitimate.

Nevertheless the *refined* labelling perspective does not purport to provide the complete explanation for stabilised mental disorder (Plummer 1974, 1979, West 1985)[5]. My own position is that although madness may be conceptualised at different times by different people in different cultures, for various purposes and in a variety of ways, that it may be in this sense discursively 'constructed'[6], it is nevertheless arguably the

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5 In 1982, Sedgwick (1982a) proposed that labelling 'theory' was defunct and morally bankrupt. Nevertheless it continues to be given sympathetic if not unambiguously enthusiastic book-space (cf. Busfield 1986, Cochrane 1983, Gerhardt and Wadsworth 1985, Miles 1981/1987, 1988, Ussher 1991). It has since received theoretical consideration within anthropology (Raybeck 1988), 'courted' by attribution theory (Howard and Levinson 1985) and 'modified' by Bruce Link and collaborators (e.g. 1989, 1990). Moreover, some recent and interesting work by Scheff (1987, 1988, 1989), Retzinger (1989), Scheff and Retzinger (1991) and Lewis (ed) (1987), has once more implicated labelling in the causal process of mental disorder, via the extension and magnification of intrapsychic shame. In this way, perhaps, the transition from primary to secondary deviance becomes more credible. At any rate Sedgwick's pronouncement of the death of labelling 'theory' (and see also Gove 1982 p295) has proven to be premature.

6 Although the social-constructionist view might be seen to draw upon 'interpretative' models such as symbolic interactionism or ethnomethodology, this perspective does not exclude 'structurally' oriented sociologies. Marxian critiques for example provide explicit accounts (e.g. Leonard 1984, Phillipson 1982) while of course 'man' for Marx did construct 'his' own history. In fact it can be argued that most sociology is about 'social construction' in one way or other. The issue, I suggest, is not *whether* reality is socially constructed but rather *how* this is achieved historically and geographically. For recent accounts of the return to Mead of the constructionist view in social-psychology see e.g. Gergen (1985),

case that the validity claims which may be raised or appealed to in any debate concerning the rationality or otherwise of a practice, behaviour or argument may be specifiable universally at a formal level. That it may be possible, in other words, to theoretically 'ground' the relativist conception which societal reaction theory introduced into the theory of deviance. How far the 'something' of 'madness' or 'mental disorder' may be usefully understood in terms of a model of formal pragmatics which may in certain respects subsume or complement the analyses of previous sociological observers such as Goffman, Scheff, Horwitz and Coulter, *and* in a manner which is directly concerned with systematically asymmetrical relations of power in the ascription process, is a question I have addressed elsewhere (Southgate 1992c). This in turn does not imply that everyday lay and professional ascriptions are or may be unproblematic or straightforward, only that formal procedures are discernable through which such decisions come to be made.

In addition, it is my view that people play a part in what happens to them, that madness may have meaning and method and be perceived as having short or long term consequences of a positive kind (see for example Braginsky et al 1969, 1976), that the '...actor is always endowed with some degree of consciousness about the likelihood and consequences of reaction against him...' (Taylor et al 1973 p276). To the extent that lifeworld understandings are shared, then *contra* Becker (1963 p9), most deviance *is* a quality of the act (ibid p147)[7].

Gergen and Davis (1985), Shotter and Gergen (1989). Kitzinger (1987) provides a good example of how social constructionism is becoming increasingly linked to rhetoric. Compare also Parker (1989) and Parker and Shotter (1990).

7 Several authors have accused labelling 'theorists' of confusing sociologists' with members' versions (West 1985) and of not doing justice to ordinary members' distinctions. See also Coulter (1973

But it is also clear that the ascription of madness, mental disorder or mental illness is often the outcome of identity struggles, in which are implicated various and historically changing forms of domination within society[8]. A full theory of madness therefore requires an analysis of how the choices and resources available to people may become so limited that it can appear *as if* people *are* 'determined'. People indeed make their own history, '...but they do not make it just as they please; they do not make it under circumstances chosen by themselves..' (Marx 1852/1958 p247). An understanding of madness demands a consideration of the dialectical relationship between lifeworld

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p62), Pollner (1974a), Rains (1975). Thus, '...deviance is not construed *by members* as something conferred upon an act (or a person) - it is construed as a property of that act or person...' (Coulter ibid). As I show below, in this research I orient to accounts as both resource and topic. And for a discussion about whether mental disorder should be called 'deviance' at all, see Ingleby (1982, 1985) and cf. Busfield (1986 p104).

8 The relationship between race, gender and psychiatry has, over the past ten years or so, been increasingly subjected to examination (e.g. Allen 1986, Fernando 1989, Francis 1989a, Francis et al 1989, Holland 1990, Johnstone 1989, Littlewood and Lipsedge 1982, Loring and Powell 1988, Mercer 1986, Miles 1988, MIND 1992, Rosenfield 1982, 1984, Sashidharan 1989, Selig 1988/1991, Sheppard 1991, Showalter 1987 and Ussher 1991). Black clients for example are considered by staff to need more medication, seclusion or coercion than their white counterparts, are more often misdiagnosed (e.g. Littlewood and Lipsedge 1982, Francis et al 1989, Sashidharan 1989), and compulsorily detained with police assistance (e.g. Francis et al 1989, Rosenfield 1984). But although authors are concerned with stigma and discrimination, the labelling perspective as such often recedes into the background, the problem being located directly in the marginal status of black people in Britain and the ethnocentricism of psychiatry. At times, it seems, psychiatry and its categories would be fine if it (they) were not racist (or sexist) and did not *incorrectly* diagnose. In a critique of the normalizing impetus of transcultural psychiatry, Mercer (1986) argues 'The liberal and humane themes of the project [of transcultural psychiatry] do not reach as far as seeking a fundamental change in the nature and functions of psychiatric provision. Rather, they propose an adjustment, a modification and a reform of the ethnocentric dimensions of the clinical encounter' (p139).

and system (Habermas 1984, 1987a, Southgate 1992b). In other words I believe that people may be driven into madness (cf. Searles 1959/1965), may choose and use madness, and may also at times have the designation 'mad' unhappily, unwillingly and illegitimately thrust upon them[9].

Although the radical labelling perspective, exemplified in Scheff's early (1966) work, has become largely unacceptable as a causal theory, nevertheless the study of psychiatric *stigma* has maintained momentum (e.g. Jones et al 1984, Link and Cullen 1990, Miles 1984, 1981/1987, 1988, and see note 5, p25 above and ch 4 below) and the convergence of geography with sociology and anthropology has resulted in several recent studies concerning societal reaction (e.g. Dear and Taylor 1982, Dear and Wolch 1987, Smith and Giggs (eds) 1988).

However there is often a sense here in which stigma theory, presented as an ostensibly separate and circumscribed area of study at the end of the labelling process, achieves respectability by avoiding some of the problems which have beset the labelling perspective. While the latter for example failed to grapple adequately with the issue of the transition from primary to secondary deviance (Mankoff 1971), and appears to indicate in its crude form that there is no such thing as mental disorder without a label (cf. Akers 1967), the study of

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[9] Whether mental disorder is regarded as 'caused' by external, interpersonal, or internal forces beyond the control of the individual, or is alleged by others of that individual, or whether the person believes him or herself to be mad, the 'reality' of such disorder must still refer to the discourses which 'sustain' or at least 'mediate' it. See the realism-relativism debate in ch 5 below. The competition between madness as a 'thing in itself', and as in some way socially constructed, certainly has rhetorical and political consequences (cf. Habermas 1971) and is a theme of this thesis.

stigma can sidestep these difficulties[10]. In place of the intensely acrimonious relationship between psychiatry and 'anti-psychiatry' there is arguably an atmosphere of co-operation between psychiatry and social science. The result at any rate is that the study of stigma and discrimination remains today an often legitimate and respectable pursuit[11]. In his recent address to the Royal College of Psychiatrists, HRH The Prince of Wales, the patron of SANE, raised it as a theme[12] (1991 and see the criticisms of SANE by MIND 1989), and its consideration also informs the recent Law Commission report on mental illness and decision-making (HMSO 1991, and see also Campbell and Hegginbotham 1991). But there is a danger here, we might say, of a kind of 'social amnesia' (Jacoby 1975) in which 'mental illness' and 'stigma' become once more conceptually separated out[13] and in which labelling, as stigma, becomes a sanitised 'output-end' and psychiatry-friendly category. From this view one may happily argue that the use of

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10 Sedgwick (1982b p213-218) has implied that the restructuring of the welfare state and de-institutionalisation, as well as theoretical problems, have rendered the radical labelling perspective redundant. But this is too simple. An more adequate socio-historical analysis would need to consider the complex inter-relations between the state and political-economy, the power of psychiatric institutions to defend and define themselves and their users/patients (Castel et al 1982, Miller and Rose 1986), together with the reciprocal development of 'user groups', advocacy and patients' rights (Pilgrim 1990, Ramon and Giannichedda 1988/1991, Rogers and Pilgrim 1991, Romme and Escher 1991), as well as critiques oriented to race and gender. In turn, the discourse upon 'rights' may itself be located via an analysis of the tensions and contradictions of advanced capitalism (e.g. Gough 1979, Habermas 1976, Offe 1972, 1974, 1984, 1987).

11 Although, as I shall go on to show, there are those who deny its importance.

12 HRH even provides an etymology: *stizein (Gk), to tattoo.* 'SANE' is an acronym for 'Schizophrenia, a National Emergency'.

13 That is, concern about stigma itself has a long history as I shall show later.

a biologically-based disease model and psychiatric hospitalisation are both fine, and that the real problem lies with the public's attitudes toward mental illness, without seeing that the two are intertwined[14].

That the issue of intentionality is important in understanding public (and professional) responses to people who have become psychiatric patients will be demonstrated in later chapters. And in chapter 9 below I provide an account of the historical development of the relationship between village and hospital in which questions of identity come to the fore.

Finally, I have attempted, more directly perhaps than some 'labelling theorists', to incorporate an analysis of 'place' into the proceedings, as an essential aspect of the ongoing dialectic between social structure and agency. This is organised by way of the concepts of Pred's time-geography which is outlined in chapter 8. The concept of place is then used to provide a bridge between a participant-observation analysis and discourse analysis.

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[14] For example there are grounds for believing that the disease model might actually amplify fear and stigma. See Farina (1982), Farina, Fisher, Getter and Fischer (1978), Farina and Fischer (1982), Fischer and Farina (1979), Langer and Abelson (1974), Ommundsen and Ekeland (1978), Rothaus et al (1963), Sarbin and Mancuso (1970), Townsend (1978) and see ch 4 below especially p58. From their vignette-based study, Norman and Malla (1983) report findings which '...imply that the more a person's behaviour is perceived as "mental illness", the less likely he/she will be socially acceptable and that such behaviour is likely to be ascribed a physical etiology. Furthermore, belief in medical /physical etiology of mental illness is not positively related either to perceived prognosis for or increased social acceptability of the mentally ill.' (p48). A full analysis of stigma must therefore examine the social power relations implicated in definitions of madness and the practices of professionals and others. This involves a sociological analysis in which society (as a complex power-laden field) is given full measure rather than being 'epistemologically eliminated', to use Renaud's (1978) phrase, by scientistic psychiatry. And at the very least, one can argue, the anticipation of stigma may deter some people at the input-end of the psychiatric process from seeking or effectively accepting psychiatric help (cf. Morrison 1987, Oliver, Huxley and Butler 1989 p91-96).

The Dimensions of Stigma

Before moving on to an examination of the research literature it will be useful to consider further the concept of stigma. One of the difficulties with such research is that stigma, like labelling in general, is susceptible to a wide variety of definitions and is approached from a variety of theoretical and philosophical positions[15].

The term stigma may be used in relation to disvalued aspects, attributes, characteristics or defining features of people. Page (1984 p4), for instance, associates stigma with 'inferior attributes which are commonly regarded as major norm infractions'.

Stafford and Scott (1986) similarly see stigma as essentially normative. Devalued aspects may range from small skin blemishes to membership of particular religious, ethnic, gender or other social groups or divisions. Goffman (1963/1968 p14) identified three 'grossly different' types of stigma: a) physical deformities b) blemishes of individual character and c) 'tribal' stigmas of race, religion etc.

At the same time, stigma is used descriptively and methodologically both to refer to people's *experiences* and feelings about themselves and their condition, what Robert Page (1984 p13) and Graham Scambler (1983, 1989 p55 *ff*, and Scambler

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15 Collins English Dictionary (1986 edition) contains the peculiar definition of stigma as *inter alia: '(d)* any sign of mental deficiency or emotional upset'. One may wonder whether the inclusion of 'emotional upset' in an expression of the British 'stiff upper lip'! Also it is important to see that to study 'stigma' is to study part of the labelling process, so that stigma *is* labelling.

and Hopkins 1986, 1988) have called 'felt' stigma[16] (see also Page 1974 and West 1985), and also to the behavioural and ascription practices of others, so that we may talk of stigmatising responses or 'enacted' stigma (Scambler 1989 p56 and op cit). This raises issues about *whose* definition of stigma is to count. For example it may be that people are excluded from certain social interactions, and yet do not feel 'stigmatised', and visa versa. At what point then do we say with confidence 'there is stigma here' (cf. Stafford and Scott 1986 p79)?

The opposition between 'felt' and 'enacted' stigma is particularly important and appears in various guises throughout the literature. In relation to mental disorder it often finds expression in a dichotomy between the symbolic and the real. Whereas 'felt' stigma appears to tap into an autonomous symbolic realm unrelated to others' 'real' reactions, 'enacted' stigma refers to what other people 'really' do. The implication here is that some stigma might only exist, as it were, at the symbolic or abstract level and that in 'reality' other people might actually be tolerant, accepting and so forth, and not in practice bothered by the label '(former) psychiatric patient' at all.

Stewart Page (1974), for example, has argued that the public are generally accommodating in practice to people who have received psychiatric treatment, but that stigma 'attaches to the *concept* of mental illness' (ibid p16, and see the literature review in ch 4). Scambler's (1983, 1989) interesting

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[16] Page's definition is wider than that of Scambler. Page includes all feelings about stigma, whether warranted by 'actual' responses of others or not. For Graham Scambler on the other hand, 'felt' stigma refers to feelings of shame founded upon a sense of 'ontological inferiority', and the anxious *anticipation* of 'enacted' stigma (1983 p201).

explanation for felt stigma in relation to epilepsy rests partly upon the notion of 'stigma coaching' by parents which induces a sense of shame or fear of enacted stigma in their children (e.g. 1983, 1989 p56-7)[17]. The centrality of shame in the whole process of labelling and mental disorder is one which has been pursued in the later work of Scheff (1987, 1988, 1989 and see Lewis (ed) 1987, Retzinger 1989 and Scheff and Retzinger 1991). Similarly the empirical work of Bruce Link and colleagues, discussed in the next chapter, implicitly links shame with stigma.

To some extent, however, the attempt to frame the issue in terms which attempt to definitively pin down 'stigma', to grasp and define it, may be both reifying and misplaced because it becomes clear that what we take to be stigma and stigmatising, and who we take to be stigmatised, as well as what we take to be 'real' or 'symbolic', is an outcome of our debates and discourses, which are finally discourses of power[18]. Stigma, in other words, does not exist outside of these discourses[19]. The

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17 Nevertheless one may still ask why parents themselves feel and transmit shame if, as Scambler seems to suggest, there is little 'enacted' stigma in relation to epilepsy.

18 This dichotomy between the real and the symbolic is unstable in so far as any 'real thing' or material structure may be symbolic, while symbols we may say are real in terms of our shared understandings of them and their consequences, as well as in terms of the real material circumstances of their production. Compare Frow (1989 p204). Thus we can say that 'symbolic' stigma is intimately related to those material practices in our society upon which the hierarchy of importance of particular attributes, personal qualities and so forth is predicated. Compare ch. 2 above. The relationship between the symbolic and the real is of course a central feature of Marxian debates concerning ideology.

19 Discussing Goffman's (1963/68) identification of the central feature of the stigmatised individual's situation in life, a search for 'acceptance' (1963/68 p19), Finkelstein (1980) argues that it is nonsense 'to conceive of disabled people as dependent upon bigots and prejudiced people for "acceptance", just as it would not make sense to consider freed slaves...as dependent on their

expectations and differences which define stigma (and shame) are arguably not irremediably fixed but like illness itself, historically, culturally and contextually variable. And although there may be some attributes which appear to be universally discrediting, this makes them no less socially defined albeit in terms of norms which are widely shared (cf. Sedgwick 1982a p33). If we follow Sedgwick's lead then illness, disease, stigma and shame may *all* be seen to relate to norm infraction.

Nevertheless I have suggested above (p29-30) that stigma can be rendered compatible with biological positivism, so that the illness-object to which society responds is regarded as independent and autonomous and is confronted by a separate subject which attempts to apprehend it. It becomes clear then that the study of both stigma and the whole labelling process may partake of differing social-scientific and philosophical positions; different epistemological relationships between subject and object and different ontologies. Some of the wider philosophical issues involved here are discussed in chapter 5 below. From the perspective of Marx to that of Garfinkel, stigma is not immune from examination and scrutiny.

In its heavy form, stigma may then be said to incorporate a number of features. The full weight of stigma bears down upon the person whose membership of a particular category or group pervades most of his or her social interactions and assumes the proportions of a 'master status' (Becker 1963, Hughes 1945) with the result that the person's identity becomes, in Goffman's (1963/68) terms, spoiled. The person so stigmatised is defined in terms of that one attribute, and is devalued, discredited and/or rejected or segregated. This identity

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former oppressors for "acceptance"' (p31). For Finkelstein, Goffman is an apologist for the maintenance of relations of domination (and see Oliver 1990 p66).

exhibits a degree of permanency and becomes difficult for the person to shake off. The conceptual organisation of the stigma of mental disorder may be further illuminated by its comparison to other illnesses, and leprosy provides an interesting starting point.

The connection between madness and leprosy is a curious one. If we follow Foucault (1961/1971) it appears that their fates have been crucially linked in at least an historical and European sense. In their study of leprosy, Gussow and Tracey (1968) argued that the two are unambiguously related so that in fantasy 'the two darkest fates are to "lose one's mind" as in lunacy or to "lose one's body" as in leprosy' (p319). Both, they maintain, involve a threatened loss of self or identity. Drawing upon the work of pathologist Olaf Skinsnes who constructed a hypothetical ideal-typical worst-possible disease, the authors detail the dimensions of such a disease and compare it to leprosy[20]. The dimensions of this hypothetical disease are as follows: It would be externally manifest; be progressively crippling and deforming; be non-fatal and chronic, running an unusually long course; have an insidious onset; have a fairly high endemicity but not be epidemic; be associated with 'low' standards of living; appear to be incurable and have a long incubation period. Gussow and Tracey argue then that leprosy comes very close to this ideal-type of stigmatising disease[21]. In their chapter 'The Dimensions of

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[20] Ideal types are problematic in so far as they are by definition ahistorical, formal and unempirical. As a result one may readily ask whom they are 'ideal' for, and what purposes their use serves. At the same time it can be easily seen that this worst-possible scenario is value-laden.

[21] Of course Skinsnes may well have derived his worst-possible scenario from his or others' ideas about leprosy, in which case the 'dimensions of stigma' become vacuous and principally rhetorical (in its negative sense) devices, which serve in the misguided pursuit of an ahistorical content.

Stigma' Jones et al (1984) provide a further typology of six dimensions which they argue is consistent with previous empirical work: concealability, course, disruptiveness, aesthetic qualities, origin and peril[22]. Taken with a pinch of salt, such broad typologies may provide useful pointers to the kinds of things which others may find threatening about mental disorder. On the other hand the precise responses of any audience are not 'determined' by such considerations in any simple sense, as the authors acknowledge.

One methodological objection which may be raised to the present project is that it takes mental disorder in one sense as given; that is, it focuses on the discursive and non-discursive practices of local people towards extant 'patients', some of whom may be said to display unusual or disconcerting behaviour, and it may well be objected that the negative responses of others come about as a direct result of patients' *behaviours*. Of course people reject patients, it may be argued, because patients behave so abominably.

The previous discussions of labelling and stigma have I hope served to rebut this objection. It is clear that a wide range of responses may be compatible with any particular behaviour[23] so that it would be naive to think that any one response is

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[22] But immediately we are faced with further definitional problems. For example although an externally manifest disease may elicit negative reactions from others and invoke negative feelings for the sufferer, the ability to hide an illness may itself render that illness more of a threat to others and potentially and actually stigmatising for the sufferer who may live in fear of disclosure (cf. Miles 1988 p83).

[23] Although the behaviour of others is often directly and unreflectively mediated by our categories, concepts and assumptions, and is normally seen immediately as behaviour of a particular type, there are occasions when we are unsure how to categorise particular behaviours. But even if immediately and unproblematically categorised, our responses may still vary widely.

determined directly by that behaviour. To suggest as much would be to assume a deterministic behaviourism and to ignore at the very least the place of repertoires of audience beliefs, knowledge and imagery concerning patients as well as local rules, values, norms; the existence or otherwise of local support structures; other neighbourhood characteristics and wider structural factors which have direct local effects. These all impinge to varying degrees upon the actor's choices and opportunities for action. The issue of audience responses therefore, together with audience images, representations and knowledge, even towards patients who are effectively well advanced in the psychiatric system, must remain a question to be investigated empirically and is not to be assumed *a priori*.

In addition it would be to predetermine the case to suggest that people who are patients are all alike in behaviour, demeanour, presentation, disability, etc. Indeed to pre-empt my later analysis it is plain that although villagers in this study felt able generally to identify a patient *as* a patient, there were many occasions when they could not say whether or not a person was a hospital patient, a discharged patient, someone recently moved to the village, or an 'innocent' passer-by. This project sets out in part to examine the methods local people use to identify patients *qua* patients, together with the strategies used to maintain 'difference' between themselves and putative patients and to define themselves as 'sane' in the process.

'Difference' may therefore be read at one level in terms of category selection and imposition so that what is to count as 'different' depends upon what is culturally important in one sense or another. In other words, in terms of the 'differences' between people, the universal aspects or specifications of 'difference' may be regarded as formal: the formal procedures

and requirements of communicative action, the interpretative openness of language, or the formal conditions of cognitive and practical development, both human and non-human (e.g. the need to be able to both differentiate and integrate, perceptually and cognitively). Viewed substantively on the other hand, 'difference' must be seen in terms of the real historical exclusionary practices of real people, groups and classes in the maintenance of power.

There is nothing here, I would argue, to suggest that we should not acknowledge many patients and especially people who are designated as 'chronic' patients, to be handicapped in many ways. The argument here is rather that such handicaps which may be interpersonal, linguistic, financial, cognitive etc are often ameliorable in appropriate settings and that what we make of them, how we define and respond to them and attempt to affect them or redefine them, need not be taken as given. Recognition of difference needs to go hand in hand, in other words, with acknowledgement of similarity.

A Brief Excursus on Mental Illness

In his critique of Foucault and elsewhere in his book, Sedgwick (1982a, and see also 1982b) pursues his agenda of challenging earlier sociological and 'anti-psychiatry' critiques of the 'mental illness' concept[24]. Because of the influence of his

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[24] There are two opposed arguments in this respect which revolve around the issue of responsibility. The first sequence links 'illness' to lack of responsibility, to lack of personal control, to perceived unpredictability, to perceived dangerousness and hence avoidance by others. 'Mental illness' is, thus, stigmatising. The second suggests that 'illness' protects patients and others from attributions of, in this case, a damaging responsibility. The mentally ill person may therefore be treated with compassion, and the concept of 'mental illness' is liberating. Both arguments are simplistic as I shall later show.

work upon critical thought it deserves further attention. I will consider here the central components of his argument. The first is his well-known aphorism 'there are no illnesses or diseases in nature' (ibid p30). All 'illness' he argues is socially constructed, including both physical and mental illness (see also e.g. Conrad 1981, Kennedy 1981/1983, White 1980, Wright and Treacher 1982). Once we recognise that *all* illness expresses 'both a social value judgement (contrasting a person's condition with certain understood and accepted norms) and an attempt at explanation (with a view to controlling the disvalued condition)' then the way becomes open for an acceptance by critics of madness as illness. Mental illness in this view can be made into a critical concept (ibid p41), 'provided those who use it are prepared to place demands and pressures on the existing organisation of society' (ibid). Sedgwick's fear is that a denial of 'mental illness' simply plays into the hands of those who solicit policies of neglect. I have some sympathy with this argument. Clearly 'illness' can be reconceptualised in the right circumstances as a critical concept (cf. Renaud 1978).

Secondly Sedgwick argues that '...the specialised medical model of illness is not the only possible one...' (ibid p39). He does not want to 'technologise' illness beyond the point it is helpful to do so (ibid p40). At the same time he wants to retain the gains of scientific 'experimental reasoning' (ibid p139) while politicizing medical goals (ibid p40). Because the current theory of the person upon which our concepts of illness are based is positivistic and physicalist, then illness and its causes become located within the body of the individual (ibid p35). For Sedgwick this constitutes only one possible manifestation of the illness concept.

Sedgwick's arguments are persuasive, yet there is often a sense in which he overstretches his case. In his critique of Foucault he argues that madness as 'illness' has an extremely long history. But when he speaks of the 'mental patient' of the sixteenth and previous centuries (ibid p136) he sounds quite anachronistic, and presents no evidence to support his view that such people were regarded as either 'mental' or as 'patients'; or better, he does not properly consider what 'mental patient' could possibly have meant in the sixteenth century (cf. Herzlich and Pierret 1985). The use of physical methods in attempts to render someone sane do not necessarily imply an illness or disease model of madness, nor 'patient' status. They may just as easily be seen as punishment or exorcism. The semantic issues here are formidable and Sedgwick tends, I believe, to gloss them.

Similarly when he suggests that each culturally specific account of illness must involve a theory of the person, and then goes on to say that in cultures with an animistic tradition the invasion of the person will be one of the spirit or the soul (1982a p35), he begs the question of whether this manifestation is always seen as one of *illness*. What then of ancient Christian or contemporary Balinese 'blessed madness' (Screech 1985, Connor 1982)?

Sedgwick wants to oppose the technologising of illness and the medicalisation of moral values (1982 p40), while spurning the 'relativist trap' of science as ideology which he asserts denies 'all the conquests of experimental reasoning' (ibid p139). But the fact is that in our culture the concept of mental illness *is* strongly tied to the alliance between psychiatry and a positivist science (Isbister 1983, and cf. Kolakowski 1972, Bryant 1985). From the perspective of the critique of positivist science and technology as domination

(e.g. Habermas 1971, Horkheimer and Adorno 1944/1979, Leiss 1972, Marcuse 1964) we do therefore still require an examination of the illness concept which takes into account its putative ideological effects (cf., e.g. Figlio 1980, Renaud 1978, Szasz 1987), its role in sustaining precisely those relations of power which Sedgwick appears to want to challenge. That this does not necessarily entail denying the 'conquests of experimental reason' has been shown for example in Habermas' (1971) engagement with Marcuse.

Finally, and connected to the last point, there is also a sense in which Sedgwick does not go far enough. His maxim 'there are no illnesses or diseases in nature' is itself problematic in at least two respects. First (and to risk being facile) we can inquire of Sedgwick where exactly the constructs of 'illness' and 'disease' are to be located. If they are separated from the realm of nature, then Sedgwick appears to imply a radical dichotomy between man and nature about which we may have cause to feel concerned. But if man is part of nature then presumably so are his constructs. Secondly, if illnesses and diseases are social constructs (or part of our particular language game, or form of life) might not 'nature' itself, and notions of our separation from nature, also be considered part of our constructed world? In other words Sedgwick wants to stop at diseases and illnesses when his logic could perhaps carry him on further. He wants to retain a materialist orientation in which 'nature' exists independently of 'man'. To be sure, the philosophical issues here are complex and I shall attempt to explore them further in a later chapter. However, although the question of the independence or otherwise of objects may be finally metaphysical, particular philosophical beliefs may have political implications. The question we should address is therefore 'What are the practical and rhetorical consequences for our practices of advancing particular theoretical and

philosophical positions concerning the 'nature' of man, nature and life?'.

There is another related argument which I wish to explore briefly here, which takes its cue from the location or 'place' of disorder. Within our culture there exists the possibility in many physical illnesses of distancing one's self from one's illness. We can say for instance, 'It's my heart' or 'I've got a problem with my leg', or even 'I've got cancer' (Billig et al 1988 ch6, and cf. Herzlich 1973 p135). However this cannot be so readily done within the parameters of our current conceptions of mental illness. It appears to be unacceptable to say 'I've just got a problem with my brain', or 'It's OK, it's only my self/mind'[25]. This is no doubt because of our society's dualistic tendencies which privilege mind over body (Kirmayer 1988). If the self is what society holds accountable for the body (ibid p80), if the brain is in charge, as it were, and the seat of the mind-self is located somewhere *in* the brain, then the possibility of discursive dissociation from *mental* illness becomes blocked.

But this argument is actually a little more complex, for it is not the location in the brain on its own which is the problem, but the fact that use of the term mental illness both promises spatial specificity but is locationally (and causally, cf. Ablon 1981) not specifiable enough *within* the brain, unlike for instance a tumour or perhaps epilepsy[26]. It may for example be

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25 And in addition, apart from ironic comments from psychiatric in-patients, we never hear someone say 'I'm feeling a bit mentally ill today', whereas we do hear 'I'm feeling physically ill'. When the lexical unit 'physically' is used in this way it may on occasions be in order to distance the speaker from the possible assumption by a listener that the illness in question may in fact otherwise be mental.

26 Although the site of discharge is often locatable, epilepsy is usually regarded as idiopathic.

possible in talk to allude to a brain tumour and thereby separate off the self from the illness. Although people do sometimes say 'I've got schizophrenia' the latter has not (yet) been sufficiently localised or causally understood by medical science to render it a concept with discursive distancing potential[27]. It is not yet, we might say, sufficiently 'ill'.

From this perspective, the use of the term 'mental illness' does not allow its sufferers to adopt the same face/self-saving strategies as other illnesses might allow. In this sense then it becomes handicapping. The 'self', seen as the seat of reason and control, is inevitably implicated so that people who have 'mental illnesses' suffer illnesses of the 'self' (Bott 1976, Scott 1974). As Bott (1976 p118) put it: 'One *has* a physical illness; one *is* a mental illness.'[28]

However this argument moves on a little. For in terms of chronic physical complaints it appears to be the case that when opportunities for action are regularly denied through various discriminatory practices and related fears such as contamination, dependency and so on, then the ill person is more likely to identify him or her self (and have her self

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[27] It is of course true that some physical diseases have a stigmatising potential even when localisable, such as cancer, leprosy, AIDS and so on. We may be more likely to say 'I've got cancer' than 'It's my lungs'. And in this case the degree to which the self becomes identified with the disease may depend upon a variety of other factors. In this sense 'schizophrenia' may never have much discursive distancing power. However this does not necessarily negate the argument presented here that differential possibilities exist for discursive mitigation and manoeuvre. See the following discussion and 'The Dimensions of Stigma' above for a worst-possible disease scenario.

[28] Compare Estroff (1981a, 1981b p244) who makes a similar point but equates the identification of illness and self with the chronicity of the illness, a theme which I also discuss here.

identified) with the illness (Billig et al 1988). In other words we could say that 'mentally ill' people may be doubly excluded in terms of place effects. As well as everyday discrimination (see chapter 4 below), they suffer the consequence of a conceptual system which places constraints upon the possibility of discursive distantiation of self from illness in ways which are open to sufferers of many physical complaints.

If we are to speak of 'mental' conditions at all, I prefer to use the term 'mental disorder' for the following reasons. First it contains the idea of (dis)order as a behavioural or action phenomenon, located within an interpersonal setting, as in "Your behaviour is out of order", or "Disorder broke out in the ranks". There is a moral, normative and hierarchical aspect involved here. Disorder expresses normative transgression which may be conscious or unmotivated. It contains the notion of challenge to order and 'breakdown' of order. It clearly invokes 'society'.

At the same time disorder connotes disorganisation, perhaps chaos, a lack of integration, a lack of purposiveness or organising agency. It even alludes to the idea that something is mechanically malfunctioning, as in 'The lift is out of order.'

'Mental disorder' therefore has the benefit of imputing both agency and non-agency. Whilst allowing for 'breakdown' and even *illness*, which the person could not control, it also allows for the possibility of conscious manipulation of the interpersonal scene by the 'patient'. The use of the term 'mental disorder' does not solve all the problems posed by the concept 'mental illness', but does, I suggest, capture and

allow wider meanings and possibilities[29]. It is the term I use throughout the thesis alongside 'madness' and occasionally 'insanity'.

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29 For an alternative view which suggests that the concept 'mental disorder' is much too woolly and 'catch-all' and is therefore in fact counterproductive in so far as it dilutes issues and diverts attention from particular needs of particular groups of mentally ill people, see Campbell and Heginbotham 1991 chs 1 & 2). For references to empirical work which addresses the social impact of the 'mental illness' label see p30 below, note 14, and chapter 4.

Chapter 4

A Review of the Literature

> Once you've seen a psychiatrist then *other* people often start behaving very strangely[1].

Introduction

The task of the reviewer of research investigating public reactions to extant or former psychiatric patients is formidable for a variety of reasons. As Rabkin (1974) and Link et al (1989) have pointed out, there is often a lack of clarity in the terms used by many researchers who regularly and uncritically interchange categories 'mental patient' and 'ex-mental patient'. In addition, researchers often employ different methodologies, using different sample sizes and population types, focusing upon different kinds of theoretical problem and using different instruments. This means that it is often difficult to make direct comparisons between survey results or to categorise material. Furthermore the presentation of empirical work itself raises issues concerning the validity of particular methods, and although I tackle some of the issues as I go along, I have reserved a more thorough theoretical critique for the next chapter. Finally, a vast amount of empirical work exists on labelling and stigma in relation to psychiatry, and it is not possible to review all of it here. I have therefore selected those studies which appear to me to

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[1] Remark overheard at a 'users' conference.

provide a representative overview, concentrating in particular upon those themes which importantly inform this study[2].

I have chosen to structure the material in the following manner. A large number of attitude studies can be categorised according to the conclusions they reach, which in a general sense are either 'positive' or 'negative', so that a number find audiences accepting of extant or former patients, while others see rejection. Another body of papers deals with the characteristics of 'markables' (Jones,E.E. et al 1984) and significant others which are most often associated with stigmatization. Yet other research is concerned with the question of whether and to what extent societal responses are a function primarily of the label carried or the behaviour exhibited. This group begins to provide an explanation for stigmatization in terms of unpredictability and dangerousness. I shall address each of these areas, which indeed often overlap, in turn, but begin however with research which has explored the *experiences* of people who have been in receipt of psychiatric help.

Experiences of Stigma

It is fitting to begin with the work of Agnes Miles (1981/1987, 1984, 1988), a sociologist and author concerned with mental disorder in Britain today. Miles' view of the consequences of carrying the label 'ex-psychiatric patient' follows quite closely that of Scheff, so that for her:

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2 The reader may wish to compare the following additional reviews: Farina (1982), Johannsen (1969), Link et al (1987), Link and Cullen (1990), Rabkin (1974, 1975, 1984), Segal (1978), Weinstein (1983). I have not included in this chapter a review of that research which bears some similarity to my own i.e. Roosens (1979) and Jodelet (1991). In addition space limitations have also precluded a discussion of other geographically oriented research (e.g. Dear and Taylor 1982, Moon 1988, Smith and Hanham 1981).

> Mental illness is a field in which labelling can have quite devastating consequences. It carries a peculiarly powerful and lasting cultural stereotype, resistant to change and extremely negatively evaluated. (1988 p18)

In her most recent research project Miles (1984, 1988) investigated the experiences of men and women, referred for the first time to see a psychiatrist, who had been diagnosed as 'neurotic' and attended for psychiatric *out*-patient treatment. There are in her work some quite compelling and dramatic images that are difficult to dismiss as 'simply' subjective. Rejection which was not anticipated became as a result more profoundly felt, thus:

> She was my friend since school, we were very close, and saw each other all the time. Since I started with the psychiatrist, she has been here only once and even then treated me strangely, she wasn't herself at all. (1988 p73)

And

> My sister-in-law doesn't want me near her children in case I hurt them or go funny, so I don't go there any more. (ibid p73)

The following respondent expected her friend who was a nurse to be understanding and helpful:

> Kitty was worse than anyone: when I told her that the psychiatrist recommended group therapy and I started to attend, she completely abandoned the friendship. She has no time to meet me, never rings, and told me that she had made new plans for her holiday. (ibid p74)

Miles' text provides ample evidence that these respondents experienced negative evaluations, rejection and ridicule from their social groups including friends, neighbours and family.

While we may be left wondering whether the subjects' behaviour at the time led to the disruption of relationships, Miles makes it clear that the portrayed responses of others were often out of proportion to the mental disorder itself. The question of whether to conceal or disclose their psychiatric referral was seldom clear-cut for Miles' subjects. People made decisions according to the particular circumstances in which they found themselves. In this respect the nature of the problem of stigma was therefore fluid, shifting and context bound[3].

In (West) Germany, work by Angermeyer et al (1987) confirmed patients' experiences of stigmatization. Using a Likert-like questionnaire method the researchers found to their surprise that patients admitted to a psychiatric ward in a modern, integrated, university hospital felt more devalued and stigmatised than those who spent time in an old, large, isolated state hospital. This appears to relate to the fact that patients in the local hospital were more likely to meet people they knew, and to be identified more readily as psychiatric patients.

In another study Teasdale (1987) analysed the views of clients in a psychiatric day unit. He conjectures that the transfer to locally based services has made stigma management more of an issue for clients by reducing the possible options available. Thus it becomes more difficult for such clients to conceal their attendance from people in the locality in which they are

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[3] Miles also shows how her respondents used negatively evaluated terms when referring to psychiatric disorder, such as 'loony', 'mental' etc. As she points out, one might have expected her respondents to eschew such terms. But it may be the case that, as Scheff (1966) argues, there are no colloquial terms which present madness in other than a negative light (cf. Brandon 1987, Nunnally 1961). Perhaps madness has after all lost something of itself in its battle with reason.

living. Clients reported overhearing remarks such as "Why should they come here, they're mental, we don't want them around here." The irony, as Teasdale notes, is that the day unit clients were already living in the town unnoticed until the day unit was proposed.

An earlier project by Neuhring (1979) set out to measure, using a Likert-like interview schedule, the degree of social stigma experienced by discharged psychiatric patients and the extent to which these people were viewed as a burden by family and friends. Neuhring's results were somewhat equivocal but she concluded that the more depressed the ex-patients were, the more stigma they felt and the more they were perceived as a burden. The identified relevant intervening variable here is the search by the ex-patient, as a result of depression, for high degrees of social interaction. The quality of this interaction is not discussed.

Two early papers which are still often referred to in the literature are of interest. As part of a wider study Cumming and Cumming (1965) interviewed 22 patients consecutively discharged from a state mental hospital. Although no direct questions about stigma were asked, 9 out of the 22 were adjudged to have 'felt' stigma, which was inferred from the interview materials. The authors found 'two basic evidences of stigmatization' (p138): the first an expression of shame or inferiority because of the hospitalisation, and the second an expectation of negative responses from others (and cf. Scambler 1989).

The retrospective study of Yarrow, Clausen and Robbins (1955a and cf. Yarrow et al 1955b, and see Scheff 1975 p24 for a critique), examining the experiences of patients' wives, indicated that in the post-hospital phase it was the

unpredictability of other people's reactions which best summarised the wives' experiences. The families in this study were then followed up over the next 15 to 20 years and the results published by Clausen (1981).

From this important study based upon a series of interviews with several different cohorts of spouses and former-patients hospitalised in the 1950's and 1970's, Clausen (1981) concluded that stigma does not play an important part in the lives of former patients, thus: 'Most former patients do not feel isolated and punished once they have been back in the community for a few weeks or months' (p288), and in the twenty years up to 1981 there had been a 'decrease in the expectations of negative reactions from others whom one knows' (p290). When they did inform friends and neighbours about their spouses hospitalisation, Clausen's husbands and wives (the exact percentages are not specified) reported overwhelmingly that the response had been sympathetic and understanding (p290) (cf. Schwartz 1957 paper on the first part of the same study). This conclusion clearly clashes directly with the results of Miles (1988) above.

On their return to employment, Clausen's former patients reported that colleagues had been supportive and sympathetic and that subjects' initial apprehensions related to doubts about their ability to perform the job (and see Huffine and Clausen 1979).

In the longer-term follow up study of people hospitalized in the 1950's, more than half of the husbands and wives acknowledged some degree of feelings of stigmatization as a consequence of the patient's hospitalisation(s), 'but only' one fifth of the wives and two-fifths of the husbands expressed

'any'[4] strong sense of stigmatization (p292). Some children who were infants or who had not been born at the time of the hospitalisation in the first study had not been informed about it 15-20 years later.

Clausen's answer to the question he poses about 'where' feelings of stigmatisation come from, if not from 'actual' responses of others, will be considered later.

In their analysis of feelings of stigma among relatives of former psychiatric patients, Freeman and Simmons (1961) reported that very few of their sample (24.2%) reported feelings of stigma, and that stigma appears to be associated with the degree of bizarre behaviour on the part of the patient, the social class of family members and their personality characteristics, so that '...family members who feel stigma may be characterised as socially incompetent and isolated.' (p319).

Gove and Fain (1973) investigated the experiences of 429 people who had been treated in a state mental hospital and concluded that only a small minority appeared to see the stigma of hospitalisation as having posed a serious problem. The authors argued that in real-life situations, audiences respond in a fairly reasonable and human fashion to people who are former patients. Townsend (1978) however has disputed these findings, pointing to possible sources of bias in the authors' research design but also making the point that Gove and Fain recount virtually nothing about the actual social and economic situations of their patients. Townsend is not quite correct

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[4] Clausen's rhetorical argument is evident here in his attempt to minimise the import of his statistics. Two-fifths we might feel is not an unimportant fraction.

here for Gove and Fain do consider the relationships and activities of former patients but primarily in terms of quantitative reports[5].

In one of a large series of intriguing studies concerning stigma and mental disorder, Amerigo Farina[6], together with Allen and Saul (1968) conducted a laboratory experiment involving 90 male psychology students. Through the judicious juggling of fabricated statements about themselves which one member of a pair falsely believed had been given to his partner, Farina et al showed that 'merely believing they were viewed as stigmatised influenced the behavior of the believer'. At the same time however, subjects in the stigma groups (history of psychiatric hospitalisation or homosexuality) were spoken to less than control group subjects: a form of rejection. The authors speculate that the discomfort of subjects in believing that the other had been given certain information about them, led them to act 'in an anxious and aloof way' towards the other person.

In a further study by Farina, Gliha, Boudreau, Allen and Sherman (1971) the authors deployed genuine former patients. One half were led to believe that a prospective employer had been informed of their psychiatric history, while the other half were told that the employer believed them to be ex-medical patients. The prospective employer was actually a researcher, unaware of the subjects group membership, who asked each

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5 And see Townsend's more recent comments on Gove and Fain in Townsend and Rakfeldt (1985). In their interesting study of 25 'first-contact' pre-patients, 13 of whom were diverted from psychiatric hospital and 12 admitted, Townsend and Rakfeldt reported that the large majority of subjects saw hospitalization as more stigmatising than diversion.

6 I have included references to a large number of Farina's projects in the bibliography.

subject to perform a task and complete a questionnaire. The authors report that subjects who believed that the interviewer knew about their psychiatric history, felt less appreciated, found the task more difficult and performed the task more poorly than those in the control group. Furthermore the interviewer, although unaware of the experimental conditions, rated subjects in the psychiatric patient group as more tense, anxious and poorly adjusted than those in the control group. Assuming that the two groups were well matched, the implication here is that believing that others know about the label may be quite disruptive for the person carrying it and also lead to greater social rejection.

The above studies of people's experiences are by no means conclusive and the results often appear to be in conflict, especially in terms of the occurrence of 'real' stigmatising responses (compare e.g. Miles with Clausen), yet most report some evidence that people who are former patients do experience 'feelings of stigma'. The work of Farina et al suggests that feelings of stigmatisation may be a consequence of believing that others know about the mark. But for Clausen (1981) the real issues are different. Clausen plausibly concludes that while negative attitudes about mental illness do exist, there is no inevitable and automatic stigmatising response from others. However, negative attitudes cannot be 'banned' because: 'there is a realistic basis for negative responses when one must deal with unreasonable behaviour, whether it is called sick, bad, or simply irritating' (Clausen 1981 p294). For Clausen the occasional 'stigma' of mental illness is to be located in the fear of 'law-abiding' residents of local neighbourhoods who are apprehensive about local levels of informal social control and social integration and who are now more likely to encounter 'chronically symptomatic patients' in the streets. Thus: 'If mental illness does sometimes carry a stigma, it is to be seen in the behaviours of such patients

and in the responses evoked by them' (ibid p295). From Clausen's perspective therefore, it is not the segregation of such people in psychiatric institutions that contributes to stigma but ironically the opposite, the more frequent appearance of 'chronically' mentally ill and behaviourally disordered people in the community.

But in addition Clausen suggests that the anticipation of stigmatising responses by formerly 'psychotic' (non-chronic) patients relates to their own shame and self-doubt about past behaviours, just as anyone may feel ashamed at having lost self-control (ibid p295), together with their anxiety about whether they will be once again able to function adequately in particular roles (ibid p294). The fear is that people may *find out* what one has actually done, or that one may once again 'lose control'. His explanations therefore focus upon the *behaviour* involved, rather than the label, and it appears that for Clausen stigma does not exist, in spite of negative public 'attitudes'[7]. We might nevertheless feel that there may be many different ways of 'losing control' and that not all are equally shameful, so that shame or fear of 'loss of control' becomes a rather woolly notion. And Clausen fails to distinguish different kinds of putative problematic public behaviour, so that we are left being unable to distinguish mental disorder from vandalism. What is it, we might ask, about someone in public which makes them candidates

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7 Or, perhaps better, that for Clausen any residual stigma has a reasonable or rational base. However, by splitting behaviour and label in this way there is almost a sense that behaviours are themselves unmediated objects, whereas I have argued that this is not the case. Clausen could reply that it is the symbolism in relation to the infraction of behavioural norms which is significant, not the symbolic weight of the label 'mental illness'; indeed that the latter is derivative of the former. Nonetheless there is the implication, lent support by his empirical work, that as a former patient one will generally not be stigmatised by others as long as one behaves appropriately. Other empirical work bearing upon this argument is discussed below.

for the predicates mentally ill, mentally disordered, mad, and so forth? In Part Three of this project I set out to consider the methods which local village people use to 'tell the difference' between 'patients' and 'non-patients'.

A parallel argument can be made that ex-patients may be over-sensitive as a result of continuing psychiatric problems and simply imagine the reactions of friends, family and neighbours[8]. However, in some of the above studies respondents have not been ex-patients themselves but rather pseudo-patients or relatives who presumably cannot as easily be said to directly share in any hypothesised pathological hypersensitivity, but who can experience courtesy stigma (Goffman 1963/68, Posner 1976). More profoundly we can still ask why, even if they are being hypersensitive, should people who have been psychiatric patients be hypersensitive about their status as 'ex-patient' as opposed to their status as 'father', 'social worker' or 'Jehovah's Witness'? Why should anxiety attach to the public acknowledgement of *this* role as opposed to another? Clausen (1981) has emphasized the significance of behaviour, yet it is implicit for example in Miles' (1988) study (and cf. Yarrow et al 1955a p44), that others' responses were reported to have been rejecting *following* the psychiatric hospital contact, rather than before. In other words the situation became most problematic *after* it had been officially ratified as to do with mental disorder in some way (cf. Horwitz 1982 p41).

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[8] Compare the study by Hamill et al (1989) which suggests that patients' accounts of seclusion experiences while in hospital are generally factually accurate although subjects tended to play down the part of their own aggressive behaviour. Dunn et al (1990), who performed a participant-observation study of a long-stay patients' club, and conducted interviews with patients, suggested that 'A close correspondence emerged between the observations of patients' social behaviour and material reported by patients when interviewed...' (p842).

Nevertheless the issue of responses to disturbed behaviour is important and will receive further attention below. For the moment it is important to note that people do use information about themselves in different ways and with different effects as I shall demonstrate in Part Three. Accounts of feelings of stigmatisation may be no exception. In the following section I shall review some of the attitude studies and experimental work which considers how people respond to those identified as mentally disordered or behaviourally disturbed, and those central features of mental disorder which are most threatening.

Audience Responses: Attitude Studies

Of the large number of attitude studies conducted in this area, a proportion have unambiguously reported positive audience responses to mentally disordered people. Thus Ring and Schein (1970) saw the general trend in attitudinal responses to be in the direction of acceptance and understanding. Respondents in a black, middle class community expressed a pronounced degree of willingness to associate with people who had been psychiatric patients, as fellow workers, club members and neighbours, and if faced with a mental or emotional problem themselves favoured consultation with a medical 'caretaker' (i.e. source of help). In their questionnaire survey of 1076 (937) General Motors workers in Baltimore, Crocetti et al (1971) concluded that respondents were almost unanimous in considering mental disorder as an illness requiring a physician's care and that they were optimistic about treatment outcomes. They found no evidence of extreme rejection by blue-collar workers of formerly mentally disordered people. The strong message from these studies is that enlightened climates of public opinion are related to the increased adoption of the medical model by the public. In a later paper, Bowen and his colleagues (1978) obtained similar positive responses from

mail questionnaires, although less than 25% were returned completed. In the words of Gove (1982 p290), such studies suggest that 'Most mental patients experience some stigma; however, in the vast majority of cases stigma appears to be transitory and does not appear to pose a severe problem...'.

In contrast to these results, a large body of survey research indicates a more or less sustained negative response from the public. Thus Star (1955/62), Nunnally (1961), Phillips (1966), Maclean (1969), Tringo (1970), Sarbin and Mancuso (1970), Rabkin's (1974) review, Solomon and Davis (1984) have all indicated that people respond with dislike, fear and aversion to the idea of mental illness and mentally ill people.

It is possible to locate two camps here which differ primarily on theoretical and ideological grounds as Rabkin (1974) has pointed out. While Lemkau, Crocetti and others (e.g. Crocetti et al 1972, Lemkau and Crocetti 1962) find positive public attitudes which they argue arise out of the medical model and illness metaphor, Sarbin and Mancuso (1970, Mancuso 1980) see negative public attitudes arising out of the same source[9].

Methodological doubts about this kind of research have led two critics (Rootman and Lafave 1969 p264) to ask 'So what?'. But some survey research is interesting not least for the inconsistencies it throws up. Rahav et al (1984) for example found that although respondents in Israel supported a modern medical approach and demonstrated a good deal of tolerance on issues of treatment, civil rights and acceptance of mentally disordered people into the mainstream of society, they also displayed fear, mistrust and rejection at the level of close, personal and intimate involvement. Rahav et al have shown then

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[9] For further references on this issue see p30 above, note 14.

how tolerance and intolerance may co-exist in a complex manner[10].

In a more recent series of studies Bruce Link and colleagues have devised and tested a modified labelling approach which focuses upon the consequences of labels and raise several objections to critics of the labelling perspective. A central point is that those researchers who obtained 'positive' (i.e. no stigma) outcomes were measuring the wrong attitudes: 'the attitudes measured often were not the key theoretical concepts required to form an adequate test.' (Link, Cullen, Struening, Shrout and Dohrenwend 1989 p420). For Link the important question is whether people believe 'that "most people" (the community at large) will devalue and discriminate against a mental patient.' (ibid p403). For Link and colleagues it is the *anticipation* of such discrimination and devaluation, whether or not it 'really' happens, which leads to negative labelling effects in terms of the responses of the patient or former patient (and compare the studies by Farina and colleagues). Their sophisticated 1989 research which explored the relationship between beliefs that 'most people' will disvalue a former patient, former patients' defensive manoeuvres, and former patients' social support networks, supported their hypothesis that stigma constitutes a major variable in the construction of support systems.

And in their 1983 postal research using vignettes, Link and Cullen concluded that although respondents expressed an 'ideal' positive view of former psychiatric patients, their notions of how 'most people' respond were much less positive (cf. Rahav et al, above).

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[10] Their results therefore conform more closely to what I otherwise take to be an often complex and contradictory social reality.

These authors therefore tend to endorse Scheff's (1966) view that the negative consequences of psychiatric labelling derive from a socialisation process reinforced by media representations, from which we all come to know that former and present psychiatric patients are devalued and discriminated against (in North American society). This tacit knowledge leads to patients adopting a variety of defensive manoeuvres (cf. E.E. Jones et al 1984 ch 6, Jones and Pittman 1982, Rogers and Buffalo 1974, Link et al 1989, Trice and Roman 1970), and often suffering the negative effects of the labelling process: '...labeling may cause demoralization (which contains components of anxiety and depressive symptomatology) and thus produce the very behavior for which a person is then rejected.' (Link 1987 p110 and see also Link 1982, Link and Cullen 1990).

Personal Characteristics

A number of research papers have addressed the issue of those characteristics of both 'markables' and audience-others which are most likely to correlate with stigmatisation and rejection. Following the earlier discussion about dimensions of stigma (and cf. Rabkin 1980) it is possible to construct from these studies a 'worst-possible' scenario. Respondents least likely to tolerate indications of mental disorder seem likely to be male (Farina, Felner and Boudreau 1973, Farina and Hagelauer 1975, Farina, Murray and Groh 1978, Norman and Malla 1983); older, poorer, poorly educated, of lower socio-economic status (Bord 1971, Clark and Binks 1966, Dohrenwend and Chin-Shong 1967, Nudelman 1965, Nunnally 1961, Whatley 1959); to have had little or no prior experience of mentally disordered people (Trute and Loewen 1978); to exhibit ethnocentricism (Mulford 1968), authoritarianism and conservatism (Nudelman 1965); and to be unlikely to perceive any similarity between themselves and the former patient (Ring and Farina 1969, and cf. Doob and Ecker 1970).

Those former patients least tolerated appear likely to be male (Phillips 1964, Linsky 1970); from a lower socio-economic group and low status racial-ethnic groups (Bord 1971, Linsky 1970); to lack close social ties in the community (Linsky 1970); and to exhibit dangerous and unpredictable behaviour (Bord 1971, Fracchia et al 1976a, 1976b, Kirk 1974, Nunnally 1961). In addition, research by Farina et al (1977, 1986) and Napoleon et al (1980) has suggested that hospitalised patients are considered to be less physically attractive than 'normal' controls.

However this scenario is not consistently supported. Blizard (1970) for example concluded that age and educational status of his New Zealand respondents were unrelated to respondents' attitudes, and that 'previous contact' and 'authoritarianism' were of only marginal significance. Trute and Loewen (1978) modify their conclusion that 'the higher the level of direct exposure to the mentally ill, the less rejecting the attitude' (p83). They suggest that previous 'direct experience' was less significant in situations involving 'personal activities' or 'social relations' with others identified as mentally ill. And a more recent vignette-based study by Malla and Shaw (1987) of female nursing students concluded that direct experience with psychiatric patients had no influence upon social distance scores.

<u>Label or Behaviour?</u>

A certain proportion of attitude studies have focused on the issue of the effects of the label in contrast to the behaviour of the labelled person (Bord 1971, Fracchia 1975, 1976b, Husek and Bobren 1964, Kirk 1974, Phillips 1964, Schwartz et al 1974).

In his study of 350 college students, Bord (1971) concluded that the 'behavioural variable' exerted the strongest and most

systematic influence on rejection. His proposal here is that rejection will increase as behaviours violate 'highly valued norms', the most salient being that people should not engage in threatening behaviour and that people should behave in a reasonably predictable fashion (see the discussion of predictability in chapter 2 above). However he also concludes that the 'threat factor' implied by any given behaviour is contingent upon the actor's socio-economic status and other social characteristics together with situational factors and the social characteristics of members of the audience.

The focus shifts a little in Kirk's (1974) study in which he concludes that it is *only* behaviour which influences rejection and that the effect of the label is negligible in comparison. Lent support by other studies, some of which rated subjects' responses to videotape sequences (Lehmann et al 1976, Loman and Larkin 1976, Lindsay 1982, Pollack et al 1976), the implication here is that in the absence of problematic behaviour in interaction, labels do not in themselves evoke negative responses.

In their research of public perceptions of former psychiatric patients, Fracchia and colleagues (1975, 1976b) reported that 'More positive perceptions of mildly ill ex-mental patients were obtained when subjects were given short paragraphs describing typical behaviors and symptoms.' (1976b p76). The implication here is that although the public respond negatively to the label 'ex-mental patient', when provided with information about behaviour they may alter their evaluation. Such research arguably supports the notion that *both* behaviour and label are important. This issue has been further tackled in a number of interesting papers by Farina and colleagues.

In an early study Farina and Ring (1965) involved pairs of male psychology students in a laboratory experiment. One member of each pair was led to believe that his partner had been twice

hospitalised for a mental disorder. The pseudo ex-patients were then consistently perceived as less likeable and competent by their partners. Furthermore when the pairs were asked to co-operate on a particular task, the pseudo ex-patients were reported by their partners as having hindered the joint performance even though this performance had been quite adequate or better in comparison to that of the control pairs. The authors conclude that believing an individual to be mentally ill strongly influences the perception of that individual in spite of the fact that his behaviour fails to justify these perceptions.

In a series of later studies (Farina, Felner and Boudreau 1973b, Farina and Hagelauer 1975, Farina, Murray and Groh 1978), five experiments were conducted using subjects who were workers at three different places of employment: department store, hospital and university. Workers were asked to meet a job applicant, a confederate of the researchers, who had been instructed to act 'normally' with half of the subjects and to behave in a nervous and tense manner with the rest, a different confederate being used for each of the five studies. In each study half of the workers were told that the applicant was a former psychiatric patient while the other half was not. While the female subjects tended to discriminate against the 'nervous' applicant and welcome the pseudo ex-patient, the male subjects unequivocally rejected the pseudo ex-patient as well as the 'nervous' applicant. The authors concluded that women tend to treat former-patients more favourably than do men (cf. Farina 1981) and that 'Not all ex-mental patients are treated badly by everyone' (1973b p371). Clearly the authors were surprised at the results which appeared to challenge some of their previous assumptions concerning the importance of the label 'former patient' in comparison to behaviour (ibid).

In addition to Farina and his colleagues, Page has also attempted some relatively unusual approaches to the subject including the 'lost-letter' method developed by Milgram (Page 1980). His 1977 study of 180 landlords/ladies, investigating the responses to enquiries for accommodation, found that the female researcher was considerably less likely to be offered accommodation if she revealed by telephone that she was about to leave a psychiatric hospital, than if she made a 'simple enquiry' with no such reference.

In a further project, Farina, Hagelauer and Holzberg (1976) investigated the responses of private medical practitioners towards people presenting with physical symptoms but thought to be former psychiatric patients. A pseudo former psychiatric patient presented to half of the 32 practitioners complaining of stomach pains suggestive of ulcers. The authors concluded that '...a former mental patient seems to receive the same medical treatment as anyone else' (p499).

Research by MIND (1986) investigated responses of prospective employers using 179 matched pairs of job applications which differed substantively only by reference to a 'nervous breakdown' and psychiatric hospital admission one to two years previously. Although discrimination was said to have applied to one quarter of such applications, in a pilot study of 80 matched pairs there appeared to be no discrimination of those applications which included the diagnosis 'depression' together with psychiatric hospitalisation (compare a similar method by Fry 1986 for the Spastics Society).

Finally, in their postal questionnaire research using vignettes Link, Cullen, Frank and Wozniak (1987) concluded that the label 'former-patient' led to high social distance scores from those members of the public who linked mental disorder with danger.

For people who did not see former patients as dangerous however the same label fostered low social distance scores. In other words for these authors the label 'former patient' is important and its significance depends upon the kinds of beliefs held by the audience. This leads to a further consideration of the relationship between danger and mental disorder.

Danger and Mental Disorder

From many of the above studies, perceived dangerousness and unpredictability often recur as twin themes which underlie explanations for rejection of people who have been psychiatric patients. There are two main arguments here. The first is that ex-patients are unlikely to be rejected by others unless they display such behaviour (e.g. Bord 1971, Kirk 1974). Some of the studies outlined above (e.g by Farina et al and Link et al) challenge this assumption. The second related proposition connected to debates about madness is that rejection may occur because people who have been in a psychiatric hospital are believed to be generally dangerous and unpredictable (e.g. Fracchia et al 1976a, 1976b, Link et al 1987).

The topic of the 'actual' dangerousness of people who have or have had psychiatric problems has received considerable research time but such efforts are again bedevilled by methodological and definitional problems which make generalisations themselves difficult and dangerous (C.I.Cohen 1980, Monahan 1988). The results depend upon whether certain patient categories are included as mentally disordered, e.g. people with diagnoses of substance abuse, 'personality disorder' and so on, and whether people with arrest histories prior to hospitalisation are included. Rabkin (1980), Treffert (1981) and others have also argued that those former patients admitted to inadequate community facilities are more likely to

be arrested for minor offences such as vagrancy, shoplifting or disorderly conduct. This represents for Treffert (1981) a criminalisation of mentally disordered people.

To simplify somewhat, Steadman and Cocozza (1977-78, 1978), Cocozza (1980) and Rabkin (1980) appear to consider that mentally-disordered people are no more dangerous than others (and cf. Steadman 1984). Teplin (1985) presented data of 1072 police-citizen encounters in an urban area (USA) and concluded that the patterns of crime for mentally-disordered and non-mentally-disordered people were substantially similar, the former group not being suspected of crimes at a rate disproportionate to their numbers in the population. As early as 1938, in research commissioned by the State Department of Mental Hygiene, Pollock reported a comparatively low rate of criminal offences committed by patients 'paroled' from State hospitals over a one year period.

The 'natural experiment' created by the discharge directed by the Supreme Court of 967 patients from a hospital for the 'criminally insane' (the 'Baxtrom case') produced fascinating results in which only 3% of such people were eventually returned to a high security hospital (Gunn 1990, Steadman and Keveles 1972). It suggests that many people whom we (or the USA) keep locked up in secure institutions really do not need to be there.

In their survey of the records of men remanded to Brixton prison over four months, Taylor and Gunn (1984) suggest that '...although most offending by schizophrenic men was trivial' (p1948), the link between schizophrenia and homicide was

strong[11]. Five out of 61 men charged with murder were said to have been schizophrenic, and all five were convicted. This link between schizophrenia and violence is endorsed elsewhere (Krakowski et al 1986, Mullen 1988), although an earlier study by Evenson et al (1974) of 'incident reports' from a large state psychiatric hospital, concluded that people with schizophrenic disorders had low risk-rates for disturbing incidents across all factors (including e.g. 'assault', 'elopement', 'self-injury', 'antisocial behaviour'), compared with patients of other diagnostic categories. A more recent longitudinal study by Lindqvist and Allebeck (1990) of 790 (644) schizophrenic patients discharged from hospitals in Stockholm in 1971 and followed up until 1986, reported that although the rate of violent offences committed by this group was four times higher than that of 'normals', the violence recorded was 'almost exclusively of minor severity' (p345).

In an earlier and commonly cited study of the hospital records of 400 hospitalised mentally ill patients, excluding patients diagnosed as having a personality disorder and as drug or alcohol dependent, Lagos et al (1977) concluded that 36% of 361 admissions 'were preceded by some form of violent, fear-inspiring behaviour.' (p1134). We are not told whether the patients were admitted 'formally' or 'informally'.

A problem with studies which utilise the retrospective review of records (see Krakowski 1986 for references) is that they play down the way records are rhetorically constructed in a manner which builds the kind of case which then becomes eligible to be read as a case of that particular kind

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[11] Earlier, Taylor (1982 p269) had stated 'There is no doubt that schizophrenics are capable of violent behaviour and, there, any certainty about the relationship between schizophrenia and violence ends.'

(Garfinkel 1967). When professionals write up case notes they have a regard for the way such notes may be used, and the same may be said of the accounts offered by relatives who are intent upon the patient being admitted to hospital. Explanations for example for compulsory detention may have to be reported to a tribunal, or a Court if the patient sues for wrongful detention. Once a decision for compulsory detention has been made, then the professional (psychiatrist or social worker) and relative will tend to have regard for justifying *their* actions as rational for all practical purposes and we may say that such accounts indeed constitute the reality of previous dangerous behaviour. But what Lagos et al miss is the often equivocal dialogic process by which such a definition is reached and in which power is implicated. From their viewpoint both mental illness and dangerousness become reified and cases become hardened. 'Dangerousness' may then be a convenient resource which professionals and relatives may (unconsciously) use in constructing their accounts, thereby reconstituting stereotypical notions[12].

To conclude with a more recent controversy, Dr Donald Dick's (1990) well-intentioned suggestion of the creation of a register of 'designated patients' in order to keep track upon vulnerable and potentially violent discharged patients has been met with angry rebuke. In a published reply to Dr Dick from the Director of International Self-Advocacy Alliance, Mike Lawson (1990) states 'We are as unanimous in not choosing his dubious

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12 From the perspective of the approved social worker the assessment of dangerousness in various guises is arguably a core part of the whole assessment. The 1983 Mental Health Act refers to the criteria for compulsory admission for treatment: 'necessary for the health or safety of the patient or for the protection of other persons' (sec 3(2)(c)). In this way dangerousness (and risk) is a central parameter around which decisions for compulsory admission are made and justified (cf. Mills 1988), and thereby becomes 'built into' assessments.

register as were Jews not wanting to wear the yellow star. The effect would be the same.' And in their discussion of the increasing use of the predicate 'dangerous', Forbes and Thomas (1990) ask 'If we are going to use the label "dangerous" why stop at clients and professionals? What about dangerous living conditions? What about the dangerous councillors and politicians...?' From the perspective of the present research programme it will be observed that while patients sometimes signify danger to villagers, a number of patients have themselves been killed crossing the road which separates village from hospital.

Attitudes and Arguments

The above review of the literature confirms at the very least that the anticipation of negative audience responses *may* be of crucial importance to people who are present or former psychiatric patients, and indeed to the rest of us in our future encounters with psychiatry and in our efforts to re-establish a dialogue with madness. That the public may indeed entertain competing opinions or views about such people is a theme which recurs within certain empirical studies of public reactions, although it may be only implicitly expressed. At the same time it will have been seen that 'danger' often appears as a central theme around which empirical projects are organised.

But before moving on to consider methodological issues in more detail, I wish to conclude with some reservations about the task of identifying public views as if there were immutable structures of belief which exist, as it were, over and above actors' experiences, lives and practices, structures immune from feedback and influence.

This position is implicit in the work of several of the above authors. Although I have sympathy with many of their arguments, the focus for example of Bruce Link and colleagues upon the central role of the common understanding that 'most people' will devalue and discriminate against people who are former patients, an understanding derived from socialisation and the representations of the mass media, is suggestive both of an relatively autonomous realm of ideas as well as a conception of actors as oversocialised and uncritical 'judgmental dopes' (Garfinkel 1967 p66 *ff*).

But this fails to adequately explain how such negative ideas originate or how they may change. If we are all inevitably socialised into this seamless view, which then at some mysterious point becomes immune to feedback from further 'real' experiences and responses, then it seems that the prospects for change are limited indeed. How, and from where, does the impetus for further debate arise which will enable the mutation of such ideas?

By way of contrast, as I have already indicated, I am interested in the way that reality is skilfully reconstructed in practice but in relation to structures which both inform such practices while being sustained, challenged or changed by them. In Parts Two and Three of the thesis I consider the dialectic between interaction and structure from different perspectives. In particular I focus in Part Three on the reconstruction of reality in dialogue, in which villagers draw differentially upon sometimes competing interpretative repertoires and with a variety of effects. Knowledge of what 'most people' will do can then be seen as a flexible structure or resource rather than something by which our actions and feelings are inevitably and *unthinkingly* conditioned. We all necessarily possess shared and common knowledge in various

forms, but may at times choose to challenge common sense understandings and knowledge claims (and see the discussion of the work of Habermas in chapter 5 below). Thus while we may understand discrimination against people with psychiatric histories to be 'what everybody knows', the contradictions, ambiguities and argumentative complexities of 'common knowledge' may not have been fully grasped by attitude and opinion studies[13]. When the *argumentative* and *rhetorical* contexts of thought are taken into account, then public responses may appear in a different light.

The neglect by attitude studies of this argumentative context is arguably the neglect of a central component of human life. Whereas the study of stereotypes is often the study of the apparently immutable and autonomous, to study the structures of argument is to show how ideas about mental disorder and patients (and, potentially, ideas generally[14]) are discursively and complexly reproduced.

And from the perspective of the patient, shame may be of central importance in understanding 'felt' stigma as well as the production of psychiatric symptoms. It is tied to socially constructed notions of the subject, of self-worth, of value and substance. Yet shame, when shared, discussed and debated may also be ameliorable[15].

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[13] Although to be fair to Link and his colleagues, they have emphasised the often subtle and dilemmatic or contradictory aspects of attitudes towards people who are former psychiatric patients (e.g. Link and Cullen 1983) albeit expressed in terms of different 'attitude levels'.

[14] Compare e.g. Thompson's (1990 p8) view that to study ideology is to study how symbolic forms or systems 'are used and understood in specific social contexts.'

[15] That it is possible for people to change their ideas and feelings about themselves and their behaviour is of course a fundamental tenet of psychotherapy.

Chapter 5

Philosophical and Methodological Issues of Researching Public Reactions

In this chapter I shall briefly explore the theory and logic of competing methods as they relate to this project. My underlying premise is that methods are tied to theories concerning the nature of social reality and the conditions, scope and possibility of our knowledge concerning such reality.

Attitudes and Experiments

My approach to attitude studies owes something to Habermas' characterisation of positivism as a 'disavowal of reflection' (1968/1987 pvii, p67-69)[1]. My position is that while it *is* possible to reconcile an orientation to truth with a social constructionist view, we should be suspicious of research which represents itself as unproblematically objective and unbiased, research which displays no acknowledgement of conceptual, methodological and philosophical problems, and which attempts

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[1] This is probably insulting to those who admit to being positivists, for 'reflection' we may say is a necessary part of any thoughtful research. Habermas is complaining about the way positivism has 'repressed older philosophical traditions and...monopolized the self-understanding of the sciences...' (ibid p69). See, on positivism, Adorno (1976), Bryant (1985), Cohen (1980), Giddens (1974/75), Halfpenny (1982), Kolakowski (1972). Cohen (1980) seems to want to argue that whether we acknowledge it or not, most sociologists are probably positivists at heart, and anyway unknowledgeable of some of its distinguishing characteristics. If the latter point is correct then perhaps this supports Habermas' view.

to discard in the name of disinterested science its inherently social nature. All research is creative, and that research which denies its creative moment is in danger of becoming ideological[2].

Sociological critiques which show how influence, persuasion, unwarranted interpretation and dubious coding practices are an inherent part of survey research, and lead to bias and error, now have a substantial history (e.g. Cicourel 1964, Bruyn 1966, Phillips 1971, 1973, Sjoberg and Nett 1968, and Webb et al 1971).

But underlying the concept of attitude, as well as the positions of some of its critics, is the notion that there is some concealed, underlying and fixed structure of beliefs to which access can be gained by asking enough of the right kinds of questions (Finch 1987a p110). Attitudes are often viewed as internal mental states which partake of an enduring and homogenous nature and as Sayer (1984 p230) has argued, descriptions of attitudes often appear to be treated as 'preliminary versions of law-like statements about eternal regularities.'

In contrast to this idea it is possible to argue that people construct and express 'attitudes' for particular purposes, in different contexts (especially the context of survey research), and with differing effects. While from one viewpoint many of the factors arising in the collection of sociological data can be read as 'biases' to be eradicated by the use of increasingly

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[2] Nevertheless in spite of his critique of positivism, Habermas' own version of natural science is ambiguous at least in its early form, as Vogel (1988) has recently argued. See also Parsons, who finds a tension in Habermas: '...in the end, Habermas appeals to *that constituted* (nature) to justify the *act of constitution itself.*' (1992 p224).

precise means, so that the object becomes, as it were, approached and scrutinised more closely by an independent subject, an alternative view sees bias itself as expressing something fundamental about human interaction and communication. Here, we might say, the relation between subject and object becomes much more complex. For Billig (1987) for example the world of everyday experience is full of shifting opinions and impressions, a rhetorical world filled with the 'spirit of contradiction' and argument, and in which logoi are perpetually challenged by anti-logoi. In Billig's (ibid p225) terms our attitudes represent 'unfinished business in the continual controversies of social life'. Thus for Billig, as for Protagoras, there are two opposing sides to every question (Billig 1987 p41)[3]. As Shotter (1989 p154-5) has put it: '...practical-moral knowledge is not a unified system, but constituted in large part *argumentatively* (Billig 1987), i.e., in terms of common-places (or *topoi*) whose discursive formulations are "essentially contested" (Gallie, 1955-6).'

Furthermore it is by no means clear that people even *have* opinions or attitudes towards objects until their attention is drawn to them by the researcher with the clipboard and questionnaire. Friedrich Pollock nicely caught the implications in the following manner:

> That lack of interest in public affairs on the part of the individual who enjoys democratic rights, which is the subject of so much lamentation, may in part result from the fact that when confronted with these matters he feels helpless, having neither the time, the energy, nor the education to put together the data necessary to form a personal opinion. By proceeding on the assumption that it is necessary to have an opinion about everything, opinion research runs the risk of seducing people in the interviews it conducts to express opinions they do not

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[3] The notion of the two-sided or two-handed nature of common-sense is pursued in Billig et al (1988).

instinctively hold, opinions which are not theirs at all. Precisely the contradiction between the compulsion to have an opinion and the incapacity to form an opinion leads many people to accept stereotypes which relieve them of the thankless task of forming their own opinions and yet enable them to enjoy the prestige of being in touch with things. (Pollock 1955/1978 p229)

In other words although it is arguably the case that all research, and indeed all social action, reconstructs social reality in some manner, the danger of survey research is that it may be said to consolidate and recreate a *stereotypical* reality[4], or in Barthes words, to awaken the monster of signs[5].

The 'problem' of the disjunction between expressed attitudes and subsequent behaviour, and the predictive power of attitudes, also has a long and controversial history (LaPierre 1934, Ajzen and Fishbein 1980, Deutscher 1973, Wicker 1969)[6]. LaPierre's old study continues to receive reference space (Ajzen and Fishbein 1980, Billig 1987), and in relation to mental disorder (Miles 1981, 1987, Rabkin 1974), while his results have been subject to alternative interpretations. Billig (1987 p188-9) shows that while for Campbell there was 'consistency' between attitudes and behaviour in LaPierre's

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[4] At the same time, the form of large public opinion polls effectively reinforces the democratic ideal that each individual opinion counts equally, whereas we may have cause to doubt this in 'real' life. And following the lines of Pollock's argument, attitude studies and public opinion polls may be considered to represent a vestigial, depoliticised and privatised aspect of a more open debate which arguably once occurred in the bourgeois 'public sphere' (cf. Habermas 1974, McCarthy 1978, Eagleton 1984 and Rodger 1985).

[5] Barthes (1983 p461) suggested that within each sign 'sleeps that monster: a stereotype.'

[6] I have not attempted a rigorous review of the literature nor of the precise arguments concerning the predictive significance and sequence of attitudes, beliefs and behaviour. See O'Keefe (1990) for a recent overview.

study, for Deutscher there was 'inconsistency'. As Billig points out, what is pseudo-inconsistency for one is genuine inconsistency for another. Again this points to the social, rhetorical and dialogic nature of our adjudicative criteria by which reality becomes defined.

One particular tool which has been used in many of the above studies is the 'vignette method' (e.g. Bord 1971, Kirk 1974, Link and Cullen 1983, Link et al 1987, Phillips 1964, 1966, Star 1955/62). Those vignettes used in the above studies tend to constitute essentially static representations. In her 1987a paper Janet Finch advocated the use of longer and more complex vignettes which can be built into a narrative structure, incorporating changes which occur as if over time. This vignette method has the merit of increasing the concreteness and contextuality of material and is congruent with the notion of dramatic narrative as the crucial form for the understanding of human action, a view with which I have some sympathy (see also Barham 1984, Gergen 1988, MacIntyre 1977, 1981).

Nevertheless although this method has distinct advantages over that of the fixed vignette, it shares some of its problems. In particular Finch has used these vignettes to 'tap the general imagery' (ibid p112-3) of the public morality of family relationships, but the suspicion still remains that she is attempting to test for the existence of an hypostatised and independent structure of beliefs. And as with more standard attitude studies, this approach is open to the criticism that reactions to contextualised vignettes are *unreflectively* constitutive of this reality as an outcome of the research process itself.

However, that her position is in fact more complex than this can be seen from a later paper where Finch hypothesises a

flexible and socially constructed normative structure which is drawn upon in negotiations between people (Finch 1987b), although she still seems to assume that such a structure is readily susceptible to investigation by survey research. And it is precisely the rhetorical and argumentative context which structures, and is structured by, ongoing 'negotiations' and definitions of the situation, which survey research, including Finch's sophisticated vignette method, arguably misses.

It may be that some of these problems of research can be resolved once we regard all research as contributing in different ways to what is essentially a public debate in which claims to normative rightness and truth become thematised. Nevertheless I also want to support and reserve for the moment the argument that different objects are best researched by different methods but in a manner whereby the competing conventions of research together with the nature of the objects themselves are socially elaborated.

If attitude and vignette-based surveys raise questions about the nature of the object under investigation, the kind of laboratory-based experiments conducted by, for example, Farina and colleagues are also beset with difficulties. A primary objection is that such experiments often amount to a form of behaviourism so that participants' responses become abstracted from their meanings (e.g. Harré and Secord 1972). In the 'artificial' setting of the laboratory we may also reasonably expect to encounter all those sorts of 'bias' which beset survey research, from modelling/ expectancy effects and acquiescence responses derived from an hypothesised desire to please the researcher, to deliberate or unconscious attempts to distort and deceive, based upon a diametrically opposed hypothesised desire to subvert the research programme.

These difficulties are, however, endemic in most forms of ~social research and Billig's (1987 p72) argument that the social psychology experiment does not solve problems in any straightforward manner but actually creates more uncertainty, can also be applied elsewhere. No 'vacuum cleaner', the psychology experiment does not suck up the confusing layer of dirt to reveal an underlying shiny reality[7] (ibid p206), but tends to create more dirt. In the terms of Bhaskar's (1979/1989) realism, social psychology experiments rather naively assume the possibility of system closure.

The Prejudice of Stereotypes

The reader will recall that negative stereotypes of mental disorder feature prominently in the work of Scheff, Link and others. According to Scheff these stereotypes are learned in early childhood and continually reaffirmed in everyday life and discourse. For Scheff they acquire a certain impermeability and are highly resistant to change. The concept of stereotypes was first advanced by Lippmann in 1930, and Townsend (1978) has provided an account of his position which I follow here.

Lippmann viewed stereotypes as emerging remorselessly out of the necessarily selective process of perception and categorisation; largely automatic, culturally determined, associated with a particular affect and subject to unconscious

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7 We may compare Popper here, for whom the elusive nature of firm and clear ground, or shiny floor, applies equally to the natural sciences. Although approaching nearer to the truth, defined in Tarskian correspondence terms, natural science rests on the swamp of falsification rather than hard rock. However, getting nearer to the truth in Popper's terms still appears to be problematic on at least two counts. First because Popper himself expresses doubts about our ability to know when we have found the truth, and secondly because of the status of his falsificationism as a method aimed at telling us when we have failed to find the truth (Popper 1959, 1963).

distortion. He argued that stereotypes are constantly used by us to justify our actions and position in society but that although inevitable, they need not necessarily remain negative and should be 'recognised', 'held lightly', and 'modified gladly' (Townsend 1978[8] p39, and see also Miller 1982).

The issue of necessary pre-judgement has been developed within the different tradition of philosophical hermeneutics by Hans-Georg Gadamer (1975/79, and see Warnke 1987 for a good account). For Gadamer, prejudices constitute our very being and may be blind or enabling, thus: 'What is necessary is a fundamental rehabilitation of the concept of prejudice and a recognition that there are legitimate prejudices...' (Gadamer 1975/79 p246). These may be distinguished, explicated or challenged not monologically but only through dialogical encounter, and indeed constitute the very possibility of such encounter. When Gadamer argues that to understand is always to understand anew or differently, he means that such understanding is only possible because of the prejudices and prejudgments that are constitutive of what we are (Bernstein 1986 p98). It is in this sense that Gadamer speaks of the hermeneutic endeavour as an ontological condition of our being in the world. From this perspective hermeneutic understanding is achieved in practice via a 'fusion of horizons' in dialogue rather than an empathetic identification of subjective meanings or a process of socialisation[9]. Gadamer's position may be contrasted, for example, with that of Winch (e.g. 1964) for

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[8] In his empirical cross-cultural study Townsend (1978) found no evidence of the extreme negative stereotyping discussed by Scheff, but did find contrasting cultural *conceptions* of mental disorder.

[9] According to Gadamer, the best definition of hermeneutics is: '...to let what is alienated by the character of the written word or by the character of being distantiated by cultural or historical distances speak again' (quoted in Bernstein 1986 p63).

whom forms of life appear hermetic and monadic (cf. Bernstein 1976/1979, 1983, Outhwaite 1975/85 p98, Habermas 1970/1988 p136, Wellmer 1971, p29).

From the direction of social psychology, Billig (1987) has recently argued against the idea that prejudice and stereotyping are merely inevitable instances of the normal cognitive processes of categorisation:

> If prejudice, or stereotyping, is the outgrowth of normal thought processes, then one can ask how, on this logic, it is possible to have tolerant thoughts, especially since we have a "propensity" for prejudice? (p126)

For Billig, cognitive theories often develop a one-sided image of the person which excludes particularisation, and in the process they fail to grasp the essence of thinking itself:

> The automatic application of categories is the negative of thinking, in that it is essentially a thoughtless process. thinking starts when we argue or deliberate about which categorisation to particularise or how to categorise a particularisation. (p140)

Categorisation does not then exist on its own but is accompanied by particularisation. People are depicted as able to choose between different argumentative strategies, drawing upon those categories suitable for the occasion. Billig is therefore arguing for the mutable nature of prejudices and stereotypes which may be challenged and used imaginatively in the rhetorical contexts of justification and criticism[10]. It is

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[10] Billig's (1987) work occasionally generates, peritropically, a hint of paradox. For if, as he argues, no argument ever has the last word, then from where does Billig's argument about arguments speak? This is another version of the relativist paradox. His efforts to avoid this appear to take him towards Habermas (Billig 1991). See my discussions below.

this process, I argue, which survey research misses.

But what may appear to be a disjunction between the views of Billig and Gadamer turns out not to be the case. Gadamer does not see prejudice as static, ahistorical or necessarily restricted to categorisation per se, and Billig does not advocate a *tabula rasa* of cognitive processes nor the possibility of a value-neutral language. Both would agree on the primacy and 'inner infinity' of dialogue, debate and argument and both would be likely to concur that on the cognitive level, prejudices involve a dialectical relationship between the general (categorisation) and the particular[11].

This brief consideration of stereotypes and prejudice has served two purposes. The first has been to reinforce the idea that stereotypes and attitudes may be used differentially in debate and argument (cf. Potter and Wetherell 1987, Quastoff 1978); in other words that while stereotypical images may well 'exist', they may or may not be drawn upon or reinforced in

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11 I have attempted to pull Billig and Gadamer together here. However the issues are at least as complex, we might say, as those which separate Protagoras from Socrates. There is certainly a notion in Gadamer of dialogue towards truth which appears to parallel Socrates' notion of a 'common search' for truth (Plato 1956, Billig 1987 p24), although for Gadamer there can be no 'closure', no end to understanding, and dialogue cannot be transcended by the attainment of an ideal world of eternal truth as Plato might have wished. On the other hand Billig does recently seem to be moving towards the position of Habermas in his suggestion that some reasons are better than others, and his celebration of argumentation which 'would express the wish for conditions of undistorted communication.' (Billig 1991 p26). Or again, Billig suggests that Socratic dialogue is not a good example of 'true conversation' as Gadamer (1975/85 p326-347) implies, but actually Protagorean in form and in its regular *lack* of agreement (Billig 1987 p24-48). Elsewhere Gadamer (1976 p24) has emphasised the interlocking ubiquity of rhetoric and hermeneutical understanding, derived from their joint rootedness in 'everyday discourse and common-sense experience' (Dallmayr 1991 p20). See also Stone (1988).

practice. The second has been to introduce the important idea of the universality of hermeneutics as dialogue, that 'the quintessence of our being is to *be dialogical'* (Bernstein 1986 p65). It is in this sense that I understand not only participant-observation and the interpretation of historical documents drawn upon in this study but also the analysis of discourse presented in Part Three.

Natural and Social Science

In contrast to a positivist view of natural science in which the observer allows him or herself to be impressed by objective reality, having removed bias, prejudice and emotional involvement, 'Observation is shot through with interpretation, expectation and wish' (Scheffler, quoted in Mulkay 1979 p47). From developments within many branches of the human sciences (e.g. philosophy of science, the sociology of scientific knowledge, the psychology of perception, critical anthropology and critical theory), the observer must now be seen as actively ordering reality, so that observation consists in the active interpretation of sense-impressions in terms of a linguistic, theoretical, and practical framework. Some concepts and theories are always present in the very act of scientific observation. Following the debates involving Kuhn, Popper, Lakatos and Musgrave, Feyerabend and others, such arguments are now no longer new[12]. The relativist-constructivist perspective has caught up with natural science (e.g. Woolgar 1988a, 1989, Knorr-Cetina and Mulkay (eds) 1983), and to paraphrase Habermas (1986a p204), a fallibilist conception of truth and knowledge has become trivial and commonplace[13]. Hermeneutic endeavour is

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[12] The arguments here probably do not require further rehearsal.

[13] Within the philosophy of science the view of the theory-ladenness of observation in fact has a long history. See Kolakowski (1972) for an account of Duhem and conventionalism. Popper produced his *Logic der Forschung* in 1934.

not confined to the social sciences but is central to the natural sciences. At the same time we may agree with Giddens (1976 p79, 1977) that since the objects of natural science do not, as far as we are willing to concede, themselves interpret the world[14], then we may still distinguish between a single and a double hermeneutic[15].

From the perspective of the 'post-empiricist' philosophy of science, natural science has become a complex affair in which there appears to be nothing in the physical world which uniquely determines the conclusions of the scientific community. In the words of Derek Phillips (1979 p84) '...nature[16] has something to say although it does not determine what we can say.' In contrast to the standard view, therefore, natural scientific knowledge has come to be seen (by some) as not stable in meaning, not independent of social context and practices or the communication structures of investigators, and not certified by the application of universally agreed scientific procedures (Knorr-Cetina 1981, Knorr-Cetina and Mulkay 1983, but cf. Lynch and Fuhrman 1991, Radder 1992, for criticisms of this position).

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[14] But see Law (ed) (1991) and my computer's independent communication in Woolgar (1991 p92).

[15] Although from Woolgar's (e.g. 1983, 1988a) relativist and 'constitutive' position, (and compare also Gadamer 1975/1979 and Wittgenstein 1953/1958), what we take to be precise differences between the respective natures of subject and object are themselves the agonistic (and textual) *outcome* of social practices (cf. Law (ed) 1991, Latour and Woolgar 1979). Or, further, in the terms of Law (1991 introduction), what appears to be 'social' is in fact 'sociotechnical'. Compare also Bhaskar's (1979/1989) realism, and Knorr-Cetina (1981).

[16] Although I think we must be continually aware of the danger of perpetuating the opposition between (wo)mankind and nature.

Rationality and Relativism: The Relevance of Habermas

The extension of the notion of the theory-ladenness of observation to the natural sciences, together with the associated idea of the underdetermination of theory by evidence, has led inevitably to the 'problem' of relativism[17]. If all observations are necessarily impregnated with theory, then it appears as if scientific knowledge is determined by its theoretical presuppositions rather than the world itself. Instead of theory-neutral observation we end up with observation-neutral theory (Sayer 1984 p70). Instead of the positivist exclusion of the reflecting subject, there is an exclusion of the object, but at the same time the subject becomes unable to account for its own objectivity as part of the natural world. Linked to such terms as 'incommensurability' and 'subjectivism', the nature of rationality itself apparently becomes problematic. Without a grounding in an objective and independent world how can we defend science as a 'rational' enterprise? This opposition of objectivism and relativism (Bernstein 1983, 1991) can be seen as the modern moment of an ancient debate about man's place in the universe. It may be reconfigured for example as a dichotomy between realism[18] and relativism (e.g. Woolgar 1988a, Potter and Wetherell 1987),

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[17] The interesting conjunction of the 'return' of madness to the community and the rise of the spectre of relativism, itself sometimes seen as a kind of madness (e.g. Lawson 1985), in philosophy and science, cannot be pursued here.

[18] In its simple form 'realism', which is often referred to here, refers to the notion that things (objects, meanings, motives) pre-exist their surface signs. In Woolgar's view this belief is part of an 'ideology of representation' (1988a ch 7, 1989). My own position tends towards ontological realism and epistemological relativism (see Outhwaite 1987). On the other hand I believe it is important to continually monitor the social consequences of holding these respective views.

scepticism and foundationalism (Hamlyn 1970), or scepticism and universalism (Ferrara 1987).

There are many ways of approaching this debate. I have chosen here to provide a very brief[19] comparison of the work of Habermas with that of Garfinkel and Gadamer.

To attempt to capture Habermas' position in a nutshell might be to say that for Habermas emancipation and critique are located in a certain kind of social action, which he calls *communicative* action. To some extent the effort in Part One of his *Theory of Communicative Action* might be characterized as the provision of a 'quasi-anthropology' in Habermas' words (1986a p213), that is, a view of what it is to be human[20] (Brand 1990 p122), and in the process Habermas takes as central not the philosophy of consciousness, not the subject-object relation, but the subject-subject relationship. This paradigm shift is central and vital. The epistemology of the philosophy of the subject promotes an isolated subject encountering, representing and acting upon, a separate object (Brandt 1990 p16, Habermas 1984 p391-2), while its ontology is much too narrow (i.e. it contains impoverished versions of world-relationships and world concepts). It is this move which allows

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[19] It is difficult if not impossible to produce a comprehensive overview of Habermas' work in only a few pages because of its wide ranging and at times extremely complex nature. As a result the following account is at best severely partial and I present a largely sympathetic reading. However, Habermas has drawn substantial criticism. See, e.g., Bernstein (1985), Held (1982), Honneth and Joas (1991). Rasmussen (1990) provides an extensive bibliography of secondary literature. Elsewhere, (Southgate 1992c) I have provided an analysis of insanity ascriptions from the perspective of Habermas' formal pragmatics.

[20] But note that for Habermas communicative competences oriented to validity claims vary historically according to the degree of rationalization of the life-world (Habermas 1976 p14-15, 1979 p98, 1987a p77 *ff*).

Habermas to distinguish between different types of action and rationality concepts, and to extend the action and rationality framework beyond that of the purposive-rational. As Brandt (1990 p10) puts it in relation to post-empiricist philosophy of science, 'Rather than accepting that the arbitrariness allegedly found in the realm of norms and values has now also penetrated the realm of science, he has emphasised that potentially, norms too can be a subject of rational discourse, as can be inner states and feelings'.

This allows Habermas not only to reconstruct for example Marx, Durkheim, Weber, and Horkheimer and Adorno, and the theory of reification in terms of the rationalization processes of life-world and system, but also to locate and ground his own reconstructive science as an immanent critique; that is, in contrast for example to the *Dialectic of Enlightenment*, Habermas' critical theory shares a common normative ground with its object of analysis (Wellmer 1985 p52, and cf. Habermas 1982 p252, Bernstein 1985 p17, Fay 1987, Roderick 1986 *passim*).

In *The Theory of Communicative Action* the concepts of communicative rationality and action are developed via an analysis of other rationality and action concepts. To summarise, Habermas' argument here is that only an understanding of communication in which the subject can be seen to relate to three worlds; the objective, the social, and the internal, with the corresponding validity claims of truth, normative rightness and sincerity, is sufficiently comprehensive to distinguish the basic modes of language use or functions (1984 p278).

Because of their central importance it is necessary here to clarify more precisely the meanings of communicative action, validity claims, and communicative rationality:

a) Communicative action refers to action which is oriented to agreement, coordination and cooperation. It designates a type of interaction that is coordinated through speech acts but which does not coincide with them. The communicative model of action does not therefore equate action with communication, and the teleological structure is fundamental to all concepts of action (1984 p101, 1986a p213).

b) The concept of communicative action contains the notion of the rational redemption of validity claims[21] which are raised in all such action: 'Thus a speaker owes the binding (or bonding: *bindende*) force of his illocutionary act not to the validity of what is said, but to *the coordinating effect of the warranty* that he offers: namely to redeem, if necessary, the validity claim raised with his speech act' (1984 p302). A validity claim therefore is equivalent to the assertion that the conditions for the validity of an utterance are fulfilled (1984 p38). In this way the discursive redemption of validity claims, good reasons, and the power of the better argument can be seen as central aspects of Habermas theory, and act here as a 'security reserve', *contra* sanctions, gratifications, force or money (1982 p269). In contrast to restricted notions of social action, in communicative action validity claims are raised in relation to three worlds: the objective world (truth claims), the social world (claims to normative rightness) and the internal

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[21] Although Habermas appears to see these claims as inherent in the structure of speech (e.g. 1979 p54, 66-7, and McCarthy's introduction pxix, also 1982 p235, 271-2, Giddens 1985a p128), his analysis proceeds via an examination of the general presuppositions of *communicative* action, an orientation to cooperation, agreement and understanding (*Verständigung)* (1979 p1). His justification is that other forms of social action such as 'conflict, competition and strategic action in general', are derivatives of, and parasitic upon, communicative action (ibid, and see the discussion below).

world (sincerity claims)[22]. Only the first two are capable of redemption in discourse (Habermas 1979 p64, Giddens 1985 p129)[23].

c) Habermas argues that different models of social action entail different relations of actor to the world (1984 p102) and that these differing 'world-relations' involve differing notions of rationality. For example, taken in isolation, the relation between an actor and the external, object, world, may implicate a cognitivist-instrumental rationality and action. But from the perspective of communicative action this becomes simply one part of a wider view of rationality and action (1984 p10). From the latter position, 'This concept of *communicative rationality* carries with it connotations based ultimately on the central experience of the unconstrained, unifying, consensus-bringing force of argumentative speech, in which different participants overcome their merely subjective views and, owing to the mutuality of rationally motivated conviction, assure themselves of both the unity of the objective world and the intersubjectivity of their lifeworld.'(ibid). For Habermas, therefore, communicative rationality involves an orientation to reaching understanding; a willingness to pursue issues discursively, based on the inter-subjective recognition of criticizable validity claims.

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[22] Habermas also refers to a validity claim of comprehensibility, that is, a claim that speech or language use itself is coherent and intelligible. As Holub (1991 p13) notes, the claim to comprehensibility is 'fulfilled within language itself and thus does not belong to pragmatics.' Formal pragmatics is therefore oriented to the other three claims (cf. McCarthy's introduction in Habermas 1979 pxix and p28).

[23] Habermas argues that the truthfulness of utterances (sincerity claim) can only be checked against the consistency of subsequent behaviour (1979 p64). Presumably this includes verbal behaviour.

For the social researcher one important implication of applying this extended framework of action and rationality to both researcher and subjects is that the methodological gap between the two thereby disappears: 'As soon...as we describe behavior in terms of communicative action, our own ontological presuppositions are no longer more complex than those we ascribe to the actors themselves' (Habermas 1984 p118)[24].

Habermas' scheme has something in common with the kind of critique offered by Garfinkel, and so Habermas is not unsympathetic for example to the notions of the documentary method, and the projection and cooperative production of an occasional commonality, or the 'occasioned corpus' (1984 p100, 125). But this sympathy has a limit, to the extent that ethnomethodology presents itself as more than a critique of method and as a theory in its own right. And this brings us to the crux of Habermas' argument in relation to Garfinkel (Habermas 1984 p128).

For Garfinkel, standards of rationality are to be treated, along with facticity, objectivity, etc, as phenomena; that is, as contingent accomplishments of socially organised practices. For Garfinkel's actors, what is universal is merely taken to be so by actors and is in fact merely locally occasioned (Garfinkel 1967 p33). As a result rational properties of practical activities should not be assessed, recognised, described, outside of the action settings within which such properties are produced, recognised, used etc (ibid). But Habermas argues that this raises problems for the status of Garfinkel's own theory and standards of validity which appear

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[24] This also means that the same kinds of validity claims are raised both within and outside the interview world, although the precise form such claims take will vary.

to lie outside the domain of those applied by the participants themselves (1984 p129). Elsewhere, Habermas (e.g. 1982, 1987b p119, 1990 p89) has termed this a 'performative contradiction'[25]. For Habermas the dilemma here is one of 'either a Husserlian absolutism or a confessed relativism' (1984 p130). This dilemma, he argues, can be escaped only if Garfinkel would

> ...take seriously the claim to universality implicitly built into the ideas of truth and rightness as pointing to *the validity basis of speech*. The social scientific interpreter, in the role of an at-least virtual participant, must in principle orient himself to the *same* validity claims to which those immediately involved also orient themselves; for this reason, and to this extent, he can start from the always implicitly shared, immanent rationality of speech, take seriously the rationality claimed by the participants for their utterances, and at the same time critically examine it. In thematising what the participants merely presuppose and assuming a reflective attitude to the interpretandum, one does not place oneself *outside* the communication context under investigation; one deepens and radicalises it in a way that is in principal open to *all* participants. In natural contexts this path is often blocked; but is always ingrained in the very structure of action oriented to reaching understanding (1984 p130).

For Habermas, therefore, the given context can be transcended, and everyday interpretations can be reflectively penetrated (1984 p128). The potential for critique is built into communicative action itself (1984 p121) so that the lack of the methodological gap between researcher and researched becomes not a hindrance but the means by which critique can be sustained. The general structures of communication which

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[25] Similar criticisms may be levelled at the discourse analysis of Potter and Wetherell, and Gilbert and Mulkay, and the rhetorical approach of Michael Billig. The latter for example argues singlemindedly that every argument has two sides. The former offer definitive versions (accounts) of the problem of identifying members' definitive versions (accounts).

competent subjects have learned to master, and which Habermas had identified in his theory of formal pragmatics, not only open up access to specific contexts, but also simultaneously provide the critical means to penetrate a given context, 'to burst it open from within and transcend it; the means, if need be, to push beyond a de facto established consensus, to revise errors, correct misunderstandings...' (1984 p120). This potential for critique can be exploited by the social scientist[26].

This brings us to what has been called one of Habermas' 'most basic and challenging theses' (Bernstein 1985 Introduction p10): that to understand involves understanding reasons, and that understanding reasons involves (at least implicitly) evaluating them, that is, taking a 'yes' or 'no' position on them (1984 p132 *ff*, p192)[27]. This '*very* strong thesis' (McCarthy 1985 p184) which has drawn substantial criticism (ibid, and Schädelbach 1991), appears to lend theoretical and practical weight to the aspect of critique which Habermas wants to find

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26 Of course it may be objected that we do not need this kind of theory in order to engage in argument over fact, norm or value. That we do this all the time cannot be denied but then the question becomes 'What is the philosophical and sociological significance of such debate or argument or disagreement?' From the perspective of Habermas what is at issue here is rationality itself. The very criticizability which, so to speak, is built into formally pragmatic validity claims, links them up directly to the anticipation of an ideal speech situation, and to a critique of structures of systematically distorted communication. The attempt to thematise validity claims and the success or failure of our endeavours may determine whether we come to suspect that some communication is systematically distorted. At the same time as rationality inheres in the promise of discursive redemption of such claims, so we can say that the (moving) ground of critique also lies here. As well as 'grounding' critique, Habermas provides I suggest a practical model for thinking about what may be going on within discourse, as I shall later show.

27 So for the researcher too, questions of meaning cannot be strictly separated from questions of validity in contexts of communicative action (Habermas 1984 p106, p115-6).

in language itself. This position suggests that in the process of attempting to make sense of a situation, to reconstruct a common definition in the face of a breakdown in communication, the participant (including the social scientist) must judge and evaluate. Habermas has himself provided some examples of how this may apply. One example, 'the least plausible', concerns 'explanations for what appears from the perspective of the speaker to be unmotivated laughter in the audience' (Habermas 1991 p230)[28].

Another way in which the above arguments can be displayed concerns Habermas' critique of philosophical hermeneutics. There has been a substantial debate between Habermas and Gadamer (see Habermas 1970/88 edition, Warnke 1987, McCarthy 1978/1984, Holub 1991). And Habermas (1970/88) has also engaged with Wittgenstein and Winch. What is common to these debates is Habermas' critique of what he views as the authors' subjectivism or relativism. His own critical moment has to be found, as above, in action oriented to communication; to the rationality inherent in the power of the better argument, rather than the argument of power.

Against Gadamer and Winch, Habermas pitches a quasi-universal formal-pragmatic framework in the discursive redemption of

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[28] It is possible to extrapolate further here. If, when asked, the audience provides the reason for laughter as 'You told a joke', I may reply 'No, I didn't', thus disagreeing with the audience, but still understanding why they laughed; a successful evaluation. In this sense, understanding, as Habermas stresses, does not necessarily involve agreement. On the other hand the audience may say 'The scenery's collapsed behind you.' I evaluate their reason by looking behind me and, if they are correct, agreeing with them, thereby understanding their laughter. However if they reply 'Because of your blue tie' I may feel I cannot say 'yes' or 'no' to this reply, and finally admit that I don't understand their laughter. Of course I may decide not to bother inquiring, in which case I again have not yet understood their laughter.

validity claims. Rationality constitutes a willingness to press on discursively. The ideal speech situation which allows consensus only through generalizable interests (Habermas 1976 p 110) can be seen to be *anticipated* in all communicative action and any attempt to challenge this argumentatively only presupposes what it tries to dispute, depending as it does upon the power of the better argument. The centrality of argumentation is of course a difficult one to dislodge in argument without raising the protest of '*tu quoque*' that is, it constitutes a performative contradiction (cf. Habermas 1990 p89, McCarthy 1978/1984 p321, T.Smith 1981, White 1988 p50-65). As McCarthy puts it:

> The arguments that relativists put forward on behalf of "primitive" cultures not only appeal to standards of argumentation absent from the cultures they defend but make use of modes of reflective reasoning (metatheoretical, metaethical, epistemological, historical and anthropological) that are largely unavailable in those cultures. (1978/84 p321)

Nevertheless, as Habermas acknowledges (1976 p109-10, p158-9), there is a decisionistic residue in his position (cf. McCarthy ibid, Smith ibid, White ibid) which concerns the non-rational decision to enter into argument, which it appears cannot itself be argumentatively justified, without entering a vicious circle. In other words argumentation is not the only language game (Smith 1981 p76). In terms of practical discourse we might say that the establishment of the principle of universalizability of interests itself rests on a mere decision (Smith 1981 p75).

Habermas attempts (successfully Smith 1981 says, unsuccessfully according to McCarthy 1978 p321) to defend his position in the following way. Criticising the notions of monological thought and action, he argues:

> Anyone who does not participate, or is not ready to participate in argumentation stands nevertheless "already" in contexts of *communicative action*. In doing so, he has already naively recognised the validity claims - however counterfactually raised - that are contained in speech acts and that can be redeemed only discursively. Otherwise he would have had to detach himself from the communicatively established language game of everyday practice. (1976 p159)

In terms of this discussion it should be noted that in his more recent work Habermas has played down the notion of the 'ideal speech situation' which is largely absent (in explicit form) from his (1984, 1987a) *magnum opus* (cf. Brand 1990 p125, Dews 1986 Introduction p18). He acknowledges that the details of this proposal may be unsatisfactory but still regards his original intention as correct (see Habermas 1984 p25, 1990 p88). He has suggested for example that if the distinction between what is held to be true here and now, and what would be taken as true under ideal conditions made no sense, then we could not explain how we could learn reflexively, that is, improve our own standards of rationality (from Brand 1990 p125).

But Habermas also stresses that practical discourse cannot generate the *content* of norms, and cannot decide issues of the 'good life' (1990 p103, 1986 p210, 1984 p17)[29]. In addition Habermas has no substantive conception of human needs, but rather argues that the definition of human needs is culturally variable (e.g. Habermas 1986 ch 7, Dews 1986 Introduction p19, White 1988 p70, cf. Doyal and Gough 1991). In relation to the principle of generalizable interests, Habermas is clear that this is only a model for *criticizing* interests which unjustly

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[29] Thus: 'Practical discourse is not a procedure for generating justified norms but...for testing the validity of norms that are being proposed and hypothetically considered for adoption.' (1990 p103).

pass themselves off as universal (1986b p175). In modern societies there is often no general interest at stake but usually only particular interests. In this sense then practical discourse cannot somehow *generate* a generalizable interest, but must be content with the *withdrawal* of legitimacy from the privileging of one side which falsely claims to represent a general interest. Where particular interests are at stake then 'even in ideal cases' conflicts of action can only be settled by bargaining and *compromise* (Habermas 1986b p176, 1976 p112). It is important therefore to realize that for Habermas the ideal speech situation is just that: an ideal, which can never be attained in reality, but may yet prove a useful idea.

I believe that the above points go some way to correcting misunderstandings which are sometimes evident in commentaries upon Habermas' work. Thus Hammersley's (1992) recent and acute critique of ethnography nevertheless only partially grasps the thrust of Habermas' position. For example, in his discussion of validity claims, Hammersley (1992) suggests:

> ...(Habermas) argues that only if these claims are accepted by other participants as what would be recognised as true in the ideal speech situation can understanding take place (p114).

As far as I can see Habermas nowhere says this, and indeed from his major work he is at pains to point out that the evaluation of validity claims need not require agreement for understanding to take place (see examples above). In other words disagreement may equally lead to understanding which is by no means restricted to reference to an ideal speech situation[30].

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[30] Similarly, Fay (1987 p188) rejects Habermas because of the latter's '...unstated assumption that to understand a speech act is to agree with it.' Although this position may have been implicitly present in Habermas' earlier (e.g. 1979) work, Fay largely ignores his more recent arguments.

Habermas attempts to add a further dimension to this issue by linking his theory of argumentation, the objectivity of discursive standards of rationality, to a developmental logic underlying the acquisition of communicative competence (Habermas 1970a, McCarthy 1978/1984 p321) via an analysis of Piaget and Kohlberg. I am unable to consider this here.

Finally, and in a manner which is of vital theoretical and methodological importance for sociology (Brandt 1990 pxiv), Habermas connects communicative rationality up with the developmental logics of life-world and system (Habermas 1976, 1979, 1984, 1987a). I have provided an outline of his arguments in another paper (Southgate 1992b).

Habermas and Rhetoric

Before moving on to provide an indication of the relevance of Habermas for this project, and to discuss the methods adopted, I need to consider briefly the relationship between Habermas and the tradition of rhetoric; both are drawn upon in this thesis. To what extent, I wish to ask, is an acknowledgement of the centrality of rhetoric for an understanding of social life and social science compatible with Habermas' project? Can Habermas' scheme accommodate rhetoric, or does rhetoric subvert it?

I have shown above that Habermas is intent upon providing a kind of formal grounding for a critical theory, located in communicative action itself, which for Habermas is the original mode of language use (Habermas 1984 p288). We might say that in order to fulfil his project he *must* persuasively argue that the orientation of language use to co-operation and agreement has a conceptual and practical priority over the strategic use of language (cf. Culler 1985). The critical moment *must* be

located in truth and agreement rather than dissimulation and domination, otherwise it would not function as a grounding for a critical theory, and indeed Habermas argues that the instrumental use of language is *parasitic* upon communicative action (Habermas 1984 p288).

His method is to turn to speech act theory for a model for action oriented to reaching understanding (ibid). Habermas defends his use of this model by distinguishing perlocutionary from illocutionary acts such that perlocutionary acts *inter alia* can serve the nonillocutionary aim of influencing hearers, only if they are suited to achieve illocutionary aims (1984 p293)[31]. Thus the use of language with an orientation to consequences 'is not an original use of language but the subsumption of speech acts that serve illocutionary aims under conditions of action oriented to success' (ibid). Perlocutions are defined here in terms of the employment of illocutions as means in teleological contexts of action and thereby conceived as a special class of strategic interactions (ibid)[32]. Habermas' effort is to ground his distinction between communicative and

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[31] In other words, in order to covertly influence another, we must still perform illocutionary acts. These arguments become a little more accessible once one understands the lexicon. Habermas 'catchphrase' for grasping locutions, illocutions and perlocutions is as follows: to say *something*, to act *in* saying something, to bring about something *through* acting in saying something (1984 p289). However I find more helpful the following distinction: in illocutions, 'the communicative intent of the speaker and the illocutionary aim he is pursuing follow from the manifest meaning of what is said.' (ibid). In other words illocutionary aims and meanings can be 'read off' the surface structure of the sentence. With perlocutions however there is a further meaning which cannot be directly read off the sentence. It is in this distinction that Habermas finds his de-centred model of language-in-use.

[32] Habermas distinguishes two types of strategic action: a) concealed (i.e. perlocutions) and b) open (1984 p333). Concealed strategic action is again subdivided into conscious and unconscious. Open strategic action refers for example to commands and requests, action oriented to success. In the strategic attitude only indirect understanding via determinate indicators is possible (1979 p209).

strategic action, not in intentions, but in the structure of language use itself, and it is this *originary* structure which, he argues, the analysis of illocutionary acts yields.

The privileging of communicative over strategic action has been challenged by a number of critics (e.g. Culler 1985, Farrell 1981, Rasmussen 1990, Roderick 1986 p159, Wood 1985). Drawing upon Culler, Rasmussen for example argues that Habermas is not sufficiently able to unambiguously distinguish perlocutionary from illocutionary acts (ibid p39). Rasmussen suggests that this can only be done by anchoring this distinction in an intentionalist semantics or a phenomenological notion of intentionality, paths that have been ruled out by Habermas as a return to the epistemological framework conceived within the paradigm of the 'philosophy of consciousness' (cf. Habermas 1984 p274 *ff*).

However, by suggesting that we must be able to clearly distinguish illocutionary from perlocutionary acts Rasmussen may be missing the point. That we cannot tell whether someone is acting perlocutionarily might arguably be seen to be irrelevant. We do not need to distinguish the two clearly in practice, for us to reject one as a potential model that is supposed to explain the linguistic mechanism of coordinating action by way of the illocutionary binding effect of speech acts (Habermas 1984 p294). While in *theory* of course, it is possible to distinguish illocutionary from perlocutionary acts as Rasmussen notes, but it is in part precisely because of the intentionality linked to perlocutions (as well as other difficulties) that Habermas rejects perlocutionary acts as the basis for his model, leaving the illocutionary act to bear the burden.

And similarly Culler's (1985) argument that the distinction between perlocutionary and illocutionary acts is not actually a distinction between communicative and strategic action may also be misplaced. Culler (ibid p136) argues that many illocutionary acts seem designed to produce certain effects rather than to bring about understanding. But in fact Habermas spends considerable time in acknowledging that not all illocutionary acts are constitutive for communicative action, but only those with which speakers connect criticizable validity claims (Habermas 1984 p305). He states:

> ...when a speaker is pursuing undeclared ends with perlocutionary acts - ends on which the hearer can take no position at all - or when a speaker is pursuing illocutionary aims on which hearers cannot take a grounded position - as in relation to imperatives - the potential of the binding (or bonding) force of good reasons - a potential which is always contained in linguistic communication - remains unexploited. (ibid)

Thus, simple commands or requests, expressions of will which lack normative authorization, may take the form of illocutionary acts which are nonetheless strategic or instrumental, oriented to success rather than understanding or agreement. However the objections of Culler and others may still promote a sense of unease which may also be derived from Habermas' minimal analysis of the relationship between rhetoric and communicative action. To a large extent rhetoric is consigned by Habermas to the bin of concealed strategic action (perlocutions) and hence cannot play a part in the grounding of a critical theory. It is perceived as identical to dissimulation and deceit, to the attempted achievement of a forced consensus (Habermas 1984 p129, 288). And yet the rhetorical use of language *may* arguably be oriented towards truth rather than deception, for example in the use of irony, as Farrell (1981 p916) notes.

Habermas does of course acknowledge that rhetoric plays an unmistakable and 'ineradicable' (Habermas 1987b p209) part in

everyday life[33] but he wants to maintain a distinction between those contexts in which the rhetorical (poetic) function assumes centrality, as in literary theory, and those of everyday life in which it plays a subordinate role (McCarthy pxiii, introduction to Habermas 1987b). In the former, rhetorical elements take on a life of their own and language is disengaged from everyday practices and routines. Habermas argues that in the work of Derrida and others, language's capacity to solve problems disappears behind its world-creating capacity (ibid pxiii, p201). And while rhetoric may be present in scientific and other discourses he suggests that it is subordinated or 'tamed' (ibid p209) to problem solving and distinct forms of argumentation[34]. The rhetorical elements in language therefore assume '*entirely different* roles' (ibid).

On the surface Habermas appears to be pursuing an old dichotomy between rhetoric and truth (Mason 1989). He wants to retain specialised discourse, such as that of science, as a realm in which rhetoric plays second fiddle to the power of the better argument. To the extent that this division appears essential for his notion of the ideal speech situation[35] (Habermas 1970a), as well as the distinction between the blocking of, and the

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[33] A related objection may be made that Habermas *underplays* the central role of disagreement and partial understanding in life (cf. Shotter 1989 p164). However Habermas does acknowledge that this may be the case: 'Stability and absence of ambiguity are...the exception in the communicative practice of everyday life.' (1984 p100, and see 1982 p235-6).

[34] See Gaonkar (1990) for a recent endorsement of the old argument that rhetoric cannot escape its marginal status and is 'parasitic' upon other discourses (e.g. of science, ethics, politics) rather than productive of them, and cannot turn itself into its traditional counterpart 'dialectic'.

[35] However there seems no logical reason why the ideality of the ideal speech situation cannot encompass rhetoric as an aspect of itself oriented to truth (cf. Farrell 1976 on rhetoric and consensus).

thematisation of, validity claims, then there may be a problem here in so far as the rhetoric of, for example, scientific inquiry, may at times play a major rather than a minor role[36]. However, while it is not difficult to locate science as a highly rhetorical activity, Habermas' point may still apply; that rhetoric may be used in the service of theoretical and practical problem solving, for instance in terms of the rhetorical standardisations of objectivity[37] or the novel and illuminating use of rhetorical tropes. The latter, although perhaps 'world-disclosing' (i.e. imaginative, creative), are still harnessed here in the pursuit of, for example, truth or the solution of technical problems. The contrast is with literature in which the rhetorical means of representation 'depart from communicative routines and take on a life of their own' (1987b p203), the 'poetic' function, in Jacobson's terms. The use of rhetoric may therefore, from Habermas' perspective, be consistent with an orientation to truth[38]. At the same time

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[36] For this position in relation to the human sciences see e.g. Nelson et al (1987), Simons (ed)(1989), Shapiro (1985-6). For analyses of the relation between rhetoric and natural science see also e.g. Campbell (1975), Gusfield (1976), Harré (1990), Overington (1977), Simons (1980), Simons (ed)(1990), Woolgar (1988a) and cf. also Gilbert and Mulkay (1984), Yearley (1981) and Kuhn (1962/1970). For sociology and rhetoric add e.g. Brown (1977/1989), Davis (1986), Edmondson (1984), van Maanen (1988). Davis and Hersh (1986/88 p57-73) and Shotter (1989) comment upon rhetoric and mathematics, while anthropology and rhetoric has been tackled by e.g. Clifford (1983), Clifford and Marcus (1986), Marcus (1980), Marcus and Cushman (1982). For a critique of the 'anti-epistemic' elements of the 'rhetoric of inquiry' perspective see Keith and Cherwitz (1989).

[37] Compare the discussion of methods 'triangulation' in Woolgar (1988a).

[38] My argument is that this recognition does not entail the collapse of Habermas' central theoretical distinction between illocutionary and perlocutionary acts. But leaving this complex argument to one side it is clear that, importantly, rhetoric in a broad sense is in any case neither identical to perlocutionary acts nor to strategic action.

although rhetoric is an 'ineradicable' part of our everyday lives, this does not mean that we cannot and do not distinguish truth from untruth. Rhetoric and truth, we may say, are in fact intertwined, both pointing to and relying upon the other and Habermas is quite aware of this[39]. As Mason (1989 p93) puts it: 'It is clear that if any truth can be expressed in words, its expression will have a rhetorical shape.'

Another way of addressing the difference between everyday, practical problem solving, and the play of literary texts, is to examine the distinction between fact and fiction (cf. drif 1991 quoted in Appendix D p481). Clearly the two are intimately and complexly related but arguably one major difference from the perspective of Habermas is the blocking or partial blocking of the redemption of validity claims which fiction involves (cf. Lamarque 1990, Pratt 1977, Searle 1975).

The above discussions suggest that although an acknowledgement of the place of 'rhetoric' in all discourse somewhat muddies Habermas' arguments, it still seems possible that from Habermas' position a rhetorical view of the world and a rhetorical analysis of the kind provided later in this research project can be consistent with the 'pursuit' of truth; or perhaps better, with the raising of truth claims, and thus with his theoretical framework of formal pragmatics. Indeed, as Simons (1980 p127) points out, the classical conception of rhetoric encourages the 'eulogistic sense' of rhetoric as the

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[39] Compare Culler (1981 p41) who argues that rhetoric logically relies upon a distinction between literal and rhetorical meaning; rhetoric cannot do without the literal, the unambiguous, the fixed. And at the same time the literal, in order to *be* literal, demands its other, the figurative. Aristotle (1991 edition) probably prefigured this argument *contra* the Platonic Socrates for whom persuasion is contrasted negatively to virtue, wisdom and the search for truth. See also Leff (1978) for an overview of comparably recent work on rhetoric as epistemic.

offer of *good* reasons in matters of judgment, while Haarscher (1986) has noted an inner connection between the work of Perelman and Habermas. And in his more recent work, Michael Billig (1991) draws upon the work of Habermas in his elaboration of the moral vision at the heart of rhetoric as a critical approach. Further, Nelson and Megill (1986 p27) consider that Habermas, in his later work, is attempting to '...harmonise many projects in social theory with communication and rhetoric' and to '...rejoin philosophy and rhetoric...'.

But should this argument still lack persuasion I think it is possible to find further signs in Habermas' work which provide for the analysis of rhetoric in sociological research. Habermas wants to argue that his delineation of formal pragmatic validity claims, central to communicative action, may be empirically useful. But how can this be when they appear to be so idealised? He suggests that what is necessary is a step by step reversal of the 'strong idealizations by which we have built up the concept of communicative action' (Habermas 1984 p330). Such a reversal involves admitting into the arena for analysis: implicit utterances, ambiguous expressions, texts and conversations, and background knowledge, and provides for the increased possibility for the analyst to better distinguish strategic from communicative action (ibid p330-1).

Elsewhere Habermas responds to an objection that no relation to normative contexts can be inferred from the meaning of nonregulative speech acts (ibid p311). Simple constatives for example do not always immediately or intuitively appear to have a normative correlate, whereas for example 'I order you to get off the train' does. Habermas replies that nonregulative speech acts can 'go wrong', that is, may be inappropriate, out of place, awkward or offensive, thereby indicating that they too

belong to the social world (ibid p311-2). In other words it is possible to see that *how* people talk, including our blunders and rhetorical manoeuvres, may be highly significant for an analysis of validity claims to normative rightness.

And if we remember that for Habermas speakers are reflective in the way they deal with raising validity claims, relativising their utterances against the possibility that their validity will be contested (ibid p99, 1987a p120), then we may also say that the use of rhetorical devices exemplifies the reflexive monitoring of communication in which validity claims may be contested (see Part Three below).

Finally, many of the above arguments appear to hinge upon how rhetoric is defined[40]. I have been proposing above a notion of rhetoric as dialogue and argument, as an approach to everyday life which stresses the two-sidedness of human thinking (Billig 1987 p49, Holmberg 1977) but which as critique demands the provision of good reasons[41]. The latter is close to Habermas' idea of communicative action. But incorporated within the ambit of rhetoric is the whole battery of rhetorical figures. Such devices may be used to persuade, but persuasion can be oriented to either truth and agreement, or to deception and manipulation, or simply to the pleasure of argument. If rhetoric is taken in its pejorative sense then it is not compatible with communicative action. However communicative action itself cannot avoid drawing upon rhetorical figures of speech, and in this sense rhetoric is an unavoidable

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[40] Dixon (1971 p1) suggests that it is notoriously difficult to get hold of, rather like a jellyfish. I am unfortunately unable to offer anything like a history of rhetoric here.

[41] The notion of rhetoric as argument has a long history stretching back to the law courts of ancient Greece.

part of all talk (cf. Gadamer 1975/79, 1976, Lakoff and Johnson 1980)[42].

A New Constellation: Habermas and Discourse Analysis

In the debates about modernity Habermas can be located as a defender of the Enlightenment tradition. However it would be a mistake to conceive of his work as exemplifying yet another totalising system. In terms of the philosophy of history, Habermas indeed rejects grand meta-narratives (Bernstein 1991 p205). His approach is rather to outline those *formal* grounds which may have universal applicability. This does not allow us to specify in advance any normative or moral (or even less, value) content, which becomes a matter for participants themselves (Habermas 1990 p103 *passim*, Dews 1986 Introduction p18 and *passim*).

On the other hand there are those advocates of 'postmodernity' who offer not groundings but their impossibility, via a kind of permanent disruption, challenging, or undermining of traditional understandings and practices. In Woolgar's terms this takes the form of a 'dynamic irony' (1983), an interrogation of the author and of 'ideologies of representation' (1988a). This relativism may become even more

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[42] Richard Lanham has raised an interesting point that rhetoric offers a form for argument but not for compromise. He maintains that in suggesting that all arguments are, or can be, polar opposites it '...does violence to any issue that falls into the "both-and" rather than the "either-or" category' (quoted in Dixon 1971 p69). And certainly Billig's picture for example is of interminable debate, of the 'intrinsically argumentative' nature of discourse (Billig 1991 p206). I think Lanham is wrong however. The understanding that there is always another side to an argument may itself foster conciliation while recognising that some arguments are more reasonable than others (Habermas 1984, Billig 1991 p25). Also, the logic of 'two-sides to an argument', like two sides of a coin, itself contains both identity and difference.

sophisticated in so far as it attempts to deconstruct the very opposition of realism-relativism, or objectivism-relativism itself[43].

Woolgar (1983) celebrates a reflexivity in which the ironicist encourages ambiguity and ambivalence in the effort to bring the reader to a kind of experiential awareness in the joy of irony. This effort to push reflexivity to the limits, to 'radical constitutive reflexivity' (Woolgar 1988b p21), has resulted in the exploration of new ways of expression, in 'New Literary Forms' (e.g. Ashmore 1989 p66, Potter and Wetherell 1987 p183, Woolgar 1982, 1988b, 1989, and cf. Atkinson 1990, Billig 1991 ch 9, Brodkey 1987b, Krieger 1984). These textual methods, which attempt to perpetuate 'dynamic irony', arguably offer the means to reflexively comment upon one's own constructions, one's own rhetoric, *without* in the process establishing a further metaphysical centre, or authorial 'presence', immune from the strictures of one's own arguments[44].

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[43] I might include here Rorty (1982), for whom there only seems to be 'conversations of mankind', without foundations or grounding, as well as Derrida and Foucault. See also Pollner (1991). The link between reflexivity and madness can be gleaned from the predicates used by Pollner to characterise his 'radical reflexivity' (cf. Woolgar, above), viewed from the perspective of traditional social science, thus: 'incomprehensible', 'intolerable', 'unsettling', 'insecurity', 'wild', 'absurd', 'pointless', 'subversive', 'abnormal discourse', 'disrupting'.

[44] The discourse analytic approach advanced in Part Three below is itself seen by Potter (1988) as one such new textual form: '...the researcher's entire reasoning process from discursive materials to conclusions is documented in detail. The discourse analytic report is thus itself a New Literary Form; that is, a specific textual organisation designed explicitly to draw attention to the constructed nature of the analyst's readings. As such the reader is given the opportunity, indeed challenged, to offer alternative readings or better constructions.' (p49). I shall consider in detail below whether this version of discourse analysis solves the problems it claims to solve. At any rate its own kind of reflexivity is less textually ornate than many, including that offered in Appendix D below.

These perspectives of modernity and postmodernity overlap in certain respects but remain apparently irreconcilable in others (cf. Papadakis 1989, Richters 1988, White 1988). It may be possible to imagine them, in the manner of Bernstein (1991), as comprising a 'new constellation[45]' in which both have their place, and in which neither dominates the other; indeed in which each is the other's 'other' (ibid p219), and in which the logic of both/and, replaces that of either/or[46].

From the perspective of an empirical research project concerned with madness and exclusion, critique becomes an inevitable issue (as it may be in all understanding, cf. Habermas 1984). The question then is 'from what place may this critique speak?' In line with Bernstein's recent efforts I propose in this project a juxtaposition of modern and postmodern moments to answer this question. The aspect of modernity is provided in particular by the work of Habermas. I have attempted here the basic effort of showing how his often very abstract theory of communicative action and formal pragmatics may be drawn upon in an empirical programme in a useful and critical manner. References to Habermas and validity claims are sprinkled throughout Part Three. And perhaps ironically I have suggested that a rhetorical analysis conducted in chapter 14 may itself be used to identify the kinds of validity claims which are the most problematic for local people, the kinds of dilemmas which

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[45] Bernstein has always been good at reconciliation, see 1983, 1986. The phrase 'new constellation' had already been used by Habermas (1984 p2).

[46] Although this in itself might be said to privilege the 'postmodern', in so far as it is an aim to deconstruct either/or logic. See Culler (1981), Sampson (1989). On the other hand, by opposing both/and to either/or so that we have to choose between them, he privileges the logic of the latter.

people face. These problematic claims, once identified, become candidates for thematization in a 'discourse' or 'critique'[47], in Habermas' terms, whereby they may be subjected to the power of the better argument, thereby connecting up an otherwise abstract textual analysis to the (formal) pragmatic issues and problems of the real world[48].

It is in this way that the method of discourse analysis of Potter and Wetherell, drawn upon in chapter 14, may be accorded a critical moment which their 'theory' might otherwise deny them[49]. Discourse analysis may then be seen as a form of critical social action in Chilton's (1990) terms, which addresses the validity claims of speakers. In this fashion therefore I have tried to show how rhetorical and formal pragmatic analyses may complement each other[50].

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[47] In his later work (1984 p42) 'discourse' refers to situations in which participants suppose that problematic validity claims can be rationally addressed; and 'critique' to the use of arguments in situations where participants 'need not *presuppose* that the conditions for speech free of external and internal constraints are fulfilled.'

[48] It might be objected that a formal pragmatics linked to counterfactual reconstruction oriented to the model of the suppression of generalizable interests, is itself abstract, or extravagant. But Habermas regards it as concrete and worldly (cf. Habermas 1986b p176, 1990 p103).

[49] Or put another way, formal *pragmatics* provides an extra dimension which links rhetoric with critical theory.

[50] Further, we may say that a central task of rhetorical analysis, 'to make explicit the functioning of rhetoric in the production and reception of discourse' (Gaonkar 1990 p358), is not a million miles from Habermas' concern with the analysis of 'systematically distorted communication'. Compare Habermas (1984 p105) in relation to unconscious processes: 'The interpreter can...uncover the systematically distorted character of processes of understanding by showing how the participants express themselves in a subjectively truthful manner and yet objectively say something other than what they (also) mean (unbeknownst to themselves).'

However in this new constellation it is important to be careful not to simplistically identify rhetorical analysis with the postmodern (cf. Derrida 1988, Culler 1981), for as Derrida points out, rhetoricism may be just another face of logocentricism (Derrida 1988 p156)[51]. Rather, the 'postmodern moments' of the thesis may be 'found' in the juxtaposition of the literal and the figurative, of 'realist' and 'relativist' genres, out of which further meaning emerges. Or, it may be more accurate to say that the postmodern moment is relegated to Appendix D, the experimental chapter. This sets out to reconstruct a dialogue between villagers and patients while at the same time re-presenting the dialogue within a graphically configured relationship. It attempts to provide an evaluative and evaluating framework within which the validity claims raised by villagers can begin to be debated.

In this way I hope that I may be able to capture not only something of the way of life in this particular place; the problems and dilemmas faced by villagers, the relationship between villagers and patients, village and hospital, but also something of the sense in which sociological methodology also faces a dilemma about rationality. How to allow some room for the problems of objectivity, relativism and reflexivity, in a manner which is not simply confined to *theoretical* debate? How to allow madness some textual and methodological room or slack (Connolly 1983, 1987) if such room courts contagion and risks losing the sense of the whole? These are the questions of text and method with which I have been struggling, perhaps in some

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51 And see Billig's (1991 p195 *ff*) discussion of the relation between postmodernism and rhetoric. In the revival of rhetoric Billig wants to avoid accusations of encouraging 'pragmatic rhetoric' (a co-option of rhetoric in the interests of a pragmatic persuasion) or 'romantic conservatism' (which looks backwards to a past 'golden age' of rhetoric). The nature of the 'new rhetoric' is clearly in the process of being 'hammered out' to use Rorty's (1980 p330) phrase.

ways reminiscent of those struggles and dilemmas faced by villagers in relation to the hospital and its patients.

Chapter 6

The Research Sequence:
From Participant-Observation to Discourse Analysis

Introduction

In these pages I provide an account of the practical and theoretical difficulties which I faced during the Shenley study, and how the research itself developed. The provision of a 'natural history' of the development of the project and its problems is arguably necessary in the interests of providing the fullest grounds upon which the adequacy or otherwise of the research program and material may be judged. In this respect I concur with Clarke (1975). Such accounts have found favour in recent literature (e.g. Fielding and Fielding 1986, Hammersley and Atkinson 1983, Shaffir et al 1980 and see Johnson 1975). First then, why Shenley?

In the early days of this project I had set my sights upon a naturalistic study which I believed had considerable advantages over 'attitude' studies. What I sought was a way of examining how people 'actually'[1] behaved in situations and cultures where they are faced with others whom they believed to be psychiatric or former psychiatric patients.

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[1] The inverted commas around the word actually serve to indicate the problematic nature of this quest and account to a some extent for the more recent design changes as I show below.

I chose Shenley village in part because the village and hospital were very closely related, at least in physical distance, while I had previous knowledge that patients used the village for various purposes and that villagers were therefore likely to have contact with, or at least to come across, patients in the ordinary course of village life. The village itself was considered to be a manageable size for a participant-observation study and it had the further advantage of being accessible in terms of distance from my home.

An Overall View of the Research Design.

Broadly conceived, I adopted three complementary methods of research and information collection: I talked with people both informally and on occasions using a tape-recorder and a semi-structured interview schedule; I observed interactions between villagers and others including patients; and I collected and read a large amount of written material (detailed below).

From one perspective these methods can be viewed as attempts to articulate validity and reliability via a 'triangulation' which is brought to bear upon social reality (see especially Denzin 1970, also Fielding and Fielding 1986, Hammersley and Atkinson 1983, and Woolgar 1988a for a critical review of this concept). However I prefer to theorise the research in terms of a flexible if critical process or hermeneutic endeavour. In practice this means that an objective in research design, as the Fieldings (1986 p91) argue, 'must be to make our methods readily accessible to fine-tuning, ongoing critique and running repair.'

An initial research dilemma turned on whether to use, in particular, discourse (including, that is, texts of accounts) as directly informative by its content of the reality of

practices in Shenley, in other words as a resource; or whether to lean with ethnomethodology and certain forms of discourse analysis towards accepting such discourse as a topic in its own right, and which includes taking into account the position of the researcher in his reflexive contribution to the context of action (see e.g. Habermas 1984, Heritage 1984, Pollner 1987, Zimmerman and Pollner 1970 as well as Yearley 1988)[2].

My position is that it is quite legitimate to take different theoretical and analytic attitudes towards one's research material, and that it is possible to theorise basic research methods in different ways. I therefore argue that there is a discernable reality to the reactions of villagers, but also that villagers' practices recreate this reality, and that these practices may themselves be investigated. My general position on social research is that it must be seen as a dialogue between the researcher and his or her subjects.

In his recent review, Yearley (1988) has shown how, when viewed from the perspective of the other, each side (referred to as 'actionists' and 'accountists') faces both methodological and epistemological difficulties, while simultaneously evincing particular advantages, so that Yearley's 'solution' is a 'tolerant pluralism'. From Yearley's position there is no unifying framework.

In this thesis I have attempted a juggling act, to derive poise from a blur, in Moerman's (1988 pxiii) words, by utilising in Parts Two and Three a variety of analytic methods and textual forms, the structure of which I have outlined below (p130). At

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[2] However this dichotomy between resource and topic is problematic in certain respects, for example the way that ethnomethodological studies cannot themselves avoid drawing upon (other) unexplicated 'resources' in analysing 'topics'. See Atkinson (1985), McHoul (1982), Silverman (1985) for related comments upon the topic/resource distinction.

the same time I have drawn upon the formal pragmatics proposed by Habermas as a kind of umbrella under which, so to speak, both resource and topic may shelter. It may be useful to rehearse some of the arguments briefly here.

With the acknowledgement that speech acts exhibit a 'double structure' of propositional content and illocutionary component, indicating two communicative levels, we might propose the idea that research which takes speech as a 'resource' focuses principally upon one level, adopting in Habermas' terms a 'cognitive orientation' to language, in which the content of the communication is thematised while the interpersonal relation between speakers is only indirectly expressed (Habermas 1979 p53).

On the other hand, (and stretching Habermas' arguments somewhat), to take discourse as a 'topic' indicates a concern with both levels in which the metacommunicative and reflexive component may also be thematised as well as the propositional content[3]. In other words by allowing for both the cognitive and the interactive uses of language we may grasp both the content, the reported facts (be they related to the external, the internal, or the social worlds) and the discursive processes of the immediate interactive relation within which these facts

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[3] And consider the discussions in Atkinson (1985 p130), and also Silverman (1985 p170-2) who considers these issues in relation to social scientific interviews: '...when interviews take place, we witness both artful and possibly *universal* conversational practices *and* the display of cultural particulars expressing variable social practices. Put another way, the internalist concern with form and universality and the externalist commitment to content and variability are complementary rather than contradictory.' (p170). My argument here is that Habermas' formal pragmatics provides another framework from which to understand this complementarity.

are recreated[4]. To pursue this line of thought leads to the examination of the relationship between Habermas and rhetoric which is tackled in chapter 5 above.

An additional and important point which devolves from the above analysis is that the researcher's discourse (as discourse or as subsequent text) also raises the same validity claims as those raised by his or her subjects.

The Criteria for Completion

A number of criteria exist which might indicate when the empirical component of the study is or should be finished. In the manner of Glaser and Strauss (1967) it may be suggested that the study continue until a coherent theory is developed which accurately reflects the data. Or, in the manner of Cressey (1953) that the (causal) hypothesis be modified until it is no longer falsified by cases or events.

Alternatively, appeal might be made to tests of validity, to whether the researcher has acquired sufficient knowledge to be able to 'pass' as a member of the research setting (Douglas 1976 p123), or whether the research subjects themselves concur with the account as presented to them by the researcher (cf. Douglas 1976, Rock 1988).

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[4] However there is a caveat here, for as Habermas makes plain (1979 p 43) it is not possible to simultaneously perform and objectify an illocutionary act. We can therefore only analyse the structures of speech in an objectivating attitude with the consequence that metacommunications can only be thematised retrospectively. I cannot in other words make meta *statements* about the form of discourse in which I am engaged without simultaneously raising a new non-objectified metacommunicative level (in which statements cannot be made). The functions of language use transcend validity claims, but may only be discursively addressed through such claims.

There are further criteria which may be less theoretically adequate. I would argue that much research anticipates certain obstacles which *de facto* set limits to the investigation but which may be rationalised after the event in terms of plausible theoretical statements. These criteria are essentially pragmatic and are to do with finances, energy and time. Given that the study of (social) reality is potentially never completely exhaustible then Smith's thoughts on literary composition may apply equally well here:

> The completed work is thus always, in a sense, a temporary truce among contending forces, achieved at the point of exhaustion, that is, the literal depletion of the author's current resources or...the point where the author simply has something else...to do. (Quoted in Brodkey 1987a, p43)[5].

Research Phases

It is possible to think in terms of phases through which this project developed. For example, for approximately 18 months I spent time, as indicated above, taking part in village activities. This period was important and allowed me to get to know a number of people within the village and enabled me to gain the co-operation (and perhaps the trust) of certain villagers who would not, I am sure, otherwise have agreed to

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5 From my own point of view the constraints which have been most felt have been those which have related to CNAA regulations concerning the length of the thesis, and my own domestic situation, in particular the effort to do research and remain married. Janice: 'I remember when we were sitting in the Duke of Marlborough and you said "Can I do a PhD?", and I said "No", and you went ahead and did it anyway. You said, "Of course I'll be able to work, have a family and do a PhD at the same time, and wash up and hoover..." '

be interviewed by me, and others who may not otherwise have been so candid[6].

It is from within a long-standing ethnographic tradition that it is argued that the phenomena under study can most faithfully be grasped using the method of participant-observation where understanding comes about through the physical accompaniment of actors in some of their day to day routines.

It is clear that the emergent nature of the 'problem' during such research is a result of the dialectical or hermeneutic play between the general (the overall informing theories and hypotheses) and the particular (the substantive engagement with an often obstinate reality) (see e.g. Bromley and Shupe 1980, Hammersley and Atkinson 1983). That this type of research is also susceptible to, as well as reliant upon, the 'accidental' (that is; meeting, liking, understanding), can be readily seen from a perusal of many such studies (e.g. Johnson 1975, Whyte 1943/1955, 1984, Karp 1980).

Serving a number of functions, this part of phase one provided a preliminary description and account of those interactions, both verbal and non-verbal, between villagers (and others within the province of Shenley village) and Shenley patients, interactions which have occurred predominantly within the locale of the village. It also served as an opportunity to explore the background expectancies, norms and routines of village life; the taken for granted common-sense understandings, knowledge and practices of members of this particular lifeworld; to consider whether patients were included as an ordinary aspect of this world, incorporated conceptually and practically within it by the villagers (indeed

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[6] At the same time my request of other people for interviews led to new opportunities to take part in village activities.

whether they were accepted as *villagers*) or whether the everyday practices of villagers differ according to the presence or absence of people who were patients. Observation and participation in village life was therefore conducted both in the presence and the absence of patients and took place in formal and informal settings.

In addition to participant-observation, the first phase involved the collation of documentary material concerning both Shenley village and Shenley hospital. This entailed investigation in the hospital staff library as well as the nearby local authority library in Borehamwood; making arrangements for the weekly collection of the two local papers which in part cover the Shenley area - the 'Borehamwood Times' and the 'Borehamwood and Radlett Advertiser'; subscription to the monthly Shenley Parish News Magazine published and distributed by members of the Church of St.Martin and helpers; the application to Hertfordshire County Council and Hertsmere Borough Council for information concerning both the demographic details of the village and more specifically planning and redevelopment proposals for the Shenley Hospital site as well as details of the planning application of, and objections to, proposals of the Praetorian Housing Association to extend their premises. Other sources have included the local authority Social Services Department, concerning their involvement in Shenley village; the Hospital League of Friends; and the Hospital Managers who have supplied details of in-patient statistics. The aim of this kind of documentary research was primarily to supplement and check data obtained from other sources on topics outlined above. A small number of villagers were also more formally interviewed during this period, and the interviews tape-recorded.

After this initial period I concentrated upon semi-structured interviews with villagers and patients. During this second period I also researched a number of old Hospital Management Committee documents, back copies of the Herts Advertiser, and other local newspapers held in the British Library Newspaper Section. I also visited the Herts County Archives in search of old copies of Parish Council minutes, and was grateful to be given access by the Parish Council to more recent minutes.

At the same time during the process of participant observation I came more clearly to realise that this method in itself was extremely time-consuming and in certain respects problematic. In the following pages I shall consider some of the problems I encountered.

Participant-Observation: Some Problems in Practice

1: The Nature of Evidence

From the ontological and methodological concerns of interpretative sociology, evidence is said to derive not from 'indicators' or 'variables' but participation in lived human experience in a human culture (e.g. Bruyn 1966, Ford 1975, Hammersley and Atkinson 1983); or less traditionally and more recently, to the 'making of texts' (e.g. Atkinson 1990, Brodkey 1987a, 1987b, Clifford and Marcus 1986, Van Maanen 1988). The suggestion here is that to frame the question or the answer solely in terms of observables is to imply an inappropriate behaviourism. Nevertheless the question of what criteria of evidence might count as demonstrating the exclusion, discrimination or 'status engulfment' of patients, or indeed the opposite, the acceptance, inclusion and systematically

impartial or affectionate treatment of patients by the villagers, is one which has preoccupied me throughout the project[7].

Evidence, it seems, may be attached to a variety of criteria derived from several sources. Previous empirical research has addressed the many ways people who are former psychiatric patients may be excluded by others. My own experiences and knowledge concerning racial, sexual and other discrimination are equally important sources. As Garfinkel (1967) and others have shown, research in sociology and other human sciences inevitably has recourse to such personal knowledge although this may often go unacknowledged as a resource.

An analysis of theories of power and domination is also suggestive of the various means whereby people may be excluded[8]. The relationship between situated action and social structure is of enduring interest for power theorists (see e.g. Barbalet 1987, Clegg 1989, Lukes 1974, as well as Giddens 1979, 1981, 1984). From the realist perspective social structures have reality and 'are no more or less than the ways in which historically situated human practices are done' (Isaac 1987 p59). However from Giddens' position such structures do not exist in space-time and are hence non-empirical conditions of activity although their adequate theorisation does rely upon historical and empirical knowledge. Precisely how a social

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7 I suspect it reflects a residual positivism on my part.

8 From non-decision making (Bachrach and Baratz 1962, Clegg 1989 p77) through Marxian concerns with structural relations (e.g. Isaac 1987), via structuration (Giddens 1981, 1984), to 'postmodern' accounts (e.g. Clegg 1989, Foucault 1980), underlying all accounts of power there exist normative, political and philosophical positions which pertain to the nature of the constitution of the actor and society.

structure which is non-empirical may be investigated empirically gives pause for thought. One answer is to adopt the perspective of viewing interactions wherever possible as inquiries into, negotiations and reconstructions of, social structure, the kind of approach favoured by ethnomethodology (see for a recent example Sharrock and Watson 1988). A second is the time-geographic framework adopted by Giddens and Pred in which structuration is seen in terms of the intersection of individual paths with institutional projects. Both of these approaches are drawn upon in Parts Two and Three of this thesis.

The start of fieldwork led me from my initial supposition that there would be 'exclusion' of patients, to examine the claims of some villagers that patients are in fact 'accepted' by villagers. But the position became complicated by the competing accounts and opinions of villagers. Some villagers have accused others, for example, of being intolerant and so forth. And some patients have regarded villagers' behaviours as warranted, while other patients have been quite critical. This very heterogeneity pushed me inexorably towards the fine-grained analyses of villagers' talk as one method of addressing and understanding variability.

2: The Diversity of Practices and Sites.

Although Shenley was chosen in part for its size, and indeed it is not a large village (the distance between the hospital at one end and the store at the other being no more than one half mile), in terms of fieldwork it proved to be practically and experientially very large indeed. It became impractical to hope to participate in and observe the whole range of places, events, meetings and practices of village life, and a small number of sites and types of event therefore had to be

specified, excluding a large chunk of Shenley reality in the process.

Fieldwork which was geared to observing patient-villager reaction was focused primarily at sites along the major pathway used by patients (thereby making an assumption about patients' routines), a route which anyway contained a large proportion of more formal facilities, so that I tended to focus in particular upon the village store, two of the four village pubs, and the village hall. However fieldwork was also conducted at other locations as I shall later show. In addition to some of the less formal sites of interaction, I attended a number of more formal functions, such as meetings of the Parish Council, the Village Society, the League of Friends, and the Village Hall Society. The aim here was to investigate the possibility of exclusionary practices as they might be manifested in these settings but also to assist in building a picture of village life and village concerns as I have indicated above.

Part of the problem in this respect was that I had to work to a large extent on my own. On occasions my wife and son accompanied me on field trips and an effort was also made to co-opt a member of the village as an informant/assistant. This had some limited success but the project remained primarily a one-researcher effort, with its inevitable and associated problems of labour economy.

The narrowing down of the study to a limited number of sites in the interests of research economy nevertheless failed in certain respects to overcome an ongoing problem, for the direct observation of patient-villager interactions logically entailed the co-presence of both villagers and patients (or others the villagers might believe to be patients). But it often proved

very difficult to predict the presence of patients in certain places at certain times so that many hours were spent in disappointment, although attempts were always made to turn such hours to gain, in discussions with local people. The converse has also been the case, however, so that in some instances when patients have been present in substantial numbers, villagers have been absent.

3: The Patients.

Alongside the problem of how to refer to patients (i.e. as 'people', 'patients', 'them'), there rode the analogous question of how I might actually identify patients. To a considerable degree I found myself in the same position as those villagers and others who have been unclear about the identity of another person. Relying upon commonly held notions of what a 'patient' might look like, say and do, I have also been tempted to draw conclusions from my own observations about the paths which I have seen people travel. For example the fact that a candidate for a 'patient' ascription emerges out of the entrance to the hospital could be taken as lending further weight to such a judgement.

From the point of view of procedures of identification I was forced to depend initially upon the help of villagers. Eventually, however, when I had gained the consent of the hospital ethics committee, I was able to introduce myself to patients on the hospital wards and in this way became clearer about the identities of at least some of the people observed within the village[9].

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[9] It may be of importance that one (virtually) certain method of identifying people who are psychiatric patients as patients is to meet them on the hospital ward. In chapter 14 I show how villagers tell how they know. As I show elsewhere (Southgate 1992c) those formal procedures for warrantably identifying insanity (which is not the same as identifying a 'patient') are, or should properly be, essentially discursive.

4: Practical Problems of 'Participation'.

The literature on ethnography indicates a potential range of possible degrees of involvement, so that the fieldworker's orientation may lie towards one end or other of a spectrum stretching from a detached observation of behaviour, the Skynnerian end which retains no vestige of involvement with the 'data' apart from supplying it with food, to the opposite pole where Winch persuades Evans-Pritchard to throw away his notepad and join the Azande as their motor-mechanic (e.g. Ford 1975, Hammersley et al 1983, and especially still Gold 1958).

My own research position has been somewhat ambiguous and in this respect is perhaps not unusual. The effort of trying to maintain sufficient 'distance' to be 'objective', while at the same time trying to draw close enough to people to gain adequate understanding and privileged information was demanding. And the fact that my time was limited, that I had a part-time job to perform, and a family to be part of, meant that it was impossible to become as involved in local life as I might have wished (although of course close involvement brings its own problems).

To some extent it might be argued that my anxious experiences in attempting to gain access to village life may closely parallel those of others such as patients, who attempt a similar feat (see Sanders 1980 for this kind of view, and also Clarke 1975, Johnson 1975, Wax 1971, for a consideration of the personal and experiential dimensions of fieldwork). Although it smacks a little of the empathic orientation of an old style interpretive sociology, there may nonetheless be something in this. Rubin (1981) is one sociologist who has been convinced of the importance of listening to her feelings during the research process, as one valid means of gaining insight into

the reality of her respondents, rather in the manner of a therapist using the counter-transference[10].

However it would not be correct to say that my fieldwork orientation has been consistent. Rather, I have utilised different modes of participation for different places and types of occasion, a flexibility which has been advocated by for example Schatzman and Strauss (1973). In other words my involvement was greater in some settings than in others, not necessarily as a result of differential attempts or strategic planning on my part but mainly as a result of the exigencies of particular settings which have brought their own practical difficulties of involvement and observation.

While the village store, for example, provided the most welcoming atmosphere for my researches it was nevertheless physically tiring, sometimes embarrassing as well as occasionally monotonous to 'hang around' the store for any length of time.

On the other hand while the public houses provided seats, it proved more difficult to engage people in direct discussion about patients when they were more interested in talking about 'the races', Gower's feeble attempts at captaining England and Arsenal's chances for the next season, without at the same time being too obtrusive.

This raises a further and related point, which I have touched on above, concerning the apparent inability (or unwillingness) of people to talk about patients, for it often seemed the case

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[10] To allow credence to this view need not imply acceptance of her underlying tenet that 'the beginning of all knowledge lies inside the individual'.

that people had very little to say in any spontaneous way about others who were patients without being probed on specific issues. The setting, however, often precluded lengthy debate about the subject, sometimes because of the to and fro movement of people within the room or the fact that other topics were already being discussed, or at other times because I felt that it would be inappropriate to raise the subject at that particular moment - perhaps a kind of squeamishness about introducing a possibly 'ugly' topic. This feeling may have come out of those attempts to start discussion which were dealt with in summary fashion by villagers.

5: Recording.

Accounts of fieldwork were recorded as soon as possible, usually within an hour, with the help of a dictating machine, and the recording was later transcribed. From a practical point of view it did not always prove possible to rush to the toilet every twenty minutes to jot down notes (see e.g. Festinger 1956) without drawing undue attention to myself[11]. As a result fieldwork sessions were usually limited to a maximum of two hours at a time, by which time I would often feel exhausted[12] with the combined effort of managing interactions and remembering events. It therefore proved impossible to record conversations in any systematic word for word fashion.

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11 Hammersley (1990 p121) has described how on one occasion, in his research, he jotted down notes in the teachers' common-room on his Guardian. I have always found this method tricky to say the least.

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From Participant Observation to Discourse Analysis.

In the above pages I have detailed a number of problems which I experienced in my efforts to participate in village activities as a researcher. These problems contributed to my turn towards a discourse analytic approach and my concentration in phase two upon more formal interviews with villagers. The idea of a discourse analysis had been present at the early planning stages of the project, but it was only after I had subjected some of the preliminary interviews with villagers to such an analysis that I more clearly realised its potential.

Nevertheless it would be a mistake to imply that this time had been unproductive. At the very least, as noted above, I believe it contributed to easier and more candid interviews. A conventional view of the relationship between fieldwork and semi-structured interviewing as presented by for instance Zweig in 1948, is that such interviews cannot be started without prior detailed knowledge obtained through participation or observation (referenced in Fielding and Fielding 1986 p50). However as the Fieldings also point out, the reverse position may also be true, so that observation can be seen as being informed by interviews. In Part Two of this thesis I provide a picture of the relationship between villagers and patients for which I have drawn primarily upon my fieldwork notes, but which cannot help but also be informed by other sources[13].

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[13] Although in Part Three I focus in particular upon the *discursive* methods which villagers and others use to construct 'identity' or 'difference', this should not be taken to mean that extra-discursive practices should not equally be viewed as constructive of (e.g.) identities. In Part Two below I argue that the routines and physical practices of villagers or others must also be examined for their structures of discrimination and stigma in relation to patients, not in isolation from, but in addition to, language in use.

And I also believe it to be the case that my interpretations of interview transcripts, presented in Part Two below, were again made that much easier by some understanding, albeit often semi-articulate, of local practices, which I gained from fieldwork. I would argue then that discourse analysis relies upon an understanding of context. But that things cannot be quite so simple becomes clear when we understand that context cannot itself be viewed as independent of the practices which constitute it (Garfinkel 1967 p76), as more 'solid' or 'real' or less 'interpreted' than discourse; or that ethnographic context is actually a constituent part of talk so that the distinction between talk and ethnography collapses[14].

My focus upon recorded interviews and the discourse analytic approach of Potter and Wetherell therefore emerged from various considerations over time. To bring these threads together here, the first point is that I had an interest in this method from the beginning of the project. Secondly, after attempting such an analysis at an early stage I came to believe that it might have potential in terms of its ability to illuminate the local life of the village together with villagers' views about patients within an argumentative context. Thirdly I had an interest in the way that discrimination might be a largely 'hidden process' (Gumperz (ed) 1982) and have an often subtle linguistic dimension. Participant-observation did not provide me with sufficiently fine detail of conversations. And finally other problems thrown up in attempting to *do* ethnography,

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14 I discuss this problem a little more fully in relation to the work of Potter and Wetherell, and offer some solutions, in Southgate (1991). In his introduction to a recent debate, Watson (in Watson and Seiler (eds) 1992 pxv) says: 'It is by invoking ethnographic context that most contributors to this volume resolve the predicament that, while there is nothing but the text, not everything needed for its analysis is in the text.'

described above, encouraged me to look more closely at discourse analysis.

The aim of the type of discourse analysis presented in Part Two is to examine the construction and functions of discourse, *inter alia* its argumentative and rhetorical features. It is concerned with those discursive methods used by villagers to recreate difference and identity within an argumentative context, and yields a sense of the dilemmas facing villagers in their relations with people who are patients and the hospital.

Sampling

Details of the numbers of people interviewed, the kinds of questions asked, and the general format of the interviews are provided in chapter 13 below. However it is important to consider the process whereby interviewees were recruited. During the project I had to consider whether to attempt to obtain a random sample of interviewees or whether to remain within a traditional ethnographic form whereby the researcher draws a purposive sample from those people he or she comes to know[15]. I chose the latter.

To the extent that the 'findings' of discourse analysis constitute a specification of the reality of the village, then arguably some kind of 'representative' sample seemed called for, since it could be the case that one section of the local community might use different argumentative methods and draw upon different interpretative repertoires than another section.

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[15] Compare 'theoretical sampling', Glaser and Strauss (1967), or alternatively 'snowball sampling' where interview subjects provide the researcher with further names of potential interviewees.

But the sheer effort involved in fully transcribing and analysing interviews made it clear that the sample would be too small to be statistically significant. At the same time I had difficulties in specifying precisely the universes from which random samples might be taken[16]. In addition I still have some reservations about the way statistical significance is, or can be, used to imply substantive significance and lend a sheen of legitimacy to research projects. Without implying the rejection of statistical evidence for the social sciences, I came to believe that this project would benefit little from the application of devices of statistical significance (for some of the arguments see Camillari 1962, Henkel and Morrison 1970, Irvine et al 1979, Kish 1959, McGinnis 1958, Selvin 1957, Willer and Willer 1973).

Although the representativeness of respondents is therefore not assumed, a simple statistical breakdown is presented in chapter 13, specifying age, sex, and length of stay in the village, but without the accompanying imputation of statistical significance.

Structure, Theory and Textual Modes: An Ethnography of the Text[17]

In Parts Two and Three of this thesis I have drawn upon several different theoretical, philosophical and analytic orientations to the research material. It is possible to view these differing approaches as if they were different windows through which the object may be perceived; or, in a manner more appropriate to the 'linguistic turn', as contributors to, or

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16 For example I wished to interview villagers who drank at certain pubs, but the universe of such drinkers seemed indeterminate.

17 This phrase is used by Woolgar (1988b).

partners in, a dialogue concerning mental disorder and discrimination; or further, from the perspective of the 'rhetorical turn' (Simons (ed) 1990), a juxtaposition of different rhetorical modes. Together they form a 'constellation' of perspectives (Bernstein 1991 and cf. Atkinson 1990 p168, Hammersley 1992 p54, Richardson 1990 p49).

In chapter 7 I provide basic information about the village, hospital and patients by setting this information after a short analysis of a village story, drawing upon the framework of Habermas' formal pragmatics.

Chapter 8 provides an account of the travels of patients in the village together with their interactions with villagers, in a manner informed by, *inter alia*, the time-geography of Allan Pred. This chapter has been constructed predominantly from fieldwork experiences and notes made during a period of participant-observation in the village, but also includes some material obtained from semi-structured interviews with villagers. It is written in a realist mode; that is, as though the descriptions, events, thoughts and so forth unproblematically exist separately from my own interventions, although it has recourse to a theory of structuration.

Chapter 9 presents a history of the relationship between the village and the hospital which draws upon the work of Emerson and Messinger who furnish a non-deterministic framework in which the labelling process may be understood. The material used in this chapter derived primarily from searches of local newspapers, documentary material found in the Hospital library, the remaining Hospital Management Committee minutes, minutes of Parish Council meetings, and interviews and discussions with villagers and present and former hospital staff. Again, while the theory stresses process, contingency and negotiation, the

textual mode is realist, portraying these events as if they possessed autonomy and independence from the author.

In Part Three, chapter 14, by far the longest, is devoted to a rhetorical analysis of tape-recorded interviews with villagers, drawing upon the discourse analytic framework of Potter and Wetherell and interweaving it with the formal pragmatics of Habermas. Here I have attempted directly to explore the argumentative context of opinion and attitude. Realism and anti-realism again become intermingled here. On one level it possesses an anti-realist textual orientation; that is, in terms of theory and content it presents the reality of patients' and villagers' identities and local facts as an outcome of discursive practices. On another level it tends to invest interview transcripts themselves with an existential certitude, thereby retaining in its form of writing a realist residue.

In these three chapters, 8, 9 and 14, the precise theoretical component is detailed as part of that particular chapter, rather than being separated off in Part One from the empirical material. In this way I hope to maintain the now commonplace point that theory and data are intertwined; that how we read historical material, observe interactions, even interpret our own fieldwork notes and so forth, is 'soaked in theory', in Popper's terms, or in Gadamer's terms becomes a hermeneutic endeavour. Thus the hermeneutic orientation of theory is juxtaposed to the often realist manner of writing.

The experimental Appendix D has already been touched upon above

(pages 11, 22 above). It includes (or comes with[18]) an Introduction and Annexure, the general form in which it was presented to the DARG reflexivity workshop at Brunel University in April 1992, with slight modification. It serves partly to provide a space from which patients' voices may be heard but in addition it sets out, in the manner of a 'constitutive reflexivity' (Woolgar 1988b, 1991), to disrupt some of the more comfortable assumptions of method which have gradually built up in the previous chapters.

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[18] My original paper was entitled 'An Appendix, Its Introduction and Its Annexure'. Thus the Appendix in this paper 'comes with' other parts. However Appendix D in this thesis 'includes' certain parts, including 'An Appendix' etc.

PART TWO

Chapter 7

Village and Hospital

A Village Story

> All ethnographies begin in stories.
> (Brodkey 1987a, p32)

For the few years up to 1989[1] village talk was consumed to an overwhelming extent by arguments concerning the hospital. Following the publication of plans to close the hospital and sell the site (see Hertsmere Borough Council 1986, 1987) villagers were involved in an ongoing and sometimes acrimonious debate about the implications of this development for the future of the village. Letters appeared in the local press voicing fears of the destruction of the local community, the Village Society fought a rearguard action, opposing the plans and collecting a petition of 667 signatures which was sent to the Secretary of State for the Environment, while at the same time the Parish Council supported the planning proposals[2].

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1 This section of the thesis was originally written in October 1989 and revised in February 1992. During this period both the village and the hospital have changed in many ways. At the present time of writing (1992) neither are quite as I depict them here. As a consequence of this revision, the verbal tense used in the following pages oscillates a little between present and past. This serves to highlight the part that rewriting plays in the construction of such a text.

2 Headlines in the Radlett/Borehamwood Advertiser on 14th November 1986 read: '50m hospital row splits village.'

The story which attends this local social storm is quite simple. Many villagers recount that although villagers resisted the building of the hospital in the first place, although they were adamant and united in opposition, and although many have complained over the years about the hospital, some of the same people are now heartily resisting its closure (although at the time of re-writing most resistance has petered out in the face of what has appeared to many to be the obduracy of central government decision making). The irony of this about-face is usually pointed out by the teller of the tale in its telling.

This identification by the villagers of the irony of the present situation, itself the focus of the story, has been lent greater poignancy by a central addition, varying in precise detail, recounted to me by a number of villagers and hospital staff. For I have also been told that the land of Porters Park Estate was originally sold to the Middlesex County Council in 1924 by its owner Cecil Raphael with the specific condition that a mental hospital be built on the site, in order for the owner to extract vengeance upon the village for his exclusion and stigmatisation by some of the local people. In this case, the story goes, the problem was that the owner was a Jew[3]. This part of the story it seems has become part of local folklore, folklore which is sustained in the telling.

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[3] In Nazi Germany the murder of mentally disordered people began before that of Jewish people. Some 100,000 mentally ill or disabled people are estimated to have been exterminated (Meyer-Lindenberg 1991 p7), with the complicity of many, but not all, German psychiatrists. Already in 1920 Binding and Hoche were advocating the 'extermination of worthless life', while the first law concerning hereditary health was passed in 1933, the first year of Nazi rule (ibid). See also Gardner (1982), Hill (1983), Meyer (1988), Proctor (1988), Wertham (1966).

There are a number of ways in which this story may be decoded[4]. Approaching the story from the perspective of Habermas' formal pragmatics (1979, 1984, 1987a), the teller may be said to raise validity claims to truth, sincerity and normative rightness, which each assume a particular relationship between actor and the world[5]. One advantage of analysing a story from this perspective is that it points not only to the putative functions of the story but also to those avenues along which the claims of the story may be criticizable, to the way the validity claims raised in the telling may be thematised. At the same time it shows how the story itself is oriented to critique, in the way that the story portrays some actions as morally wrong or at least morally problematic.

Thus the truth of the claim about Mr Raphael could be questioned, as well as the proposition that the villagers were in fact united against the hospital.

Claims are also raised concerning the inner world of the speaker - the sincerity of the person making the utterance - so that we may question whether this person *believes* what he or she is saying or 'genuinely' feels it to be true, or whether

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[4] Narrative analysis is of course an extremely wide field. See for example Polanyi (1979, 1981, 1985, 1989) and Linde (1986). A modern classic analytic scheme has been provided by Labov and Waletsky (1967). Atkinson (1990), Eagleton (1983), Polkinghorne (1988) provide good overviews of narrative analysis, while Culler (1981) (and see also Young 1987) deconstructs the 'double logic' of Story (content) and Discourse (form or structure). In his study of prejudice and discourse Van Dijk (1984) draws upon the scheme of Labov and Waletsky. My use here of formal pragmatics reflects my efforts to sustain a Habermasian theme throughout the thesis, and to explore the use for everyday empirical work of formal pragmatics. For a different treatment of a village story which draws on the work of Polanyi (above) and Smith (1978) see Southgate (1991).

[5] See especially chapter 5, and Southgate (1992c).

the telling of the story in the present is being used to demonstrate local knowledge and local understanding; that is, as a management of impression and identity.

A further interpretation of the place of this story in village life, which emphasises its internal and affective component, provides for the idea of double punishment; not only, the story implies, *has* the village been punished in the past by the hospital but it is presently being punished again by the hospital. Having adapted to some degree to their punishment, having made the punishment routine, regular and almost subliminal, the rug is being pulled, in a manner of speaking, from under the villagers' feet.

I have also been struck by the way this story in its elementary or embellished form has been told to me by people comparatively new to the village in a manner which suggested that they were almost present at the time of the first 'visitation'. The story of Shenley Hospital and Shenley Village may therefore pull into its ambit or event horizon villagers whether of recent arrival or of long standing. Its subscription serves to draw newcomers into one or other of the village *folds*. All may draw upon the irony who share in the village, while the telling serves to perpetuate the myth and confirm the teller as a putative villager even in those situations where he or she has in fact a relatively tenuous connection with the village (such as the researcher). In this respect the telling of the story raises claims to more than just truth and sincerity. It serves to raise a further validity claim, that of normative rightness or correctness, which connects as it were the actor with the social world and the locale, actualizes an already established pattern of relations, and provides the relational aspect in which the content is to be understood. This, it appears to remark, is what is *correct* to say here.

This claim to normative rightness also points to an understanding which may be more than local. The very fact that this is comprehensible to readers as an ironic story shows us how stigma retains a certain currency as an important concept in relation to mental disorder. It is, in other words, normatively right to recount this story about discrimination in this place in the confidence that it will be understood as such even by those who do not originate from the village. The fact that it is told now, displays stigma as an issue still worthy of attention, as still 'storyable'.

Although the story does not explicitly state that discrimination is morally wrong, it does none the less seem to problematise the issue of discrimination, to highlight what may otherwise be a taken for granted background assumption.

This 'formal pragmatic' analysis shows how the telling of the story does more than just transmit and renew cultural knowledge. Although we may thematise and attempt to redefine the situation in relation to the three formal world concepts, as suggested above, this analysis already shows that communicative action also functions to assist social integration and establish solidarity, as well as serving to demonstrate and reconsolidate individual competence and identity. The formal pragmatic analysis may therefore be said to point beyond itself to those symbolic structures of the lifeworld which Habermas has identified as culture (stock of knowledge), society (social integration and solidarity) and person (socialization) (1987a p138)[6]. In the process of telling

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[6] Habermas makes it clear that the structures of the lifeworld are not identical to the three formal world concepts and their validity claims. The lifeworld is constitutive for mutual understanding *as such*. The formal world concepts however are those things about which we may debate, argue and attempt to reach agreement (Habermas 1987a p126). In other words, if we debate 'social integration' we are thematising that part of our *knowledge* of it,

and no doubt as an unintended consequence, the story draws upon and serves to reconstruct part of the very reality and life of the village itself and the identity of the teller.

It is clear that the logic of this ironical story depends upon the present historical context. Someone investigating Shenley ten years ago would not have been provided with quite the same account simply because there were no immediate plans to sell the hospital site. In this sense, although told in the present and affecting the present, the orientation of the story can be said to lie with the anticipation of future events. It is possible to argue therefore that the telling of this story has to be seen in the real historical perspective of a psycho-social and cultural transition, rather like the analysis of the importance of myth for the pupils in Measor and Woods (1983) study, for the changes facing villagers may be extensive.

Following Brodkey (1987a) the telling of and listening to stories can therefore be seen as 'twice encoding' culture, so that stories are at once both practices and artifacts of culture. In her excellent article Brodkey goes on to argue that:

> One studies stories not because they are true or even because they are false, but for the same reason that people tell and listen to them, in order to learn about the terms on which others make sense of their lives: what they take into account and what they do not; what they are and are not willing to raise and discuss as problematic and unresolved in life (p47).

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which is discussable. For Habermas, 'tests' of social integration and socialization are not measured directly via criticizable validity claims or standards of rationality but against standards for the solidarity of members and for the identity of socialized individuals (1987a p139).

However, any analysis of myth or story needs have recourse to factors which lend validity to its decoding. In the present context this may begin to be provided by a limited description of the area, the cultural and economic resources of the village and the possible futures faced by the villagers. But at the same time the rest of the thesis can itself be read as an elaboration upon the theme of this story, which may be said to encapsulate the truth of the relationship between village and hospital[7].

The Village: Geographic and Demographic Data

Shenley village is geographically situated 5 miles south-south-east of the city of St.Albans in Hertfordshire and 4 miles north-west of the town of High Barnet in North London, as the crow flies. In a direct line it is approximately 14 miles from the centre of London (Marble Arch), and postally is allocated a position near Radlett. According to the most recent Hertfordshire County Household Survey of 1986, which was a sample survey and subject to sample error, Shenley village, identified by the coterminous boundaries of Parish and Ward, consisted of a total of 695 households of which 340 were owner occupied, 159 local authority owned and 153 privately rented. Figures provided by the Hertsmere Borough Council Housing Dept however show that in 1989 there existed 178 council housing units in Shenley village, so it may be assumed that the number of owner-occupied and privately rented units in Shenley is correspondingly less than that indicated by the Sample Survey. Keeping in mind therefore the likely error, the Survey indicates that in 1986 Shenley had a population of 1325 people aged 16 and over of whom 911 were 'economically active' and 414 'economically inactive', that is students (31) retired persons

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[7] Alternatively we may say that the story grasps a truth of this relationship.

(228) and 'other'(155). The same survey, analysing residents by sex and age, gives a figure of 299 men and women over the age of 65.

In 1986 according to this survey, Shenley had a total population of 1778 people of all ages, while the 1981 census indicates a total of 1943.

Village Institutions and Culture

From the one half mile which separates the Hospital to the north from the village store to the south, the traveller through Shenley on route B5378 might observe four Public Houses, two churches, an estate agents, a school, village hall, public toilets and a type-copy shop, a garden centre, as well as a number of houses, some terraced, some flats, a home for retired people and residentially grander properties. Next to the King Harry pub and the village pond is situated 'The Cage', an old lockup of indeterminate age. The mottos carved in stone tablets which adorn the Cage have been investigated by a Shenley scholar, Ted Stebbing, who has provided an account in the village magazine of their misrepresentations in various books and articles on Hertfordshire. The mottos suggest 'Do well and fear not' and 'Be sober, be vigilant'[8]. The structural problems of the Cage and the cost of its restoration have recently been under investigation by the Parish Council.

On the southern edge of the village beyond the store lies a petrol station and garage, and a Bonsai nursery. Further still on the way to Barnet and still on the main road, there are several farms and a vetinary surgeon's practice. The village

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[8] The second motto probably derives from 1 Peter 5, 8: 'Be sober, be vigilant: because your adversary the devil, as a roaring lion, walketh about...'

store provides food, alcohol, general domestic consumables and incorporates a post office. The hinterland or back regions of the village contain *inter alia* further farms, residential housing[9], some light industry, an equine stud farm, a hotel and playing fields. Shenley is therefore primarily linear in structure, built along an important route into London.

This main road which runs through Shenley and crosses the M25 motorway provides a direct link from St.Albans to North London. It is a small, sometimes narrow road, which is nevertheless very busy. In other words there is a considerable amount of through traffic some of which may stop in passing at the store or the pubs. A rail link, a fast line into London, is available to villagers from nearby Radlett or Borehamwood.

A preliminary study of village life suggests a cultural heterogeneity which I have chosen to structure in a particular way. Some indication can be provided from the Parish magazine which every month provides a list of village activities. This list is of interest not only for what it includes but also for what it leaves out. In addition to this official program, less formally organised activity proceeds apace, much of which is centred on the public houses. While the Hertsmere Borough Council Shenley 50+ group meet every Wednesday afternoon in the village hall and older members of the community may attend a luncheon club on Thursdays from midday at the village school, an alternative 'club', a loose informal group of retired villagers meets daily at the King Harry public house from around 12 p.m. Although this group has no official name and is

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[9] In spite of the proximity of Shenley village and hospital, house prices in the village have tended to be high in comparison to those in nearby St. Albans. See research by Dear (1977) and Boeckh et al (1980) on the relationship between mental health facilities and property values in Philadelphia and metropolitan Toronto.

not included in the village magazine it arguably constitutes an important part of village life for its members. In addition the landlord and landlady of this particular pub organise regular coach trips for the regulars to the races.

During the hot summer months of 1989 the pub barbecue was a regular feature of Shenley night life. The pubs draw custom from both within and outside the village and clearly act as social centres, particular territories where informally linked and local friendship networks are developed, maintained, and solidified. A more detailed account of this is provided below.

One bastion of more formal activities is the church. Although only a relatively small number of events are held on church premises, there exists locally a small group of people, mainly church members, who are involved in the organisation of many local events such as coffee mornings at St. Martins church, jumble sales at the Methodist church and Village Hall and so on. This church-related activity also plays a vital part in village life, although the Church of England vicar voiced concern about the ageing nature of his congregation. By 'church' here I am referring to members of three local churches: Church of England, Methodist and Catholic. There is a further building in Shenley, next to the Praetorian cottages (see below: The Housing Association, p153), which is the redundant church of St. Botolphs, and within the walls of which a house has been built. In its graveyard lie the remains of Nicholas Hawksmoor.

In another sense the church has further power to the extent that it controls one of the formal means of dissemination of information within the village, the Parish magazine, 'Shenley Parish News'. However it is likely that people gain as much or more information through talk and gossip, chats with the

neighbours, conversation in the village store, with the milkman, in the pubs, or in the street.

In addition to churches and public houses as major centres of organisational power within the village, there is the Village Hall. This is situated on the main road and is managed by its own committee, which stages local events, including day-time fund-raising activities such as jumble sales, and evening entertainment of, for example, music and theatre. The Village Hall also hosts meetings of local organisations such as the Parish Council and the Village Society AGM[10].

A further institutional resource which for many has focusing power, that is, the organisational structure of which can channel everyday interactions, is the school. This is a 'first school' from which pupils must move at the age of 8 or 9 years. The school tends to provide for the possibility of conversation and informal talk for adults who have young children. As with many primary schools throughout the country, mothers and occasionally fathers meet outside the school at home-time waiting for the children to emerge. Small groups form, information is exchanged, arrangements made. In addition, school functions, including jumble sales, or evening events such as discos for parents, provide chances for social activity.

There are also a number of other important village organisations and activities. The role of the Parish Council will be highlighted in a later chapter. The Village Society has been in existence since 1965 and the Women's Institute for considerably longer.

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10 The more frequent Village Society committee meetings are held at the houses of committee members.

The hospital has in some respects more ambiguous influence. No groups of local people meet outside its walls to talk as they do at the school. The hospital does not organise events for local people, apart from the occasional car-boot sale or the hosting of craft fairs, and in former years hospital dances (of which I have seen none advertised over the course of this study). However, none of these events was advertised in the Parish magazine over the period in which I monitored it.

Neither it seems does the village organise social events for the hospital or patients. Although a number of patients do attend functions in the village, these functions appear to be organised principally for the benefit of the villagers. On the other hand many villagers depend upon the hospital for employment, while many are also former (retired) hospital staff. Economically then the village has come to rely to a considerable extent upon the hospital and not only from the point of view of the employment of labour. The vicar's tea party (of which more later), a successful fundraising event for the local Church of England, has probably benefited financially from the attendance of patients, while the village store (see chapter 8 below) has similarly gained in turnover.

The Death of a Nice Village?

The village is facing probably the most important changes since the hospital was built. It is unclear whether Shenley village will be able to maintain its identity or whether, without the geographical and cultural buffer of the hospital, it will be absorbed into Radlett, perhaps eventually Borehamwood, and become part of another sprawling suburb of Greater London. These have been villagers' fears.

Although, when pressed, people will often express ambivalence

about the village, most of the people I have spoken to say that Shenley is a *special* place, a *nice* place, in which to live. It is situated in pleasant surroundings in Green Belt country; is leafy and rural in spite of being close to London; is small and compact in the sense that it has no sprawl, and is quiet in so far as it has no major entertainment attractions to lure people from the surrounding areas in search of a good time. Situated in rural idyll, it nevertheless offers convenience, as Estate Agents might say, for journeys into London. Shenley has no crime to speak of, a small community of people who know and support each other.

There is some truth in all of this, although Shenley is never quite what it is made out to be. Short of the kind of glimmers of terror lying just below the surface of ordinary life portrayed in some sociological literature, for example Goffman's (1961) reference to 'status bloodbath'[11] or his marvellous (1971) depiction of the paranoid logic haunting 'Normal Appearances', the village is at once as simple, more complex and in some respects less idyllic than people who live in it are inclined to make out.

Following a talk with the village constable, for instance, I was led to believe that he dealt informally with any potential lawbreakers and that crime failed to exist in the village. The policeman, who has lived in the village for 25 years, and has been the village constable for 13, knows most families, is aware of who is involved in what, and simply has to 'have a quiet word in someone's ear' to solve any potential problems. This view has coincided with the conclusion gained from the content analysis of local newspapers. Full of reports of muggings, thefts, fights etc in the surrounding areas, over the

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[11] Compare the use by the psychiatrist R.D.Scott (1974) of the term 'identity warfare' to refer to the battle for emotional and psychic survival between patient and relatives.

twelve months to October 1989 there were no accounts in the press of any such incidents occurring in Shenley village.

It is not difficult to explain this absence in terms of selective reporting and indeed it was not long before I was told across the bar of one pub how one villager had just had his car stolen from its usual parking space in the village for the second time, and how a lot of other cars parked nearby had been vandalised, yet nothing appeared in the local press. This is not to imply that local people were necessarily involved as perpetrators, only that Shenley village is not quite as incident free as it may be made out to be.

There are other problems of which the researcher has gained a whiff on occasion. During my researches a member of the community was said to have attempted suicide following an argument with his wife. A number of male drinkers clearly have alcohol problems -that is, they routinely drink quantities of alcohol well beyond the current recommended limit. There may be a direct link with the hospital here for the hospital authorities recognise that the alcoholism rate is high amongst nursing staff and the local G.P.s acknowledge that such a problem exists. In addition the G.P.s have conceded that it is not unusual for villagers in the privacy of the consulting room to voice anxieties about 'going mad', and they have suggested (without caring to support their assertion with data) that the referral rate of villagers to the psychiatric hospital for their area has been quite high. If they are correct then it may be reasonable to conclude that the presence of psychiatric patients may not always act as an 'immunity' to madness. Unfortunately my approach to the hospital in question, Hill End, requesting some indication of the admission rate from Shenley village failed to secure a reply. The Social Services Department covering the area was more helpful but failed to

find any record of compulsory in-patient admission from the village 'within living memory'. The home help organiser reported that referrals to her service were similarly few and far between. The conclusion she drew was that Shenley villagers were on the whole supportive of their neighbours and relatives and did not require the use of council services. There may be other explanations for this lack of service up-take, but the overall point here is that it has been very difficult to obtain data relating to the mental health of the villagers themselves.

As I have already noted, there is also the fact that Shenley village is built along a busy main road. Cars often speed through its main street and there is constant danger of accident. The Parish Council have pressed for further speed restrictions but it appears that the traffic problem is an old one and likely to become worse following the anticipated development of the hospital site (see below). Ted Stebbing, one of the local historians, has provided an account in the Parish magazine of traffic concerns in 1931 when schoolteachers were reported to have been worried about 'the heavy vehicular traffic constantly streaming through the village'.

Village Futures

What, then, does the future hold for the village? Plans for the hospital site include an estate of 900 housing units to be built in several phases and including a park. Provision has been made for the possibility of another school and there are plans for three shops on the site, light industry and some form of 'health care facility' or residential home. The last of the patients will probably not be moved from what then remains of the hospital until well into the next century.

The village is therefore faced with a major influx of people

who, it is feared, will bring with them cars, congestion, noise and chaos. The character of the village is likely to change as a result, so that it may become quite impossible to describe the village as being akin to an isolated rural jewel on the edge of London.

The economy of the village will be affected directly, positively for some and adversely for others (cf. Moore's 1981 study in New York State). Local pubs are likely to increase their trade, while the manager of the village store has not ruled out the possibility of bidding for one of the proposed new retail units. A number of local people who have been employed at Shenley Hospital have already been redeployed by the Health Authority to staff new mental health projects in London. The future of other local staff is less certain. Indeed many of the hospital staff live in hospital accommodation and have been concerned about the security of their tenure. In addition the village will lose its patients.

Patients and Hospital

From figures provided by the hospital managers, Shenley Hospital had a population of 656 patients in July 1989. The average patient age was 59.8 years while the average length of stay of all patients was 15 years. Although there is therefore a substantial long-stay and elderly patient population, a small proportion of patients are still short-stay and young, e.g. 42 patients were 35 years old or younger at the registration date.

The 'acute' wards were moved from Shenley to the Central Middlesex Hospital in 1988 but Shenley still retains a 'disturbed' ward which tends to have younger patients and also a mother and baby unit which accepts referrals from outside the normal Shenley catchment areas. The disturbed ward will

continue in existence until appropriate buildings are built or found in London. The immediate future of the mother and baby unit is unclear. Shenley hospital serves and accepts patients principally from two areas, the London Boroughs of Harrow and Brent. Exceptions include the mother and baby unit as indicated but also instances by arrangement where staff at other psychiatric hospitals need psychiatric admission or attention.

Shenley hospital therefore has an unusual mix of patients compared to other local psychiatric hospitals such as Napsbury or Hill End which still operate acute admission wards. However this should not be taken to mean that during the period of this research Shenley patients were necessarily less psychiatrically 'disturbed' than patients elsewhere[12]. And in spite of the closure of the acute wards, several young patients (see above) continued to travel into the village.

The hospital itself has substantial facilities. Several wards accommodate semi-independent patients; there are occupational therapy facilities, a hospital patients' shop and social club, and a small 'farm' area with a number of animals, together with a newly opened social centre for elderly patients called the Evergreens. Staff have their own social club.

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12 Compare for instance Leff's (1990) analysis of data concerning 770 'long-stay, non-demented' patients at Friern Barnet and Claybury Hospitals, of whom 50% had been in hospital for over 20 years. Their modal age was between 60 and 65, and the diagnosis primarily that of 'schizophrenia'. Leff concluded that '...no convincing picture was found of a clear decline in psychotic features over time' (p30). In other words, at least for this 'long-stay' sample, there had been no 'burn-out' of symptoms.

In The Hospital Archives

Shenley Hospital is situated at the northern and western end of Shenley village and its entrance is approximately 100 yards from the nearest village pub. Opened in 1934, it was one of the very last of the large mental asylums to be completed in this country and the first to be opened by a King and Queen, King George V and Queen Mary. Based upon what was considered at the time to be a revolutionary villa system, it is arguably best known within psychiatry by its association with the treatment practices, research and philosophies of Cooper, Esterson and Laing. Cooper was a Senior Registrar at Shenley when he cooperated with Laing in 1964 on 'Reason and Violence' and with Esterson and Laing on a joint research paper (Esterson et al 1965). Thereafter he continued to publish widely on themes which became popularly known at the time as 'anti-psychiatry' (Cooper 1967, 1974, 1980). Villa 21, which Cooper founded and which became known for its unconventional treatment methods, was subject to criticism in a confidential[13] NHS Hospital Advisory Service report in 1973, where it was recommended that the villa's patients be transferred to other wards (H.A.S. 1973). Interestingly the same report makes use of references to the local village to help justify its recommendation to close the ward:

> The team found obvious signs of apprehension on the part of the nursing staff in case a patient should abscond (via the ward garden) and appear in the adjoining village of Shenley. Such patient appearances in the past have contributed to the state of tension which appears to exist between the hospital and the local population. (Brackets added)

This appears to be the only apprehension of nursing staff noted

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[13] This report was marked 'confidential' but was freely available to any Library user.

in the report although the latter does suggest that the 'possibility' of injuries to the staff as a result of the patients' phases of "excitement", "have to be born in mind". Whether any nurses were injured and the extent of any disturbances within the village remain unaddressed.

Whatever the reality of the situation in 1973; whether or not this particular ward group did constitute a danger to staff and a problem for villagers, or whether these grounds might be seen as rationalisations for closing a ward unpopular for other reasons (see e.g. Wood 1973, for an analysis of a DHSS investigation at nearby Napsbury hospital), it is clear that the hospital in 1989 was taking fewer chances over the possible absenteeism of patients on the 'disturbed' ward, if the present height of its garden fence is anything to go by.

As indicated above, Shenley Hospital accepts patients from the catchment areas of the London Boroughs of Brent and Harrow. It does not therefore take local Shenley people although one or two of the villagers said they had heard of villagers being admitted. Officially, should they need psychiatric hospital admission or out-patient care, residents within the village are referred to Hill End Hospital in St. Albans, which is also scheduled for closure. That Shenley is not 'their' hospital has been cited on many occasions as the reason that villagers are reluctant to become too involved with it or its patients[14]. Whether villagers would be more or less interested if some of their number were in-patients in Shenley hospital remains an open question. As I have shown, some of the previous research on stigma and mental disorder indicates that people do not like being seen to attend local psychiatric units and prefer the

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[14] On the other hand, and according to the argumentative context, villagers may also refer to Shenley Hospital patients as 'our' patients (see ch. 14 below).

comparative geographical and social isolation of a hospital away from their home (see ch 4 above).

A search of the Hospital library[15] provided little else of reference to the relationship between the hospital and the local population or to the village itself apart from some documents concerning the opening of the hospital, although one directive issued by the Nursing Managers in June 1976 (revised 1978) could have had implications for the local population.

> 1. It is the policy of Shenley Hospital that sexual intercourse between patients is not permitted within the confines of the hospital.

If carried out to the letter by nursing staff then this directive would have meant that patients either had to desist completely, become much more covert in their operations, or go elsewhere - out of the hospital grounds, perhaps to the village.

The Housing Association

In addition to Shenley Hospital, this particular corner of Hertfordshire is remarkable for a fairly dense concentration of mental hospitals and hospitals for those with learning impairments. Within an area which covers Shenley, Radlett and St.Albans, there are five old hospitals of this type; three psychiatric and two 'learning impaired'. Both Harperbury hospital and Napsbury hospital are within just a few miles of Shenley village.

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15 On the occasions when I conducted the search of the Hospital library I was struck by its sense of neglect. Most of the periodicals were old and out of date, the librarian was in the process of leaving and the library was usually empty of staff.

Approximately one mile north of the village, at the bottom of Black Lion Hill, there are a number of cottages, some of which are occupied by Shenley Hospital staff and others which belong to the Praetorian Housing Association and which are offered as accommodation primarily to people discharged from psychiatric hospitals. Opened in 1984 by the Duchess of Gloucester, there are places here for up to twenty people, the majority of whom are former Shenley Hospital patients although some residents come from other hospitals in the area. A number of these residents use facilities within Shenley village.

Chapter 8

Patient Paths:
The Insanity of Place Revisited

> An individual is not distinct from his place; he is that place. (Gabriel Marcel, cited in Relph 1976 p43)

Introduction

The following analysis provides a way of orienting the description of discourse to be provided in chapter 14 below. It provides a way of thinking about the possible interpretations of discourse, and a background in front of which interpretations offered in that chapter may achieve perspective and enhance cogency. But focusing as it does upon space-time paths, sites of interaction and the movement of bodies, this chapter can also be read from a theoretical perspective as an 'embodied' corrective to what could otherwise be taken to an undue emphasis upon language[1].

In the participant-observation study I set out to focus principally upon the village store, two public houses, the village hall and church related places, sites of more formal occasion including the Parish Council and Village Society and finally the $^1/_2$ mile of road and pavements, including benches

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[1] To recontextualise Moerman's (1988 p90-1) comment on de Saussure and Chomsky, the embodied world is, we might say, more than just a speech impediment. And cf. Stimson (1986) who makes a plea for the reincorporation of place and space into sociological fieldwork.

and bus-stops, which stand between the hospital and the shop. Most of my time was spent, however, in the pubs and the store and it proved to be in the latter place that I felt most 'at home' and most accepted by staff. This account draws primarily upon the fieldwork notes taken during this period, but also occasionally from material obtained from tape-recorded interviews with villagers and patients and other sources such as newspapers, minutes and other documents.

During the process of the participant-observation study I began to realise that one guiding concept of the project should be that of 'place'. This understanding has a number of components. To begin with, the guiding theme of place could almost be read as a natural outcrop of the first phase of the research design; the emphasis on observation at particular places within the village; the choice of *this* village as opposed to another; the weighty spatial presence of a psychiatric institution; an analysis of exclusion or social closure, all inevitably involve at least a consideration of 'place'. Several of these factors might however be said to apply to the majority of participant-observation studies.

The works of Goffman (1961/68, 1969/1971) and Rosenhan (1973) as well as Scott (1973a and b, 1979) have also provided in their different ways an impulse towards a conceptualisation of madness as 'place'-related. At the same time, and in a manner which I hope will become clear in due course, I was struck by the importance for the villagers (and patients) not only of how patients behaved, but *where* they behaved. I came to realise that patients routinely (or chronically) trod fairly well worn paths through the village. It seemed almost as if they were channelled somehow by a conduit which comprised a discipline of sorts along which institutional projects almost conspired to steer them.

In my effort to theoretically unpack these observations regarding 'place' I have drawn from time to time in the following pages upon some concepts from 'humanistic' or phenomenological geography, in particular from the work of Relph (1976) and Seamon (1980) as well as those of time-space geography and structuration theory (Pred 1982, 1983, 1985, Giddens 1984). The 'Institutional Ethnography'[2] of Dorothy Smith (1988) has provided a useful complement to these approaches. In addition, the works of de Certeau (1984) and Shields (1991a, 1991b) have proved helpful in offering further ideas about how to conceptualise 'place'. The approach proposed here is therefore to some degree congruent with a recent convergence between geographic and other social sciences in relation to mental health and especially de-institutionalisation (e.g. Dear and Taylor 1982, Dear and Wolch 1987, Smith and Giggs (eds) 1988, C.J.Smith 1984, Rabkin 1984, Rabkin et al 1984, Segal et al 1980).

However I do not intend a systematic mapping of space-time paths or the use of space-time diagrams advocated by Pred (eg 1985 p31) and Giddens (1984). It is also important to note that because of the space-time restrictions upon my own project I do not attempt to provide here a comprehensive time-geographic theory of exclusion or closure, although this account could be read as a prolegomenon to such a theory.

In my attempt to map the journeys of patients through the village I have drawn in an often *ad hoc* fashion upon those concepts which have provided the heuristic means by which the interactions between villagers and patients might be more fully

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[2] Smith is also interested to show how everyday individual practices intersect with institutional projects. Her aim is to unpack the 'implicit organisation' of ordinary daily scenes, by which local settings are tied to 'larger generalised complexes of social relations' (1988 p156).

described and understood. I therefore aim to bring the journey into focus from several 'dimensions', just as Smith (1988) allows us to see the everyday in a new light[3]. The following pages are intended to show how the everyday paths which patients tread through the village are both negotiated with and constrained by institutional projects in Pred's terms, and how patients contribute to the process of the 'structuration' of the locale. Because the understanding of 'place' and the guiding imagery derives in large measure from the work of Allan Pred, a brief account of his work will be provided here.

Time Geography

Pred has provided a way of understanding the 'becoming of place' as human practice via the integration of structuration theory (cf. Giddens 1979, Bhaskar 1979/1989, Bourdieu 1977) and space-time geography, so that 'the structural properties of a social system express themselves through the operation of routine and non-routine daily practices' (1985a p8)[4]. A central component of his theory is the idea of the intersection of 'individual paths' with 'institutional projects' occurring at specific temporal and spatial locations (1985a p10, 1983 p46, 1982 p163). An individual path concerns movement of an actor through space-time. A project refers to the sequence of tasks 'necessary to the completion of goal-oriented behaviour' (1982

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[3] One problem I have faced here concerns that of the sequence of writing. The section on public houses was one of the first to be written, followed by the history chapter, then the discourse analytic component, after which I returned again to the participant-observation study, to complete the 'journey'. The latter has been very difficult to do without anticipating and intruding upon in particular the discourse analysis.

[4] It should be noted that although my emphasis below is upon routinization, in principle this by no means excludes the notion of strategic action. Indeed as Barnes (1988 pxiii, p167) has argued calculated action and routine are, pragmatically and conceptually, mutually dependent.

p165), while an institution is 'synonymous with the everyday and longer term projects for which it is responsible.' (ibid). In other words both individuals and institutions can be said to have projects which themselves involve space-time paths.

Institutional projects possess a relatively enduring nature although they remain the outcome of the most important power relations and practices within a particular place. Thus:

> In any becoming place certain institutional projects are dominant in terms of the demands they make upon the limited time resources of the resident population and the influence they therefore exert upon what can be done and known. (Pred 1985b p341)

These dominant institutional projects can therefore be said to occasionally or regularly structure daily paths by influencing the sequence and pace of other institutional and independently defined projects undertaken by individuals, and by constraining participation in yet other projects (ibid p341-2), what Pred calls 'coupling-constraints' (1982 p177). In the process they are likely to reproduce the dominant structural relations. The most substantial social transformations therefore result from significant changes (or abandonment or inception) of dominant institutional projects. Thus in advanced capitalist societies the dominant projects are those of 'large-scale, corporately owned, and distantly controlled business organisations, and those of economy-intervening and service-providing organisations that are part of the state apparatus.' (1982 p175).

For example from the perspective of people who are patients, a dominant institutional project, the formal organisation in Habermas' (1987a) terms, of Shenley hospital, regulates the possible bodily movements of patients by restricting individual projects and projected space-time paths into the life-world of

the village. It does this, for example, by its use of formal law (eg the 1983 Mental Health Act and its related regulations) or by formalised administrative codes which specify the times which even 'informal' patients may be 'allowed out', or by other informal means. In order to retain an 'informal' status, patients must conform to some considerable extent with these rules. They must receive permission from nursing staff to stay out overnight, and will otherwise be expected to return to the ward by a particular time at night, for meals, and so on. At the same time patient-paths and projects in the village are also enabled and/or constrained by their intersection with the paths and projects of others and village-based institutions.

In Pred's terms, hospital, village store, churches, pubs and village families are all institutional projects. Buildings, paths, walls and so on in the village are sediments, objects deposited in turn by these or other projects.

For Pred, people both produce and are produced by, history and places. In a play upon Marx's famous dictum, Pred suggests: 'People do not produce history and places under conditions of their own choosing, but in the contexts of already existing, directly encountered social and spatial structures.' (1985a p198). Social reproduction is inseparable from everyday labour and other practices and also 'from the reproduction of the material world of buildings, transportation facilities, eating utensils, tools, furniture and other man-made objects' (1982 p159).

From this perspective, humanist or so called phenomenological geographers who are concerned with the notion of 'sense of place', that is, place as a focus for emotional or sentimental attachment, or as felt significance (Pred 1983 p49), betray their idealism and voluntarism (ibid p50, and cf. Entrikin

1976, Hudson 1979, Sayer 1979). In a fairly easy critique Pred argues that 'sense of place is too frequently seen as a free-floating phenomenon, in no way influenced either by historically specific power relations that enable some to impose upon others their view of the natural and acceptable, or by social and economic constraints on action and thereby thought' (ibid). Pred therefore aims to rethink 'sense of place' to make it an embodied by-product of structuration[5]. For Pred, social structure comprises 'generative rules and power relations (including the control over material, symbolic or authoritative resources) that are already built into a specific historical and human geographical situation or into an historically and geographically specific social system' (1985 p9). However, such rules and power relations do not just constrain and enable human action, but also emerge out of human agency and practice. They in turn are reproduced via the intersection of individual paths and institutional projects (1982 p175). These underlying and human-produced rules 'form the underlying grammar of activity and behavior in particular contexts' (1985 p9).

The analysis of space-time paths and routines and their deviations affords a way of beginning to grasp the dialectic of social action and social structure which in a sense can be

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[5] Nevertheless it might be argued that Pred still retains a humanistic residue in his conception of space-time and place in so far as he emphasises, like Giddens, the centrality of human agency in reproducing social and spatial structures. (For critiques of Giddens see e.g. Layder 1981, 1985, 1987, Clegg 1989). As Sayer (1985) for example points out, the spatial is only partly constituted by the social. Spatial structures may for instance be constituted primarily by 'natural' rather than social phenomena. But Sayer also argues that although space can exist only in and through objects (social or 'natural') it cannot be reduced to them (p51). In other words space is independent of the *types* of object present (p52). Yet if space does make a difference, i.e. becomes significant, it is only through the nature of the particular things which constitute it and their causal powers and liabilities (p52).

said to materialize or take fleeting shape at particular sites. Here, there is also a potential for understanding relations of power, sketched in terms of the movement of bodies, objects and materials in space/time[6]. Thus for Pred (1985a p26), following Foucault, to exercise power 'is to structure the possible field of action of others'[7].

In the intersection of paths and projects, power plays a central part and may be analysable in terms of the dialectics of practice and structure in a particular historical and geographical setting (1985a p3). Pred argues that:

> Thus, whatever power relationships are, however elusive they may be and whether they exist at some micro- or macro- level, they ultimately cannot be separated from the realm of action and daily practices or from the direct or indirect control of who does what, when and where. (1985a p26)

Language occupies a fundamental role here. In the terms of the discourse analysis presented later, language may be seen as a resource which is differentially and creatively drawn upon and which performs a number of functions. But while language pre-exists individuals, it is also reproduced by them and as such

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[6] Variations on this position have also been adopted in other fields, for instance in the sociology of social work (Sibeon 1991 and cf. Hall 1991), and the sociology of scientific knowledge and technology (Law 1986, (ed) 1991).

[7] Foucault has of course devoted considerable space-time to the relationship between power and space. As he finally concedes in Questions on Geography (1980 p77), 'Geography must indeed lie at the heart of my concerns.' And elsewhere, 'A whole history remains to be written of *spaces* - which would at the time be the history of *powers*...' (1980 p149). For Foucault, modern technologies of discipline and power advance via the organisation of individuals in space (cf. Shields 1991a p39, Dreyfus and Rabinow 1982 p154-5, Foucault 1975/1979). See also the essays in Rabinow (ed)(1984/1986).

can be seen as an important part of the dialectic which Pred is addressing.

Pred argues that language is essential to the achievement of path-project intersections because it provides a foundation for describing, grouping and differentiating objects, events and experiences; because it is essential to legitimation; and because it is the medium through which the component tasks of institutional projects are routinely or creatively defined, made mutually understandable and subsequently recounted (1985a p16-7). Following Habermas (1984, 1987a), we might say that language constitutes the means whereby people may cooperate in and coordinate their space-time paths. From Pred's perspective the linguistic and discursive form and content which an individual evidences cannot be divorced from the host of path-project intersections generated over time. Discourse and bodies, affect and cognition become in this process inextricably connected. Pred further connects these up in a variety of ways.

Pred's view of the world is extremely rich and utilizes a range of other concepts, such as the 'dialectics' of corporeal action and mental activity and intention (the external-internal dialectic), and life-path (the biographical) and daily path (the everyday). He provides a non-mechanical view of individual and society in which contingency and structural inertia both play a part and allows one to see how agency, structure, space-time and everyday life are interlinked. For example it becomes possible to visualize an individual and her biography (itself the outcome of path-project intersections) negotiating the paths and projects of others and institutions and thereby contributing to the life-paths of others and reproducing social structures. In this way socialization is not confined to childhood but persists throughout an individual's life,

although the opportunities for further movement and choice change according to the way the person's life-path/daily-path dialectic has evolved since birth.

The vision here is of a medley of bodies and biographies moving in space-time. But even something as mundane as sitting quietly reading a book can be configured in terms of a space-time path intersecting with the product of an institutional project. Indeed this analytic structure also points to the intersection of my own research project with those of villagers, patients and institutions. Out of this an account is born which, reified, may itself become a resource of an institution and at some point intersect with other space-time paths (including for example that of the present reader).

Other Places

But this overview of ways of conceptualising place is incomplete as it stands. Theorised as 'context', the notion of place can be said to have become a commonplace in branches of social science which emphasise the locally organised and contingent nature of social practices (e.g. Garfinkel 1967, Sacks 1972, Sacks et al 1978, Eglin 1980). But in particular it is the notion of 'commonplace' itself that I also wish to explore briefly.

The concept of place arguably provides a bridging theme between the analysis of movements of bodies and space-time paths in the village and a discourse analysis which is represented as an inquiry into those rhetorical devices and argumentative structures displayed by villagers in talking about patients. Within the tradition of rhetoric, 'place' has played a central role as a method, an aid to memory for rhetoricians of the ancient world who spoke without a manuscript:

> While he delivers his oration, the speaker's mind is supposed to walk through the rooms or parts of the building, stopping to consider the things onto which he previously (and habitually) conferred the status of "places" of memory...(Fabian 1983 p110).

Hence the '*topoi*' (Greek) or the '*loci*' (Latin), of rhetoric; those items, positions, or strategies which 'effect an entry or give the writer an initial hold on the subject' (Nash 1989 p7); positions from which to discursively manoeuvre. But where such 'topics' consisted less of strategies than of appeals to ordinary and everyday experiences then they were known as 'commonplaces', '*koinoi topoi*' (Greek) or *'loci communes'* (Latin) (Nash ibid). As Nash also notes, while 'commonplace' may today have become a pejorative term, commonplaces were once regarded as repositories of shared wisdom and experience.

And so in chapter 14 below I attempt to identify those commonplaces used by villagers in their discussions and arguments; the (rhetorically organised) wisdom of the village as it relates to people who are patients at the psychiatric hospital, a wisdom which we might argue is distinctly place-related. And indeed which draws upon 'place' itself in a manner which has rhetorical implications, as I shall show[8].

Drawing in particular upon the core concepts of 'paths and projects', I intend to provide below an account which stems primarily from participant-observation within the village which covered a period from October 1988 to April 1991, and which was

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[8] Drawing upon Foucault and Bourdieu, de Certeau (1984) has provided an interesting 'rhetoric of walking', which poetically elaborates upon rhetorical 'tropes', thus: 'The walking of passers-by offers a series of turns (*tours*) and detours that can be compared to "turns of phrase" or "stylistic figures" '. And '...the "tropes" catalogued by rhetoric furnish models and hypotheses for the analysis of ways of appropriating places.' (p100). And see p183 and footnote 40, p397 below.

at its most intense over the twelve months of 1989. I have focused in particular upon the sites of two village pubs and the village store. The sequential depiction of these sites, from the Black Swan to the King Harry, along the main road to the village store, retraces the outward journey through the village by patients along routine paths which encounter and intersect with certain institutional projects. In this way it may be possible to begin to understand how patients both affect and are affected by the village in terms of the space-time constituents and parameters of social action and material and symbolic reproduction of the life-world.

Public and Private Houses

The observations in public houses referred to below relate primarily to lunchtime hours, from eleven o'clock to 2 or 3pm. These observations have taken place on various days of the week and at two principal sites.

The Black Swan[9] is nearest to the hospital, just across the road from the main hospital entrance, and the King Harry is approximately 100 yards further along the road. The pubs are different in many respects, according to character, age, bar staff, internal spatial structure, clientele and not least prices. Both pubs can be read as institutional projects in Pred's terms.

The Black Swan is said to be some 300 years old. Its last landlord stayed for 30 years and the present incumbent has been in post for a few months only. The pub can be entered via two outside doors, one giving access to the public bar and the other to the saloon. The two drinking areas are separated by

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[9] I have altered the names of the public houses referred to here.

the bar itself. Both bars are linked by a passageway that leads to the toilets and to the landlord's accommodation, and there is further access to the bars from the garden at the rear of the pub. The garden is furnished and has a barbecue area.

The two bars are very different. The saloon, in traditional form, is better furnished. It has a number of small tables, is larger, and has a more refined atmosphere. The public bar on the other hand is in poor repair, with holes in the seat covers (although the landlord has been talking about replacing the furniture). It has several long tables - which can be quite difficult to sit at without disturbing others who are already seated (rather like the problem with cinema seats), and in addition it sports a 'fruit' machine, a darts board and a photograph of the landlord. Both bars and the outside windows and doors have received a new coat of paint recently.

The landlord and landlady live on the premises together with their two children, but also employ bar staff some of whom live outside the village. Following in the tradition of his predecessor the new landlord keeps the price of drinks high in comparison to those of the King Harry.

Although there is no rigid demarcation between the two bars, it is fairly clear that the public bar enjoys the status of a 'regulars' bar whereas the saloon bar attracts a wider range of customers including some regulars. The saloon bar, then, is more likely to entertain the casual or irregular drinker, the person who wants a quiet drink but also staff from local offices or the hospital who may or may not be 'regulars'. The public bar on the other hand accommodates people who tend to know each other or who have mutual acquaintances and who are known by the barstaff. The researcher's experiences in the public bar were often those of acute discomfort, feelings which

were not engendered in the saloon bar. There were occasions when regulars in the bar made it clear that the researcher was interloping on home territory. Attempting to look 'safely disattendable' in Goffman's (1971 p328) terms, sometimes by hiding behind a newspaper, other times by trying to sustain a studied interest in a drink or the wallpaper, led on occasions to continual glances of enquiry from regulars and bar staff, enquiries which have been largely absent when seated in the saloon bar. Unfortunately there was insufficient time to strike up relationships with people in the public bar but some useful information was gleaned.

From observation and conversation in both bars from opening time to lunchtime it is possible to construct a pattern which may to some extent be indicative of relationships between patients and non-patients in this context, although such a pattern does not of course have the status of an invariant rule, and its instantiation on any particular day cannot be entirely predicted.

The first point is that patients who drink in the pub at lunchtime are more likely to use the public bar than the saloon. Their motivations for this practice are unclear but the practice itself has repercussions of a particular kind, for unaccompanied[10] patients choose that very place most likely to elicit a territorial defence by 'regulars' (see e.g. Katovich and Reese 1986, Lyman and Scott 1967). However, the likelihood of such defences being activated is minimised by the patients' simultaneous management of time, for their attendance at the public bar in substantial numbers[11] has occurred particularly

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10 By 'unaccompanied' I refer to patients not escorted by staff. Groups of escorted patients may be led to the saloon bar.

11 I have observed up to six patients independently enter the public bar at the same time and before other clients arrive.

when regulars are less likely to be present e.g. immediately the pub is opened and before the lunchtime clientele arrive. In this sense it can be argued that patients have colonised their own place at the Black Swan which is separate from the territory of others. However the situation is further complicated by the question of whether or to what extent some patients themselves can claim the status of 'a regular'.

The analysis provided by Katovich and Reese (1986) of the establishment and negotiation of full-time membership and 'regular' status in an urban American bar provides some useful pointers. For Katovich the negotiated status of 'regular' is indicated by a number of factors. The authors argue that the routine structuring of space/time permits the construction of a shared past and the practice of projecting a shared future. Membership includes here the process of becoming memorable and 'talked about'. Maines (1989) has put this latter point succinctly: 'Regulars become narrators of other people's lives and their membership is secured when their lives become the stories other people tell' (p 198). In this respect membership is defined in terms of biographical knowledge and its telling, the occasion of which is space-time structured[12].

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[12] It is of course arguably the case that human conduct is irremediably 'storied' and that narrative is a basic and everyday means of representing and structuring the world (Mitchell 1981, Polanyi 1981, Polkinghorne 1988, Sarbin 1986). Narratives and their analysis have been of interest in for example philosophy (MacIntyre 1977, 1981, Lyotard 1979/1984), in social psychology (Mishler 1986, Gergen 1988, Sarbin 1986), sociology (Plummer 1983, Thompson 1984), linguistics (Labov and Waletsky 1967, Polanyi 1981, Linde 1986), literary criticism, as well as within the world of psychotherapy (Bettleheim 1976/1986, Cox and Theilgaard 1987, Keen 1986, Sarbin 1986) and neurology (Sacks 1986). As Barbara Hardy has written 'we dream in narrative, day-dream in narrative, remember, anticipate, hope, despair, believe, doubt, plan, revise, criticize, construct, gossip, learn, hate and love by narrative' (quoted in MacIntyre 1981, p211). For the link between ethnography and 'story' see for example Atkinson (1990), Brodkey (1987a), Clifford and Marcus (1986), van Maanen (1988).

Although patients may routinely make spatio-temporal delineations within the pub, those who drink in the Black Swan and other pubs cannot readily be included in the category of 'regular' as defined by the telling of personal knowledge. Even as a group, patients do not interact greatly with each other[13] but perhaps more importantly even those patients who share their own biographical knowledge are seldom talked about by other people except in the generic sense of 'them' or 'the patients'. There are exceptions to this rule of course, exceptions which may occur in those circumstances which are especially unusual and disruptive of local life. Such an event occurred for example when a well-known patient went missing and was later found dead in a nearby field. During this time a collection for flowers was organised by the landlady at the King Harry, and especially significant, a story began circulating around the village about the circumstances of her death to the effect that these circumstances looked suspicious. Katie, in other words, had finally become talked about[14].

In the routine life of the pubs, however, individual patients have not generally constituted a focus for discourse. This 'silence' leads to the conclusion that the status of patients within the Black Swan should be seen as that of 'regular irregulars' a term used by Katovich and Reese to describe those people who often frequented the bar but who remained outside the discourse, gossip and chatter of the 'regulars'. On the whole, those patients who drink in the Black Swan at lunchtime,

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13 See Sommer (1959b, 1969) and Horowitz et al (1964) for studies of how 'schizophrenic' and other psychiatric patients use personal space, and Ainlay et al (1986) for an interpretation of interpersonal and spatial distance based upon stigma as a major variable. Goffman (1961/68) has also analysed the use of space by psychiatric inpatients.

14 A history of incidents which have led to complaints by villagers is presented in chapter 9.

although they may be well enough known for the barperson to address them by name, sit by themselves and do not engage others in discourse or encourage others' approaches at conversation. Again there are exceptions as I show below.

A further criterion for the achievement of 'regular' status is the demonstration of 'impressive' drinking, which allies consumption of alcohol with sustained reasonableness, a lighthearted approach to interaction and a willingness not to disrupt the conversational flow. As I have noted, most patient drinkers sit on their own but there are occasions when a patient may be voluble, rude and disruptive of ongoing conversation. This also marks him out as ineligible to be a 'regular' but may qualify him for another part.

What has become apparent in these situations, particularly in the Black Swan, is the way such behaviour within certain limits may on occasions be laughed at and encouraged. One patient named Harry would make a practice of addressing anyone and everyone in the public bar regardless of whether or not they wished to talk, and chat about his problems, the inequities of other landlords, and the great film parts he has played or wished to play, his favourites being Genghis Khan or the Czar of Russia. Those non-patients in the bar have smiled, laughed and joked with him and the landlord has bought him beer.

In their 1985 paper Nieradzik and Cochrane have argued that 'toleration' of mentally disordered people derives from the assignment of an extra role to a person otherwise seen as mentally ill. For example the role of 'comic' or 'gifted painter', which are not incompatible with mental illness but which may ameliorate it in some way. In the Black Swan the landlady's epithetic reference to Harry as 'the cabaret' suggests that this reclassification of Harry may make his

behaviour more tolerable for others, and may prevent Harry's more immediate eviction from the premises.

But on other occasions when Harry has been swearing about a particular injustice or directly addressing a regular in an overly familiar manner he has had abuse and invective turned upon him. Harry has responded with equanimity, apparently without taking offence, and it has been hard to resist the idea that *this* to and fro brings him nearer to achieving a kind of authenticity, if not 'regular' status, within the pub culture.

However, further occasions on which Harry has tried to persuade a regular to buy him a drink have met with simple unelaborate negation from which he has quickly retreated.

It is possible of course that this situation comprised a temporary stage resulting from the arrival of a new landlord who was testing out his own and others' limits - exploring and reconstituting in other words the possibilities of local rules, for it certainly appears to be the case that patients are dealt with differently in the two pubs examined here.

Although it has not been possible to explore what it is that constitutes a non-patient seriously 'stepping out of line' in the Black Swan, a preliminary impression is that the criteria of exclusion are probably not very different for these two groups in this pub and indeed that the kind of intrusive behaviour demonstrated by Harry, which Davis and Schmidt (1977) have identified with a particular 'psychological type' named 'the obnoxious', may be more likely to be tolerated if it is exhibited by a patient who is *'known'* (although not talked about in his absence) as opposed to a 'strange' patient or even a prospective regular. That very different criteria exist between the two pubs will be shown below.

Before moving on to examine the King Harry, an important distinction needs to be made between the reality of the Black Swan as it has existed during my observation and that of the 'Big Derby Lounge' of Katovich and Reese. For the regulars of the latter there were certain groups, categories or traits of people which were *never* welcome and 'totally intolerable' to the community, people who were treated as intruders to be 'ignored, isolated, insulted, asked to leave and even "escorted" out if his departure was not imminent. He was persona non grata' (1986 p327). Such people, the authors recount, included 'emotionally disturbed people'. It has become clear that such people are not immediately evicted from the Black Swan, that to some extent they have colonised their own spatio-temporal territory within the pub and that they may be encouraged to 'entertain' others. That 'entertainment' implies an ambivalence and condescension will be addressed later, but is not presently at issue.

The King Harry public house has a different internal structure from the Black Swan. Two doors situated on the main road both lead directly into one long drinking area. This area may be divided functionally and socially into different sectors. At one end are the tables which at lunchtime are set out with placemats and cutlery, and through which one may go to reach the garden. In the center is the long bar along which stand a number of tall stools. A fruit machine stands by the wall. Alongside and at the other end of the bar there is a space large enough to contain several tables some of which are set into the bay window. Finally there is a smaller side room which is served by an extension to the bar and which is more spartan, contains tables and chairs and a dart board. The landlord, landlady and their children live on the premises and have been resident for approximately four years.

One principal difference, then, lies with the arrangement of space. Unlike the Black Swan where there are two bars each with their own door, entry into the King Harry is by way of the central long bar. There is no sense here of there being two separate bars. The side room has seldom been used in my presence and most of the activity has gone on in the long area. Within this area however there are discernable social-spatial and temporal partitions, some of which are more fluid than others. From opening time onwards a distinct movement of different groups of drinkers occurs. The first to arrive are the retired and elderly group, the members of which always sit in the same place, the most informal and comfortable area. After one or two hours this group is joined by 'regular' local workmen. Office workers who may be known by name but who are not 'members' then arrive, by which time some members of the group of older villagers have left and others taken their place. This elderly group is not entirely cohesive, for one or two older drinkers sit at the bar with their backs to the main group, quietly consuming alcohol, and remaining independent of the others.

Nevertheless there is a distinct sense in which this particular space and time zone both enables/constitutes and is constituted by an area of 'sociability'[15] in which membership is tacitly acknowledged and from which those who cannot exhibit the correct credentials are excluded. Such credentials, in addition to age, include those discussed above.

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[15] Following Simmel (1950), Byrne (1978 p428) defines sociability as '...the feeling of being in a mutually acknowledged relationship with others with a derived sense of satisfaction', and '...an experiential substance of felt significance in the now...' (ibid). Sociability might therefore be said to constitute the experiential component of communicative action. Habermas speaks of communicative action as a principle of 'sociation' (*Vergesellschaftung*) (e.g. 1984 p337) (and cf. Amirou 1989, Frisby 1988 p124).

Although predominantly a male domain (cf. Hey 1986), one or two women may take part with their husbands and play an active part in the proceedings. The time here is spent mainly in talking and drinking. Topics of discussion include sport and politics but also reminiscence and the recounting of anecdote, personal histories and local village events. In addition there has been a substantial amount of joking about sex and the *sotto voce* bandying of profanities, while members have also shown considerable interest in matters of physical health and illness. Membership is not confined, as Katovich and Reese have also shown in their study, to those present, for absent members are often discussed, praised, ridiculed, sympathised with, laughed about, and 'storied'. The point here is that they are *talked about*, and it is this 'talking about' that links them to the group. Or as de Certeau (1984 p122-3) puts it, the telling of such stories 'found' and demarcate spaces and boundaries.

Paraphrasing Kirby (1988), what is at issue here is a continuous process of reproduction which is rooted, contrary to the argument of Meyrowitz (1986), in particular places, and which perpetually recreates what Vico has termed *sensus communis*, a *common* sense - a unity which is subtly different to that which takes place elsewhere (see also Shotter 1986).

A preliminary comparison of the two pubs has illuminated the relative absence of patients from the King Harry. Throughout many hours of observation and in spite of the landlady's claims to the contrary, only two female patients have been seen in the pub during lunchtime hours and these have paused only long enough to buy a box of matches. One possible implication here is that the landlady has wanted to provide a good impression about her track record with patients, at the same time that the pub may have been actively discouraging 'patient' drinkers. But

it can also be hypothesised that other factors identified as being operative in the King Harry may directly contribute to the absence of patients.

Firstly, as outlined above, there exists in the King Harry, fairly soon after opening hours, a clearly demarcated group of people who exhibit an intensity of camaraderie which might be off-putting to putative interlopers and who appear to be content with their membership, whereas the Black Swan has a vacant and separate space in which patients may gather[16]. The principal interpretation of the King Harry is that at lunchtime it has a more 'regular' and intimate client group. Perhaps some testimony to this may be found in the dozens of coffee mugs to be seen hanging behind the bar, brought by regular customers following journeys to faraway places and sporting motifs, mottos and chauvinistic slogans. These mugs signify by their giving not only 'membership', but also the fact that the customer was *thinking* about, if not *actually talking* about, the 'local' during his or her absence. The implication is that the customer also expects and indeed wishes to be talked about by those left behind.

Secondly, the landlady has made it clear that although she still has customers from the hospital, she will personally only tolerate a small number of patients at any one time for several reasons. She recounted how she 'had a bit of trouble' when she first moved in a few years ago. This 'trouble' consisted of patients arriving at the pub in 'large groups'. Her philosophy, she explained, is that the patients are alright in small doses, so that she says she can only tolerate two or three in the pub at any one time:

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16 Of course the contrary could also be asserted; that the colonisation of the public bar in the Black Swan by people who are patients has led to non-patient others becoming reluctant to frequent it at that time.

> You can't have the sane and the insane together otherwise we'd all go mad. You've got to keep them separate.

A further reason provided by a barman in the King Harry was that the patients were lazy and could not be bothered to walk the extra hundred yards involved. However any study would show that patients, including some of those who drink in the Black Swan, have no hesitation in walking to the village store on occasions, which is further from the hospital than the King Harry, and this in spite of the fact that the Hospital has its own patients' shop. This 'distance' explanation therefore seems unlikely to stand up to close scrutiny.

The difficulties of properly identifying stigma, discrimination, inclusion or exclusion, have been exemplified in this context by particular interactions between members of this group, interactions of a subtle nature.

Sitting at the edge of the group in the King Harry, listening, observing and making such comments as might appear appropriate for an 'outsider', I have become on occasions aware of the potential and subtle difference between the playful collusive glances that are about intimates and those glances which effectively 'excollude' another (see Goffman 1981). When Bert's wife winked at me when Bert had made a social gaffe, not only did she not mind that her husband would see her wink, but the fact of her wink was an essential prop to her husband's management of his impression - that of 'the fool'. In this case what appeared to be a collusion between Bert's wife and myself was actually a collusion between Bert and his wife aimed at an audience and involving a bit player. Such collusive and 'excollusive' glances may be of a different order in relation to patients. For example, the winks and smiles that the landlord of the Black Swan pointed in my direction when discursively jousting with Harry did not appear to be intended

to be seen by Harry, although again the possibility of a further unconsciously staged drama cannot be ruled out.

A further incident in the King Harry brought home the difficulties of defining the practices of stigma. Members of the retirement group were busy criticizing one of their absent members, talking about his bossiness and overbearing habits, when the man in question walked in. The group members instantly changed the subject and welcomed their member in a positive fashion. It became clear eventually that in spite of the complaints and gossip Sam was a valued member of the group, and he proceeded to join them in exchanging stories and rumour. The point here is that if taken at face value without the subsequent observation of further events or discussion with subjects, it would have been easy to draw overly simple negative conclusions. If then the group had been talking about a particular patient in the same way, such discussion could have been used in the researcher's description of negative responses without the researcher being aware of the complexity of the picture.

A number of conclusions can be drawn from this preliminary examination of the interactions in two public houses. But first I want to note two virtual paradoxes which flow from the above appraisal.

The first is the paradox of paranoia. If the above analysis is correct then a central aspect of belonging, of being a member, or a 'regular', is that one both 'talk about' and be 'talked about' at particular discourse sites, with the proposed corollary that one be *aware* at some level of consciousness of being talked about. In other words the *understanding* that one is most likely being 'talked about' is a positive, valued and sought-for experience. But believing that one is being talked

about is also considered to be a sign of paranoia, of mental disorder expressed paradigmatically in terms of an obsession about being talked about and plotted against, when in fact this is not the case. From an interactionist perspective therefore this disorder may be seen as a caricature of the mundane. It both refers to and exposes what everyone desires and at the same time expresses an ambivalent longing for the same state and social conditions[17]. Madness and sanity are linked here by division and unity, where the unity relates formally to 'being talked about' and the difference lies in the perceived and substantive possibilities for its attainment - in the case of the Shenley pubs, the separation from patients of that discourse.

Of course the paradox also includes the fact that 'being talked about' by members may itself cultivate a paranoia as Lemert (1962), for example, has shown. What seems important here is that the talk be matched within the group by extra-discursive (but discursively mediated) actions which succour authenticity and wherever possible combat possibilities of paranoid misrepresentation. Within pub culture such actions are varied. In the King Harry they include the routine buying of drinks for others and the inclusion of regulars in 'fieldtrips' to the racecourse - a kind of family outing.

A further issue attends this discussion. I have been arguing here that the experience of being talked about and also the talking about of others is closely related to those socio-

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17 Keen (1986) has argued that the paranoid person is not just lonely but also wants to be left alone. My suggestion here is that the paranoid person, in articulating talk and story as themes, not only highlights the mundane centrality of such talk, but also points to the possibility of some residual if ambivalent desire for integration and sociality, of sharing stories; albeit a desire which may be experienced as hopeless (cf. Cameron 1943). And see the comments by Laura in Appendix D, p490.

temporal i.e. 'placial' possibilities for their achievement. Paranoia on the other hand may contain both a placed aspect and a placelessness, so that reference may be made in discussion with the prospective patient to particular space/time locations when he or she felt abused, but may also refer to a generalised and free floating sense of persecution by everyone in all places. In the latter sense we might say that the paranoid person has lost his or her 'sense of place'[18].

A further virtual paradox turns on the question of 'self-talk' (Goffman 1981). Goffman has drawn attention to the situational requirements for those comments, sounds or cries which are directed at oneself, at no-one in particular, or overhearers in general. As Goffman shows, in our society 'self-talk', i.e. talking to oneself, is in most circumstances, taboo:

> ...In our society at least, self-talk is not dignified as constituting an official claim upon its sender-recipient... There are no circumstances in which we can say, "I'm sorry, I can't come right now, I'm busy talking to myself." (1981 p81)

Goffman continues by pointing out the serious fact that an adult who continually fails to attempt to conceal his self-talk or to stop if discovered and if necessary offer some covering comment may be open to the ascription of 'mental illness'. This position characterises that of a number of the patients (but by no means all) who frequent Shenley village.

From the perspective of a customer at a village public house there follows an interesting implication, for 'self-talk' is also conventionally related to drunkenness. It may indeed be the case that in some of the pubs e.g. the Black Swan, self-

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[18] This may also apply to other types of psychiatric disorder. Compare Godkin's (1980) proposals for 'place-therapy'.

talk which is attributed to mental disorder may be more acceptable to the barstaff than the implication and attribution of drunkenness. Goffman reports the following story:

> An instance is reported to me of a barroom self-talker being misframed as always having had too much and temporarily solving his threat to his drinking rights by retreating to the tavern's telephone booth to do his self-talking. (ibid p82)

It is yet an open question whether Shenley village drinkers purposefully refrain from either drinking so heavily that they may inadvertently talk to themselves as a result or whether they have developed sufficient self control to be confident that they will not talk to themselves even if they are roaring drunk, or whether indeed they ever consider this to be an issue.

This 'virtual paradox' points again to the social and linguistic intertwining of madness and sanity, their conceptual and substantive relations. Like the dialectic of Hegel's master and slave, the relationship between the concepts mental disorder and sanity are logically related while the real, substantive relations between patients and non-patients bespeak relatively durable social relations between groups of people in the performance of definite social practices i.e. they constitute a social structure of sorts existing in the real world, a structure which although not entirely monolithic is still relatively 'enduring' (cf. Isaac 1987).

The knowledge of 'place', indicated by a routine management of space-time and of the social relations embodied in space-time, has both interesting repercussions and exceptions. There have been occasions in the Black Swan public bar and The Crooked Chimney (a public house not otherwise addressed here) when I have become aware of single women entering the pub, ordering

a drink and sitting by themselves. I have had independent reason to believe these women to have been patients at the hospital. This practice has not otherwise been noticed in Shenley pubs, so that non-patient single women have only been observed entering a pub on their own to meet up with friends. The conclusion then is that one can routinely follow a path already opened up by others and at the same time 'break through' what I call barriers of place, i.e. place-related social barriers. To what extent this encourages or discourages local women from pushing at these barriers themselves is an open question (cf. Hey 1986).

Within the village, patients can, as I shall show, be seen as relating to and negotiating places which range from the most public to the most private and with various consequences. The public houses, institutional projects in Pred's terms, which I have focused on above largely as sites of routine interaction can be seen as both public and private places. They are open and public to the extent that *almost* anyone can enter them, but private to the degree that they constitute a *sensus communis* which is potentially and often actually exclusive. This exclusion is place-related in so far as it may involve a ban from the pub itself or internal barriers of place which cannot easily be breached. The experiential corollary is that while the lone drinker may be able to 'see and feel the community as it flows amongst the regulars' (Katovich and Reese 1986 p320), he or she may nevertheless also feel excluded and isolated amongst a 'private' gathering.

But taking leave of the pubs we step out again onto the main road.

The High Road

In summer or winter, rain, sun or snow, people who are patients may be seen walking backwards and forwards along the main road which links the hospital and the village store. Often they may be poorly dressed. Night provides a 'frontier' (Melbin 1978) beyond which patients do not often tread, except on early winter evenings. I have also seen one patient walking to the store before sunrise at 6 a.m.

In his discussion of 'pedestrian speech acts' de Certeau suggests:

> ...if it is true that a spatial order organizes an ensemble of possibilities (eg by a place in which one can move) and interdictions (eg by a wall that prevents one from going further), then the walker actualizes some of these possibilities. In that way, he makes them exist as well as emerge. But he also moves them about and he invents others, since the crossing, drifting away, or improvisation of walking privilege, transform or abandon spatial elements. (1984 p98)[19].

Walkers, in other words, make selections about where they will walk; they may go here rather than there, may take shortcuts and detours, or may forbid themselves to take paths generally considered accessible or even obligatory. Thus the walker may condemn some places to extinction or with others compose spatial 'turns of phrase' that are 'rare', 'accidental' or illegitimate. (ibid p99).

But to a large extent the walkers from the hospital find their opportunities for deviation curtailed by the institutionalised

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[19] In this respect consider for example the tussle between farmers and those who walk the countryside footpaths in order to keep them open.

channel itself. I have described the route through the village as a conduit, a channel which conducts patients and others. For Foucault this ambiguous term 'conduct' is useful for understanding the specificity of power relations, thus: 'The exercise of power consists in guiding the possibility of conduct and putting in order the possible outcome' (1982 p221). The main road, its pavements, and its flanking private property can both be read as indicative of, or as constituting, significant and powerful institutional projects in Pred's terms, legitimated in law, which conduct patients and others. For example, although a 'public' highway, the road may not be defaced or dug up without authority. Neither may new roads be laid without approval by planning departments and without adhering to local planning regulations. It becomes as it were a power channel from which pedestrians and (especially) motorists alike cannot readily escape[20].

This power channel is itself perpetually sustained by imperatives which flow from a variety of institutional projects and in various ways. Not least we might say is the (small) role the smooth road plays in the perpetuation of an ethic of individualism, the myth of personal freedom and the happiness of consumption of one's new car. But not only is this a power channel, but it is also both potentially and actually lethal. During the period of participant-observation at least 2 patients died trying to cross the road, and I heard of several other accidents[21]. Such accidents are in a sense no accidents at all but the specific outcome of a institutionally enmeshed

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20 Motorists are in a good position to appreciate the significance of this especially when they are sitting in a traffic jam.

21 One way of limiting its power is to change its form by laying 'sleeping policemen' or to 'strangle' it, by drastically narrowing its width. At nearby Napsbury hospital the road has been narrowed to some extent by the use of central bollards.

and particularly lethal transport system (cf. Jacoby 1975 p141, Perrow 1984).

In addition however the road is flanked by private property of various kinds which serves to reinforce and define the boundaries of the channel (and conduct) itself. Historically in fact private property has an interesting relationship to mental disorder. For John Locke, for instance, there existed an equation of property and rationality so that only men of property '...are capable of that rational life - that voluntary obligation to the law of reason - which is the necessary basis for full participation in civil society' (quoted in Sayer 1991 p86)[22].

If the majority of patients (especially longer-stay patients) are in fact propertyless, then their channelling along the road points to the intersection of relatively impoverished personal projects with the dominant organising principle and project of our society. Patients are conducted by private property which is institutionally guaranteed and secured. In relation to private residential houses in particular, social relations embedded in these institutional projects extend beyond the 'local' or locale to implicate the property market, the work of the legal profession, estate agents, building industry, DIY and furniture markets, as well as employment and educational opportunities, laws of inheritance and so forth. In other words something which we may take to be as simple and as local as a house, implicates the state and a host of interlinked, institutional, national and international projects which articulate (or are built around) the principle of private property (cf. D.E.Smith 1988 p156).

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[22] Similarly Hegel held that 'It is in property that person primarily exists as reason' (quoted in Hawthorn 1976 p47).

However, the regular distinction which I have raised here between public and private space is a difficult one to sustain for too long (cf. Hammersley 1990 p132) so that it quickly becomes clear that even the private spaces of houses are not immune to intrusion by for example formal state organisations[23]. And as I show below this distinction is also directly challenged by patients.

And as I have pointed out the 'public' houses described above, although they are 'open' to the public and meet a variety of social needs, are nonetheless also private enterprises functionally linked to, constrained and supported by, a whole matrix of private corporations and markets, advertising and production processes, as well as various state agencies. These houses may also be regarded as powerful institutional projects in Pred's terms, with which the paths of patients intersect.

Channelled along the main road, patients have a number of opportunities for legitimately stopping off *en route*. I have witnessed patients attend: a vicar's cream tea afternoon held on the vicarage back lawn; jumblesales and bazaars at the village hall; the school fair; village fête, coffee morning in a church sideroom; and jumblesale at a second church. On the majority of these occasions I have noticed only a handful of patients at any one event, one exception being the vicar's cream tea party. At most events patients have quietly kept to themselves, with the exception of Bill and Janet, a patient and an former-patient who have made themselves well known to villagers and attend a variety of village events. Of these two, Janet appears to be the most welcome to the extent for example that women at the vicar's tea party made room for her to join them at their table. Bill is known by name by many villagers

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[23] Compare Habermas (1987a) thesis of the 'colonization of the life-world'.

who stop to chat to him, although some complain about his verbosity[24]. At the tea party Bill was asked to leave by an organiser because he was being 'cute'. That is, although he was said to have money, he was alleged to be attempting to freeload. On another occasion, at a church coffee morning, Bill was interactionally excluded by the simple manoeuvre of another coffee drinker moving his chair and turning his back to him.

It is often the case that in these places villagers' responses to patients are subtle and *sotto voce* (cf. S.J.Smith 1984, 1988)[25]. On occasions all that may be discerned is an exchange of smiles or knowing glances, or a casual nudge to the person sitting alongside, when someone who is a patient walks in or leaves. During one village hall bazaar a non-patient (my wife in this instance) was served before Janet even though Janet had arrived before her at the drinks counter. And although Janet sat at a table with villagers she sat largely silent, while the others at the table talked to each other. In other words patients are not explicitly excluded from such events, and at some appeared to be more or less welcomed. On the other hand I began to develop a sense that villagers experienced an ambivalence and that they often concealed a certain antipathy towards patients. Such antipathy may find expression in a variety of ways including the reluctance to make an effort at translation.

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24 Some patients appeared to consider themselves to be on very good terms with villagers, although villagers often complained about them. Such patients could be said to evidence 'pronoia' (Goldner 1982)!

25 For Goffman (1961/68) subtle and *sotto voce* remarks constitute everyday ways by which people resist domination (p269). See also J.C. Scott (1990) who prefaces his book by quoting an Ethiopian proverb: 'When the great lord passes the wise man bows deeply and silently farts.' In the context of Shenley, subtle nudges and glances may bespeak a more complex relationship between villagers and patients, village and hospital, as I hope to show.

On one occasion for example a small group of three people whom some villagers later thought were probably former Shenley hospital patients, attended a Saturday evening Village Society AGM. The discussion of the meeting centred around the opposition of the Society to the closure of the hospital. One member of this small group then raised an issue concerning the courtesy stigma (Posner 1976) which attached to Shenley village via its hospital. The gist of his contribution was that the village would lose "what some people refer to as the curse of Shenley". When further afield villagers would not have to worry about saying in public "Oh, we're going back to Shenley now". Would the villagers be sad or happy that the hospital was disappearing, the speaker wished to know. The questioner was not engaged by anyone else, and left with his companions shortly after. Villagers later said that they did not understand what his point had been[26].

In addition to public houses and shops, village hall and church coffee room, there are other openings and opportunities along the route. As well as side roads and small footpaths there are small areas such as a green with a seat by the war memorial, a pond and its surrounds and a public toilet with a seat outside, shielded from the road by a shrubs and bushes. Indeed it was some while before I realised the seat was there. I had been told that it was a favourite seat of the patients, but on those occasions when I looked, I found only indirect evidence in the form of large numbers of well-smoked cigarette ends by the bench, perhaps territorial markers (Goffman 1971 p65) indicative of visits by patients (cf. Webb et al 1966). I have a vision here of patients sitting huddled together conspiring with each other, voicing the dissent and resentment which they

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[26] Of course villagers may simply have felt that a debate about stigma would have been tangential to their main concern, that of resisting the closure of the hospital.

could only voice in an offstage space shielded from surveillance, a space which they had themselves colonised (cf. Scott 1990 pxii)[27]. But less dramatically perhaps, and unfortunately for them, it may be more likely that they sit apart and largely silent. Other benches are also sited along the route[28].

Nevertheless I came to understand that patients took advantage in a variety of ways of the gaps and cracks in the discipline of the hospital and village to slip out and find their own space in certain parts of the village, and at the same time that their trips to the store, the pubs and the relatively unguarded open spaces of the village were not simply a function of their desire for 'a drink', for food from the store and so on, although such desires no doubt played a part, but also for space, comparative freedom and a kind of sociability. The direct evidence for this is sparse, although one or two patients I interviewed told me that they needed places to go, outside the hospital, and several villagers felt that patients came to the store to be closer to 'ordinary' people. To extend

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27 Compare Goffman's (1961/1968) description of the use of hospital toilets by patients: 'It was here patients were sent who wanted to smoke, and here it was understood attendants would exercise little surveillance. Regardless of the smell in this section of the ward, some patients elected to spend part of the day there, reading, looking out of the window, or just sitting on the relatively comfortable toilet seats.' (p207).

28 I did not spend any time researching the toilet itself, although this may have proved interesting in terms of interactions between patients and villagers. To what extent for example do patients conform to the typical behaviour of treating immediate others (villagers) in such places as 'nonpersons' (Cahill 1985 p41, Goffman 1963 p84)? It is also possible to view public toilets as status and identity levelling devices. As Cahill (1985 p53) put it, behaviour in public toilets '...often contradicts the parts or roles that individuals publically perform.' In such places socially constructed differences between group members may not easily be sustainable. In this respect perhaps public toilets should be called places of deconstruction (or decomposition). For a famous study see Humphreys (1970).

a concept advanced by Lewis and Hugi (1981) and Segal and Baumohl (1985, 1988) we might say that patients utilize places along the route as 'therapeutic stations'[29].

One central criticism of hospital life is that it is simply dull, monotonous and boring, and it may be readily understandable that, at the very least, patients should seek diversity for a while and to escape from enforced idleness. Goffman (1961/68 p67) for example wrote of the 'sense of dead and heavy hanging time' in the hospital which he saw as explaining the pursuit of 'removal activities'. This need may speak to us all. As Relph (1976 p41) put it 'The places to which we are most committed may be the very centres of our lives, but they may also be oppressive and imprisoning.' And for Robert Burton in the *Anatomy of Melancholy* '...death itself, another hell...to be tied to one place.' (quoted in Relph, ibid)[30].

From the villagers' perspective, however, patients from time to time presage the incipient breakdown of the ordinary world (e.g. Habermas 1979 p3, 1984 p131, Pollner 1987, Wuthnow et al 1984). The taken for granted and everyday becomes problematic. Something gets out of hand. Routines break down or become

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[29] The authors use this term to refer to the way impoverished and 'chronic' former-patients may selectively use institutional sites and personnel for purposes which differ from the stated aim of the institution. Thus: '...the hospital is not viewed as a site of treatment, but as a temporary refuge; the aftercare clinic not as a site of therapy but as safe place to make contact...' (Segal and Baumohl 1988 p260).

[30] For first-person 'pseudo-patient' accounts which emphasise the boredom of being a patient in a psychiatric institution see Caudill et al (1952), Deane (1961), Goldman et al (1970). The latter suggest that many patients were 'painfully bored' and that '...contrary to the views of many of the hospital staff, mental patients themselves were not at all oblivious to the barrenness and emptiness of their physical surroundings.' (p430).

highlighted. The ordinary is no longer ordinary. Life suddenly becomes less ordered, less reliable and more precarious. Stories tell of this. And even in a place where the extra-ordinary is ordinary, there still exists the unusual, the bizarre, the extra-ordinary extra-ordinary. For villagers, such problems may occur when patients challenge the institutionalised framework and arrangements of space/time paths; when they deviate from the paths which are laid down for them, and for others, to follow, and slip through the cracks in the institutional order[31].

Although, as I have indicated, patients may be said to 'know their place' in the village while continually renegotiating it, there are nevertheless occasions when some patients deviate radically from those paths previously set down and with a kind of revolutionary zeal attempt singlehandedly to carve out new paths at tangents to the old. Such patients may simply lie down on a front lawn, or find their way into the seat of a car left briefly unattended (see ch. 14.4 below). Or, more radically, reach an unoccupied kitchen of a village house by walking in through an open door, or even, (villagers recount), find their way into bedrooms and onto unoccupied beds.

Such movement is understandably considered by villagers to amount to invasion and attempted colonization[32]. For not only may the patient enter a private place but he or she may slide directly into a back region (Goffman 1959) without first

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31 Compare Goffman's (1961/1968 p280) suggestion that sense of selfhood is related to resistance to the pull of social belonging: 'Our status is backed by the solid buildings of the world, while our sense of personal identity often resides in the cracks.'

32 See my unpublished paper 'Life World and System' (1992) for an account of such incursions by patients from the perspective of Habermas' (1984, 1987a) thesis of the 'colonisation of the lifeworld'.

knocking at the front. These back regions have been presented by Goffman as those most intimate places where people may let down their guard; places which are considered essentially private and which permit the expression of 'regressive behaviour'. While the kitchen, a frequent point of entry, may not be as intimate as the bedroom, nevertheless it may yet have very considerable personal, territorial and private significance. The expected result of such perceived attempted invasion is therefore invariable 'defeat' for the patient. However, one possible implication of a sudden and unexpected challenge to private space is that the patient may 'catch' the villager doing something which he or she would not ordinarily expect to be caught doing, and certainly not in public. The patient who walks uninvited into a back region stands a chance in other words of finding the villager behaving in much the same way as the patient him or herself is seen and thought to behave.

A final significant institution en route to the village store is the school. Situated directly on the main road, Shenley First School takes children up to the ages of 8 or 9 years. It is protected by iron railings. Patients have on one or two occasions wandered into the school and parents have expressed worries to the headmistress about their children's safety. But such anxieties appear exaggerated. For instance the headmistress recounted the following:

> Children will come up and say 'A patient talked to me. He said something rude.' So I would say 'What did he say?' 'A swear word.' 'What was it?' And it would be 'Hello there, what are you doing.'

On one occasion I was told that a patient had applied for a job at the school in the canteen or as a cleaner, but when she admitted to being a patient at the hospital her application was

not pursued, for the reason that 'the Council would not have allowed it.'

And of course, at least in the past, some schoolchildren have taunted and "tormented" passing patients, calling them names and "jeering" at them, so that the passage to the village store for a patient has entailed a re-enactment of mortification processes in which the patient's moral career becomes almost geographically articulated (cf. Goffman 1961/68 p31)[33].

The Village Store

The village store, historically the last remaining retail food and hardware outlet in the village, incorporates a post-office. It stocks a whole range of goods including fresh, tinned and frozen food, alcohol, cigarettes, newspapers and magazines, sweets and ice-cream, and small domestic wares. Its top selling magazine is the 'Horse and Hound'. Shoppers serve themselves using baskets, but cigarettes and spirits are kept behind a serving counter. The store is sited on the main road and draws a substantial amount of custom from passers-by who neither live nor work in the village, but it is also patronised by a large number of villagers. Opposite the store another village pub has parking spaces which shoppers also use, and there is a bus-stop and post-box immediately outside the store. The manager of the store and his family live to one side of, behind, and above the premises.

The store has an 'L'-shaped spatial structure, with the protected post-office accommodated in the smaller arm. The store till area is situated by the door so that shoppers must go past it on entering and leaving. In this respect it has an

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[33] The headmistress assured me that the children's behaviour had improved over the previous 6 years.

interesting resemblance to many psychiatric (and other) hospital wards, where the nursing station is strategically positioned by the entrance/exit[34]. The till area in fact has two tills side by side. During light business it is 'manned' just by one person but a certain flexibility normally exists whereby a second till can be opened quickly when business becomes brisk. If they are not at the till, staff will normally be busy stacking or pricing goods, and there are usually at least two, and sometimes perhaps three or more, staff in the store at any one time.

Although it has quiet periods, the store is frequently busy. In contrast to the public houses where people often expect to sit down, the store is characterized by a constant motion of bodies and short queues. The only seat in the store is for the use of staff, although customers have occasionally squatted on the window ledge. Customers draw up outside in a car, rush in to buy cigarettes or paper, and drive off quickly. Others walk to the store, pick up a basket in the usual manner and finally queue to pay, while people queue at the separate post-office counter for stamps or to cash pensions and benefits and so on.

During this whole process shoppers will often take the opportunity to gossip, to chat to each other and to staff. Clearly many shoppers know each other, the manager and staff address many customers by name, and in turn shoppers address staff by name.

There is a strong sense here of the store being a central daytime focus of the village, a place which attracts people not just for the goods it has to offer but also for the people one might 'bump into' (cf. Bauman 1972, Wiseman 1979, Shields

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[34] For an account of the way space is strategically organised in a second-hand clothing store see Wiseman (1979).

1991a). Certainly for at least one member of staff a job in the store offered a chance to get out and meet people (cf. Maisel 1974).

The store therefore constitutes a place where many individual space-time paths intersect with an institutional project. There is a certain energy and life here located in the regular and continuous flow of bodily movement, purposive action, and phatic discourse. In Seamon's (1980) terms one may witness or sense here a 'place-ballet' (p159), a strong sense of place linked to such movement and routine (cf. Relph 1976, Buttimer 1980). This place-ballet is of course not independent of actors but is sustained by the very chronicity of the intersection of individual space-time paths with this particular institutional project, a chronicity which nevertheless 'provides a foundation for surprise, novelty and the unexpected' (Seamon 1980 p163)[35].

Each person plays a part in recreating the ballet including, to be sure, people who are patients. Although patients enter the store, one or two often linger immediately outside. One particular man is well known for walking up and down outside the store, occasionally pressing his face to the window and peering in. Another man, a former patient, may sit in nice weather with pipe and paper on the wall across the road from the store, watching events unfold. The same gentleman has also stood silently inside the shop again watching shoppers. I came to think of these people as adopting a 'tourist gaze' (Urry 1990, Shields 1991a), although it seems that the pleasure they

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35 The store is only one such site in the village. The pavement outside the school at 'hometime' also constitutes a meeting place when parents chat, coordinate their plans of action, and so forth. The pubs also each exhibit their own sense of place. The store however is distinguished by the perpetual movement of customers and in this sense more clearly evokes the notion of place-ballet, although this may be matched in the public houses during busy periods.

may take derives from the authentic daily round, rather than the inauthentic and contrived (cf. Eco 1986/1987)[36]. As Shields (1991a p6) puts it: '...the sense of presence and social centrality - of something happening beyond the close world of oneself motivates many who are marginal, alone or simply idle to visit shopping centres as passive observers.'[37]

The importance of time for the organisation and smooth flow of the store became apparent when there was a delay at the till and such delays regularly involved patients. At such times the second till would be opened quickly to speed up the process. The manager was keen that customers should not be kept waiting too long in a queue. This served both to increase the viability and profitability of the store and to keep customers happy. In relation to patients the delay often concerned the effort for staff of understanding what patients were asking for. Unlike the pubs, shoppers in the store enquire about a wide range of goods. And at the post-office counter people might need help

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[36] I also came to think of this man as a 'patient-researcher' who, like me, was checking out, and contributing to, the reality of the setting. It is also the case that the stance of tourist or observer/researcher can both be risky postures to adopt. Elsewhere (Southgate 1992b), I have referred to how in their equivocality, or ambiguity of signification, patients constitute, one might say, system ciphers, 'living question marks' (Oswald Boltz quoted in Fullinwider 1982 p156, and cf. Goffman 1961/68), or even living exclamation marks! (Cipher: A method of secret writing, or secret message, or its key. Or a person or thing of no importance). Abstracted from friends, neighbourhood and family, pushed or pulled into the psychiatric system and psychiatric space (R.D.Scott 1979), patients' meanings may become, so to speak, reduced to grammar, in a living text of absences (cf. Atkinson 1990 p134).

[37] The notion that places have existential significance for people in general is not a new one (Relph 1976) but has also been addressed in the psychiatric literature as Godkin (1980) points out (e.g. Wenkart 1961, and see also Sommer 1959a,b, 1969, and Goffman 1961/68). In other words we all need access to places which enable us to shore up or reconstruct our sometimes fragile identities.

in claiming money, filling in forms, understanding leaflets and so on. In this respect the tasks of store personnel are more complex than those of barstaff in public houses.

On the majority of occasions of delay, staff, patients and other customers were patient and uncomplaining, but time was obviously an important consideration. Jim, the manager, recounted how on one occasion a patient came into the store and asked to exchange some 2p coins for 1p's. Shortly afterwards the man returned to ask for them to be changed back again and was told to 'stop wasting time' and speedily dispatched. Anne provided another example:

> Then there's the old man who comes in. Very intelligent, man. He's the one who comes in for the er, Financial Times and the Telegraph every day. And er, he takes ages giving you his money. Cos he wants to give you the right money or the nearest to it or, if there's a 2 he wants to find a 2, you know. So you're serving other people while he's still, and that's the same every day. He's just standing there and you get on serving other people because he just will not hurry. He mutters to hisself the whole time. He's an old man, grey haired. But I mean, he's intelligent. (Anne and Arthur p25)

It became clear after a while that a further issue for staff concerned the identity of shoppers. Some members of staff commented upon how difficult it could be to distinguish patients from others, while one member in particular told me how the first thing she had to do was decide whether the shopper at the till was, or was not, a patient. Certain practical consequences devolved out of this identification. These consequences concerned the interpersonal methods which staff might then use to address the shopper and involved the issues of 'danger and threat' and 'responsibility'. These issues are thematised in a later chapter and so the discussion here will be brief.

Once identified as a patient then a certain caution and tension could creep into the way staff spoke to customer. Maggie for instance told me that: 'You can only say so much to them but no more. So you have to be careful what you say to them.'

However, this stance was by no means taken with all patients. Women for instance engendered less fear in staff than men who were patients. On the other hand those men who had become 'regulars' in the store and especially those who took a little (but not too much) time to chat to staff were often considered less of a threat, although a sense of disquiet could still linger. Unlike some of the female staff, the male staff did not admit to fearing for their safety, although one or two spoke of a certain apprehension.

Yet pragmatically defensive manoeuvres were not the sole outcome of identifying a shopper as a patient. A further issue concerned responsibility and accountability. Staff considered themselves confronted by a dilemma. Should they treat people who were patients as fully autonomous and independent citizens, able to determine their own affairs, and thus as ordinarily accountable? Or should they treat them as if they lacked responsibility, agency and accountability and in need of care and external control?[38]. This dilemma manifested itself both

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[38] This issue of 'responsibility' is a perpetual theme in the literature concerning mental disorder and may be addressed from various positions. Erikson (1957) for example argued that the role of 'mental patient' is contradictory, insecure and confusing, in so far as one is expected to take some responsibility for recovery (Parsons' sick role) while at the same time being, by definition, unable to take such responsibility. This also becomes a source of confusion for staff (Bott 1976, Ludwig and Farrelly 1967). Others have suggested that patients are autonomous enough to 'use' their symptoms for their own purposes (e.g. Braginsky, Grosse and Ring 1966, Braginsky and Braginsky 1967, 1976, Braginsky et al 1969, Ludwig and Farrelly 1966, 1967, and see Lewis and Hugi 1981). Braginsky and Braginsky (1976) maintain for example that for patients, hospitals are 'resorts' within the shelter of which

in relation to perceived threat and danger and also in terms of dependency. In other words staff were unclear about whether they *should* be helping patients who were having trouble for example filling in forms at the post-office, and also whether it was economically viable to intervene regularly with assistance, and run a profitable business at the same time.

In one respect the problem of responsibility found a pragmatic solution in the way staff often spoke to customers identified as patients, that is, as if they were young children[39]. This had a number of consequences: it meant that patients could be allowed to remain, as it were, human, if vulnerable; they could be allowed some agency short of full autonomy; and they could legitimately be 'told off' by staff if they stepped out of line, allowing staff to maintain a 'caring' approach. In this way the concept of 'child' and its practical correlates was drawn upon by staff to solve a practical problem. As far as I could see patients feelings on this matter were seldom taken into account.

A story told to me by staff suggested that other villagers had also been aware of the importance of identity and time within the confines of the store. Jim recounted how a villager had approached him to say that her friend had become concerned because she had dropped some money in the store, had caused a delay, and was worried that she might be banned from the store

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fears of muggings, thefts, rape and murder virtually disappear. They ask 'Is there an informal Baedeker's guide to mental institutions?' (p84). For a legalistic perspective see HMSO (1991), Campbell and Heginbotham (1991). The latter argue strongly that '...mental illness is not to be identified with the absence of autonomy in any of its different senses'(p139). See also my discussion in chapter 14.4.

39 I later interviewed 10 members of staff, the majority of whom took the view that this was an appropriate attitude to adopt.

"like some of the patients". Jim wondered whether she had overheard him 'threaten' one or two patients, and expressed his intention to reassure her on this point, although he felt that she was being over-anxious. But, even if over-anxious, the fact that her worries had been comprehensible at all to staff suggests that she had tapped into an important issue for the store and for the village.

An extract from my fieldwork notes made at the time and dated 26th May 1989 provided the following detail which suggests that time and identity and subtle everyday conventions may sometimes conspire against people who are patients:

> While I was talking to Jim a middle-aged man came into the store. He wore an anorak in quite warm weather this afternoon. Picked up a shopping basket and put one can of Coke in it. He then stood near the checkout desk. He seemed to be standing in just the wrong position, just outside the other people waiting at the desk, not quite in the queue. Everyone seemed to ignore him. It was as though he wasn't there. No-one turned to him to say 'are you waiting'. He eventually got served when the shop had emptied and he was the only one left. He also bought a number of loose cigarettes. He was very slow and his speech was difficult to understand.

Unfortunately it proved impossible at the time to check out whether the member of staff at the till had in fact been aware that this man was waiting and had chosen for practical reasons to leave him until last; or indeed whether the man himself was consciously exercising delay because he knew the member of staff might have trouble understanding him, and he wanted to wait until the shop was empty to make his request. Such possibilities again point to the difficulties inherent in determining meaning.

But if patients constituted 'grit' in the machinery of everyday store life, they were also seen to pose another problem for

staff, that of 'dirt'. Several female members of staff expressed a fear of contamination (cf. Douglas 1966, Goffman 1971 p71, Jodelet 1991, Wuthnow et al 1984)[40]. This issue came about when a patient for example presented his money with sweaty hands, or when another had a runny nose, or a third took his money out of his shoe to pay for goods. On these occasions some staff would take the first opportunity to run and wash their hands at a sink in the rear of the store. From the Durkheimian perspective of Douglas 1966 (and cf. Erikson 1962) this washing of hands could be read as a ritualistic reassertion of the boundary between patients and villagers, sanity and madness. That it occurs in a store makes it no less a sacred ritual, a purification which repairs the moral order. The counter in this case represents the line where sanity and madness touch, and because patients have travelled along and over the line they therefore signify danger (cf. Duerr 1985)[41].

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40 Both Douglas and Goffman have drawn upon the sociology of Durkheim. In her analysis of symbolic boundaries and everyday ritual, Douglas has also used 'place' as an organising theme. *Purity and Danger* for example expresses an equivalence between dirt and deviance; both signify something 'out of place'. From this perspective both deviance and dirt become functional for the moral order (and cf. Erikson 1962).

41 In her fascinating study of a French community and its 'colony', where local people take in men who have been psychiatric in-patients as 'lodgers', Jodelet (1991) leads the reader inexorably to the seminal secret of bodily secretions - sexual pollution; secrets of local children fathered by patients and the even greater threat of 'inter-marriage'. As she puts it (p277): 'Sexual taboo, marriage taboo, emotional taboo, organic contagion and physical contagion join forces to multiply the protective partitions.' However the circumstances of Shenley village have been very different to those of Ainay-le-Château. Nevertheless, villager fears for the safety of their children have sometimes possessed a sexual flavour, and on one occasion a woman patient told me how she had been courted partly for sexual favours by a local man, who had lived just outside the village.

These fears were mitigated to the extent that the person with the runny nose, for example, was able to provide apologies and an account, to undertake 'repair' work (Goffman 1955, 1971, Scott and Lyman 1968, Brown and Levinson 1978/90). To the degree that his account counted and the accused took remedial action (see below), the source of the body fluid would remain acceptable and the bodily fluid in question would itself be rendered less poisonous and more easily discountable by staff.

Patients, in other words, could offset the charge of contamination by demonstrating their accountability and their sanity[42]. For example Penny provided a comparison between two patients:

> You can talk to quite a few of them in the shop. Alan, Alan Brown, do you know who I mean. To me he's quite, he comes in sometimes and he says, his nose is running, you know, he'll say "sorry, I've been put on some new tablets and they're making me dribble and me nose run". So I'll get him a tissue and say "there you are". Another one will come in, I mean a few weeks ago a patient come in and his nose, it was down there and I thought - Oh my God, what can I do, you know. It's going to go on the crisps so I said "There, would you like a tissue?". And he just took the tissue and put it in his pocket. (Laugh) I just had to turn away. I mean, I didn't know whether to laugh, cry or what. I thought I'm either going to be sick or (2) I just put my hand out for the money hoping that he'd avoid it, you know. (Penny p12)

On occasions however the smell has been so powerful, and the problem of contamination has become so acute, often when other customers have complained, that the transgressor has been asked

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[42] Compare Southgate (1992c) where I provide a formal-pragmatic analysis of warrantable insanity ascriptions. The issue of contamination is also touched on in Appendix D; 'Patients speaking from an often unenviable position', especially p489.

to leave the store[43].

This account would be incomplete without mention of some of the additional 'complicating action' (Labov and Waletsky 1967) by which patients have affected, intentionally or otherwise, store routines. Two situations recommend themselves. Jim recounted how, when he first took over the store three years previously, he had attempted to stop selling single cigarettes. However the patients carried on asking for single cigarettes[44]. The effort involved in continually explaining why he had decided to stop selling them finally led Jim to capitulate. By their sheer routine persistence patients had won a (minor) victory. And in fact during my period of participant-observation I also witnessed someone who did not appear to be a patient pop in for a single cigarette. When I inquired about the possible motive for this, staff suggested that perhaps the man in question was trying to give up smoking. This small story suggests that the intersection of individual paths with institutional projects is not a foregone conclusion and that power cannot adequately be grasped as, or reduced to, a balance sheet of resources or a zero-sum game (cf. Hindess 1982, Barnes 1988).

Finally, one member of staff had a tale to tell concerning a customer who was a patient who regularly came in for a packet of 10 Berkeley. After Anne had rung it up on the till the man

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43 I did not have the opportunity to find out what happened when others who are liable to carry strong smells, such as farmers or motor mechanics, came into the store.

44 The patients' shop within the hospital still sells single cigarettes. In a recent study of a patients' club within the grounds of a large psychiatric hospital, Dunn et al (1990) concluded that 'Much of the social activity that went on was stimulated by an economy based around the purchase and exchange of tea and cigarettes...' (p842).

would then always request a box of matches. On one occasion Ann challenged the man:

> ...and you get it up and ring it up and he'll say 'and a box of matches' and he does that *every time*. And the last time he came in I said, he said '10 cigarettes'. I said 'and...'. He says 'just 10 cigarettes' you know, and I rang it all up and he says 'oh and a box of matches', you know (laugh). (Anne and Arthur p6)

It is difficult to resist seeing the interaction described here as a game which this person was playing with Anne, or as one in which Anne colluded. When this tale was told, Anne laughed, and yet her amusement was tinged with a hint of annoyance that the other, a patient at that, should have prevailed again in their negotiations.

Within the village store, in contrast to the public houses, the topic of patients achieved a certain currency. Amongst staff, patients *were* talked about here. Patients constituted one of a range of topics but I gained the unflattering sense that for staff, interactions with patients could brighten up what might otherwise be a long and tedious day.

Such talk often related to unusual happenings such as Katie's death, but also encompassed the more regular and mundane topics. For example the fact that staff had not seen a particular patient for some weeks; that a patient they knew did not look too well; or the fact that they were 'fed up' with someone's behaviour.

And in addition staff often felt that they made an effort to encourage patients to talk and derived a certain sense of satisfaction by being able to elicit a response from someone, normally regulars, who had not previously spoken. A sense of challenge obtained here which also applied to people who were

not patients but who also did not speak. As Lou put it, albeit perhaps in a patronising manner, encouraging a patient to talk helps you to see that 'There's something there'. Carol, who had worked behind the post-office counter, told me:

> There's one patient, Ken his name is, and it's taken all these months for him to say good morning back to me. I find it a challenge. He's very introverted and like usually if you say good morning and he doesn't answer you'll say, oh blow you, I won't. I thought no, persevere and see what happens, you know. And amazingly about a month ago he mumbled a good morning (laugh). Because I used to ask him a little question about his transaction and he wouldn't really answer whereas now he's beginning to.

Several staff in the store had received letters from patients. These letters varied in design and purpose. Some appeared to be straightforward efforts to maintain a continuity in relationships with staff. Others were critical or perhaps apologetic in tone. One man wrote to Sid to apologise for not speaking in the store and to explain the reason for this. Clearly endowed with a sparkling wit this man addressed his letter to Shenley Stores, 'The Sleepy Backwater of Homely, Hearty, Loving Hertfordshire.' He rendered his own address as 'The Dump on the Hump'[45].

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45 The 'Hump' presumably refers to the fact that Shenley hospital (and village) is sited on a hill from which there are excellent views across St.Albans. Whether this term was the invention of this particular person, or whether it was in general use by patients and/or staff, I do not know; at any rate I am grateful for it. Store staff were not the only people in the village to receive letters from patients.

Conclusion

In the above pages I have attempted to describe some of the routes and paths which patients have taken within the village and the institutional projects with which their paths have crossed.

This analysis has, I believe, drawn attention to the way that an investigation of 'closure' or exclusionary practices within the village and in relation to those people who are patients at the hospital may be linked to an analysis of 'place', theorised mainly from the perspective of time-geography. I have suggested that the concept 'place' provides a bridge which connects patients to routines, local knowledge, discourse and social structure. In contrast to the 'pre-patient' phase of a moral career (Goffman 1961/68, 1971) the majority of patients observed in interactions with others in Shenley village appear to 'know their place' (cf. Goffman 1967). This 'knowing of place' can be read in a number of ways.

It refers for example to the way that patients appear for the most part to travel routinely along particular paths in the village, through and to particular places. Following and making paths and places is a process continually negotiated but in this case not so much discursively as physically and bodily, and not necessarily very skilfully. In Shenley it is of course negotiated with villagers and the course of the negotiations is affected by institutional influences or projects.

In the above analysis I have considered how discourse and place are directly related by focusing upon interactions at particular sites within the village and I have suggested that what is *not* said about people may be as important as what *is* said about them. This analysis has indicated that the degree

to which patients are talked about (or 'storied') by villagers does vary from site to site, while patients themselves, with occasional exceptions, have been portrayed above as often largely silent.

However, as well as being situationally specific, any discourse which *is* about and with patients within Shenley village is also likely to demonstrate a trans-situational or trans-placial pattern. Andrew Sayer (1985, p63/4) has nicely caught the implications:

> If our consciousness is shaped by the particular unique material circumstances in which we live then it should vary spatially with these conditions. But matters are not as simple as this for we can only interpret our surroundings through an available language and a range of concepts. To a certain extent these are *common* to a range of different groups at different times and places, indeed the whole function of communication is to span such differences, for without differences in experience to share, communication is redundant.

This understanding depends upon what Habermas has called the 'paradox of intersubjectivity':

> Subjects who reciprocally recognise each other as such, must consider each other as identical, insofar as they both take up the position of subjects; they must at all times subsume themselves and the other under the same category. At the same time, the relation of *reciprocity* of recognition demands the non-identity of the one and the other, both must also maintain their absolute difference, for to be a subject implies the claim to individuation (Habermas quoted in Dews 1987, p242).

For Habermas the 'utopian' reconciliation of identity and non-identity can take place in everyday discourse so that in the reflexive use of language, which is part of the 'dual structure' of speech, we present inalienably individual aspects in unavoidably general categories '...in such a way that we

metacommunicatively[46] comment upon and sometimes even revoke direct information (and confirm it only with reservations). We do this for the purpose of an indirect representation of the non-identical aspects of the ego, aspects which are not sufficiently covered by the general determinations, and yet cannot be manifestly represented other than by just these determinations' (Habermas 1970b p211). In chapter 14 I shall examine the particular use of those more general categories of discourse as they relate to people who are psychiatric patients.

I have been arguing here that an analysis of routines of both villagers and patients is important in grasping the reality of structuration of the locale, the way that routine actions both consolidate pre-existing structures and at the same time are enabled by them. From this perspective social change therefore involves the challenging of routines in either subtle or radical ways, together with those dominant institutional projects which recursively sustain and channel them. I have attempted to show above how those practices which sustain divisions between the sane and the insane can be configured in terms of space-time paths and projects which are indicative of more than the phenomenological study of place (e.g. Relph 1974) or those interactionist studies of place (e.g. Goffman 1971, Rosenhan 1973), by illustrating the simultaneous enabling of action and the reconsolidation of structure.

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[46] For Habermas metacommunication should not be confused with metalanguage since in the former, statements are not made. Metacommunication consists rather in a system of reciprocal expectations on the part of the participants in dialogue, which if themselves thematised will give rise to a further metacommunicative level etc. See Habermas 1979 p43, Dews 1987 p241, and chapter 5 of this thesis where I sketch out Habermas' theory of universal or formal pragmatics.

In the next chapter I turn to examine the history of the village and the hospital, and to chart the development and dynamics of complaint by the villagers.

Chapter 9

A Short Political History of Trouble

> They called me mad, and I called them mad, and damn them, they outvoted me. (Nathaniel Lee, 17th Century, quoted in Porter 1987 p3)[1]

Introduction

Public responses to social situations, organisations, behaviours or persons considered as candidates for the predicates 'trouble' or 'problem', may take a number of different forms. These range from the dismissal of the putative problem as a problem at all, through disattendance, studied or otherwise, in which the 'problem' is ignored (Goffman 1963, Lofland 1972), via a variety of informally organised efforts directed at conciliation or sanction, to the petition of assistance from official or quasi-official organisations (Baumgartner 1988, Emerson and Messinger 1977, Goffman 1961/1968). The reaction in turn by the 'complained-about' person, organisation or institution may follow a similar pattern with the addition that the complaint may also be acknowledged by the defendant as legitimate.

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[1] Porter provides two slightly different versions of this quotation in his two books, 1987 and 1987/90 (p2). He obtained it (them) from Byrd,M. (1974) *Visits to Bedlam*. Columbia: Univ. of South Carolina Press.

Rather than detailing the variety of individual efforts at defining and dealing with trouble, this chapter takes a slightly different position by focusing in particular upon the work of the local Parish Council as 'troubleshooter', that is, as an official 'champion', a body representing the local villagers in their complaints about patients and hospital[2].

The account developed here takes as its analytic guide the process-oriented model of Emerson and Messinger (1977) in which the definition of trouble can be seen as the emergent product, as well as the initial precipitant, of remedial actions. According to this model, deviant careers are seen as highly negotiable and non-deterministic, and the effort to do something about a trouble both helps decide the trouble's fate and shapes how it is first perceived. The authors describe the way that a 'trouble' may undergo reinterpretation as new ways of eliminating, reducing or confining the troublemaking are set in motion in a recurring cycle in which trouble may be progressively elaborated and analysed, and in which third parties may be called upon to validate and deal with claims of complaint. This approach has, I believe, the merit of grasping some of the political subtleties of the labelling process without becoming overly deterministic.

This chapter documents the often problematic relationship between village and hospital, together with the historically changing nature of the 'problem' or 'trouble' itself, from the time of the birth of the hospital to its old age and incipient

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[2] References to other methods used by villagers can be found throughout the interview transcripts. One publican gave an example: 'There was a patient in recently, a black man. I was advised to be careful of him, not upset him. He'd lost his temper on the ward - a bit crazy. I went up to him and said "I hear you break windows. If you smash windows here, I'll ram your head through a window." He laughed - it was OK.'

demise. The history highlights the way that 'trouble' has changed over time from being an outcome of a straightforward dialogue from which 'trouble' emerges uncontroversially as clearly bounded, defined and dealt with, to being amorphous in nature, disputed, challengeable and challenged (Emerson and Messinger 1977; and see Scheff 1966, 1968, Scott and Lyman 1968, for work on negotiation and reality). It considers the tactics used by both sides to attempt to enforce their definition of the reality of the situation in the face of an historically widening reality disjuncture (Pollner 1974, 1975 and cf. Darrough 1978, Eglin 1979, Molotch and Boden 1985, Potter & Reicher 1987, Potter and Edwards 1990, D.E.Smith 1978), which only of late appears to have subsided[3]. The account shows how mundane epistemology itself becomes an issue in the dispute which assumes an increasingly recriminatory and moralistic flavour, a 'stigma contest' in Schur's (1980) words, amplified by the local mass media (Scheff 1966, Schur 1980, Young 1971); and it also highlights the way that the introduction of a particular technology intended as a solution to a problem has in fact had quite ambiguous results. In its brief regard to the rhetorical structure of certain accounts, this history anticipates the following chapter on discourse analysis. It is intended that this chapter be of interest in itself, but also to set the historical scene for, as well as being contextualised by, the rest of the thesis, and in the process I have provided some early detail.

I have drawn here upon material from four principal sources: local Parish Council minutes; local newspaper articles[4]; early

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[3] In a slightly different context MacIntyre (1977) has referred to the notion of 'mundane epistemological crisis' which may be resolved by the construction of a new and enlarged narrative.

[4] According to Rosaldo (1987) a source rarely used in academic writing.

Hospital Management Committee minutes; and interviews with villagers and hospital staff. Some periods of this history are inevitably sketchy. Later Hospital minutes, which might have enabled the resolution of certain lacunae, were unavailable. Two of these sources, Parish Council minutes and newspaper articles, are available to readers who wish to consult them. I have also had access to historical records of the Village Society and the Praetorian Housing Association, but their application in this history is minimal.

Writing a history is, I believe, like the construction of an ethnography, always a creative endeavour. Rather than writing itself, a history is orchestrated by an author and constitutes the outcome of interpretative work deriving out of an interplay between the author's interests, a particular conceptual and analytic framework, the material selected and available for analysis, and the discourse of the institutional and organisational nexus within which the history is produced. It is, I am sure, only one of many *possible* accounts and as such it has no pretension to be the sole history of the village. Indeed two histories of the village, one short, one long, have already been published, neither of which bear a remote resemblance to the present one (Boswell 1986, Stebbing 1988) and many other histories no doubt remain to be published. In addition it has been suggested to me by hospital nursing staff that the book 'Brother Lunatic' by Paul Warr (a pseudonym), published in 1957, depicted Shenley Hospital and its practices. My interest here however is not with a history of Shenley's success in the Best Kept Village Competition, nor the history of its 'Cage', but with a short and narrowly focused account of the relationship between village and hospital using particular sources within a theoretical framework of the 'micro-politics of patients-as-trouble' as indicated above.

In terms of its construction this account can then be seen to share analytically the features, methods and processes of production of the documents upon which it draws, i.e. newspaper articles, council minutes etc. These may be understood, not as providing any simple evidence of a pre-existing reality, but as themselves the outcome of a range of interpretative work in which, in the processes of documentation and textualisation, shape is lent to events and happenings which mark them out *as* solidified happenings of a particular kind. The work of production may be viewed not as idiosyncratic but as organisationally situated in relation for example to the organisational demands and procedures of minute taking (for the Clerk to the Parish Council) or reporting and editing etc (for the local press) (see for the latter Molotch and Lester 1974; and generally D.E.Smith 1984).

Although I have adopted a realist textual mode for most of this chapter, on occasions I have considered the rhetorical organisation of the available evidence. However I have not had the space or time to attempt to unpack the institutional or organisational features implicit in particular texts, to look at how the practices of their construction and the readings and interpretative practices which they are produced to intend, articulate with wider political and institutional discourses[5].

Inevitably this chapter also glosses over certain other related aspects of the relationship between village and hospital. It makes practically nothing for example of the fact that in

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5 See for example D.E.Smith (1981, 1984, 1988, 1990). In an earlier paper Dorothy Smith (1978) showed how a particular text was organised in a manner which was isomorphic with the structure of the conceptual scheme, mental illness. In her later work she considers further how the investigation of documentary practices can make visible organisational and political discourses which might otherwise remain obscure, e.g. her (1984) commentary on the use of 'forms' and documentary records in the standardisations of the labour market. Compare Fairclough (1989).

earlier days villagers were able to make use of certain hospital facilities such as the X-Ray Department, and resources such as hospital furniture for the village fete; the fact that the hospital provided many villagers with paid employment and also cooked meals for the village luncheon club for older village residents; and the fact that some villagers participated in hospital staff functions and social activities such as hospital dances and that patients patronised and provided trade for village shops and pubs. It does however touch lightly upon wider socio-economic factors as they relate to one particular historical period.

Although 'Patients-as-a-Problem' is the focus of the chapter it is important to note the *absence* of the voice of the people who are and were patients. As indicated, the history charts a dialogue of sorts here between village and hospital, but a dialogue which is preeminently *about* these people. There is one interesting exception which I shall document later.

Of equal concern is the grammar of public talk. Some of the examples presented later are suggestive of the way 'people' are transformed grammatically in public discourse to something else, something 'other' and which we may currently feel are archaic and often unhelpful ways of talking[6].

The occasional use in the remainder of this chapter of capital letters as in Patient, Villager, Hospital, is intended to mimic the grammatical form of a substantial proportion of the Parish Council minutes (compare Appendix C below). Names have also been altered where appropriate to protect identities.

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6 The still current use of the term 'mental patient' as in 'He's a mental patient' may be less than helpful. See Barham (1984) Barham and Hayward (1991).

The Birth of the Hospital and its Early Years

Shenley hospital was officially opened by King George V and Queen Mary on 31st May 1934. By this date it had already acquired a substantial number of in-patients. The old Mansion House in the hospital grounds which had been administered by Napsbury, another psychiatric hospital 2½ miles away, was taken over and became part of the new hospital on 1st January 1934, along with its 115 patients, eight of whom were private. The private rate was fixed at 38s/6d by the Shenley Mental Hospital Standing Sub-Committee. The 'rate-aided' amount was 22s/6d.

The official rationale for the erection of the new hospital, one of the last major psychiatric hospitals of its type to be built, was the alleviation of overcrowding at Napsbury and Springfield Hospitals. In December 1932 the 'Commissioners of the Board of Control to the Napsbury Mental Hospital' visited Napsbury and reported 'a general appearance of overcrowding' where extra beds had been placed. They noted '...a number of unoccupied patients in a room obviously too small for free movement and normal idling activities of that number'. The same commissioners reported that their spirits 'had been lifted by the sight of the building of the New Mental Hospital proceeding apace.'

By 17th February 1934 Shenley had 327 in-patients. One month later it had 440, and by 14th April the total had increased to 655. In April the Medical Superintendent reported that Shenley had continued to take patients from Napsbury and Springfield Hospitals at the rate of 60/70 per week and that by April all patients from these hospitals awaiting transfer had been received. Of the 619 patients transferred, 174 were male and

445 were female. Some two years later, by March 1936, the in-patient total had risen to 985, of whom two-thirds were women.

The Shenley Mental Hospital Standing Sub-Committee minutes record that a very small number of patients were also being discharged each month. In April 1934 for example 7 patients were recommended for discharge after being interviewed by the Sub-Committee. Six were diagnosed as suffering from 'melancholia' and one from 'mania'. Various causes were listed which included principally certain forms of 'stress' (6-melancholia) and 'unknown' (1-mania).

The first Medical Superintendent, Mr G.W. Shore, was appointed in 1933. He had previously been the Second Assistant Medical Officer at Springfield Hospital for over 10 years. The somatic nature of psychiatric therapies of the time can be discerned from his application where he listed his experience in the following manner: 'In my work at Springfield Hospital I have carried out all modern methods of treatment, such as malarial and sulphur therapy, and I have had considerable experience in the treatment of mental illness by such means as artificial sunlight, continuous baths, foam baths and high colon irrigation'.

The opening ceremony was by most accounts a grand affair. In a letter from the Clerk of the Sub-Committee it was reported that 'their majesties' (sic) wished that every facility be given to Boy Scouts, Girl Guides, and schoolchildren, 'to see their majesties' (sic), and the Medical Superintendent undertook to 'secure the attendance of' as many children as possible. Numerous orders from the hospital administration for a variety of goods for the occasion are listed in the minutes. The sheer scale of the enterprise can be seen by reference to '1 ton of floor polish'; '1000 yards of calico'; '500 yards of

Damask'; '150 yards of Hessian'; together with '50 yards of Muslin'; and large amounts of clothing including '600 pairs of Lisle stockings'. Some of the villagers still remember the opening. The King and Queen rode through the Village and stopped off at certain points but not all the villagers were pleased as one respondent recalled:

> Clare: ...granny went and sat by the, by the pond. They took granny's chair and granny sat in state and of course she had seen the royals, 'cause living on the estate, obviously the royals were around, so granny had seen the royals, but granny was going to sit out, she was quite matronly, and she sat by the pond, and they were late. They'd stopped in Green Street to see some old girl who was a 100 or something and they were late so they went through very quickly and granny was furious about it...

In 1934 there was already some acknowledgement that the local 'public' might have an interest in the fact that a mental hospital had been built, and in January 1934 the Sub-Committee minutes note a suggestion to 'throw the hospital open to the public before the admission of patients' (although it appears that there were already by then some patients on site) and that journalists and the medical practitioners of the neighbourhood 'be invited to inspect it'.

In the Village there had already been opposition to the erection of the Hospital. The same villager noted, in response to my question:

> DS: Did you have any impression about the local feeling about a psychiatric hospital then?
>
> Clare: Oh they were anti. Oh yes. This is why, I've said, it tickles me in a way that we're all fighting to keep the hospital and when it came they, everybody was up in arms and they didn't want it, you know. But um, you know. Oh yes, the idea of putting a mental hospital in Shenley was, oh God, yes. Oh yes, they were very anti (2) Well the same thing happens when they try to put, you know like a half

> way house or anything in Borehamwood even, isn't it. I mean down what was it Beech Road all the locals were up in arms.

This is echoed by other Villagers although often with reservations, for example:

> Wendy: ...the patients, the hospital has made the village as it is today of course because it was a big employer of labour. I believe it caused a terrible stir (laugh) when it was being put up.
>
> (gap of several lines)
>
> But um, er, I don't think all, all the people condemned it because it was a source of, work wasn't it really, when you think of it they must have been better paid up at the hospital than they, some of them were in the houses.

What is perhaps surprising is that there appears to be little official or public record of this reported groundswell of opposition, or of any dispute or debate about the matter. This lack of documentation constitutes a potential methodological problem, for while the presence of documentation of dispute suggests, if not unambiguously, the presence of dispute, the absence of such documentation on the other hand does not necessarily indicate its absence. The question here is to what extent the relationship between Village and Hospital can reasonably be gauged by public records. Although the increasing public appearance of minutes, articles and letters over time about this relationship may be indicative of changes in the relationship itself, clearly the appearance of more public articles and notes may relate to changes in the use of the local mass media and Council minutes.

However the tone of the first documented complaints of a 'problem' lacks any hint of the 'problem' as one which was already ongoing and well established, while interviews with

some of the older residents in the Village have suggested that in the 'early days' of the Hospital, 'patients-as-a-problem' hardly existed, as I show below.

The local newspapers of the time register, then, no complaints, no letters from local people. Local interest can be discerned from the Parish Council minutes, but the precise nature of that interest is not clear. The following entry appears in the minutes of the meeting held on 31st March 1924, nine days after an article containing news of the purchase appeared in the Herts Advertiser and St Albans Times, and ten years before the Hospital was officially opened.

> Mr Dashwood gave some particulars in connection with the proposed purchase of Porters Park by the Middlesex County Council for the purpose of a Mental Hospital and as it was a matter of public interest it was considered advisable to have a public meeting on the following Wednesday.

Unfortunately no further reference appears in the minutes concerning this public meeting, nor in the local newspapers at that time. Nothing more appears in the Parish Council minutes concerning this matter until 24th May 1934, just one week before the royal opening was scheduled to take place. The entry reads:

> Mr Ruck asked what the Parish council intended doing to welcome the King and Queen and (sic) visiting Shenley to open the new Shenley Mental Hospital. The Chairman replied that he thought it should be left to the Middlesex County Council to make the arrangements, and after a little more talk on the matter the subject was dropped.

The organisation of this minute, in particular the wording 'the subject was dropped', hints at controversy on this matter. And it is no doubt surprising that the Council was apparently so opposed to making some arrangements to welcome the royal pair,

bearing in mind that they would be passing directly through the village. A reading of this passage which is generous to the Royal Family suggests anti-hospital rather than anti-royalist sentiment[7].

The same Chairman of the council had, one year earlier, written to the Shenley Mental Hospital authorities in his capacity as Churchwarden at Shenley Parish Church in an effort to gain a financial payment which one might be tempted to read as some kind of perceived compensation or payoff:

> I am writing to you on behalf of this parish to ask you to be good enough to use your influence to persuade the Middlesex County Council to make some contribution to Shenley Parish Funds, in view of the ownership of Porters Park.

But, even if this reading is correct, it is still clear, as previous extracts suggest, that not all the village was completely opposed to the development. In October 1934 the Rector's Warden at St.Botolph's church (now redundant), on the edge of the Village, wrote to the hospital authorities offering the use of the church for the patients, 'except between 10-45 and 12-30 Sundays, so as to allow some margin on either side of the service itself.' Agreed by the Parochial Church Council, a discounted 'pew rent' of 10/- per sitting was suggested (reduced from £1) making a total of £115 per annum. But although it extended the hand of friendship and the opportunity for worship, the offer is not unambiguous for it appears to be suggesting that people who were patients at the hospital should worship separately from the rest of the congregation, while it also illustrates a potential pecuniary interest.

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[7] It might be argued that this minute simply shows the Parish Council demonstrating a realistic self-awareness of its unimportance in relation to higher tiers of Local Government.

In the early days of the Hospital, in-patients were strictly segregated according to sex, and many wards were locked and encircled by high iron railings. The book of 'General Rules' of the 'Middlesex County Mental Hospital, Shenley' was finalised in 1934. It contains reference to the degrees of freedom of movement of patients:

> Such patients as the Medical Superintendent may direct shall, at approved times and as he thinks expedient be allowed to take walks or to make excursions beyond the grounds of the Mental Hospital... (p20)

Patients were allowed into the village but to begin with were generally accompanied by nursing staff as the following extracts from interviews with Villagers suggest:

> Wendy: And they would stream out of the hospital wouldn't they. And the nurses would bring them out to do their shopping, take them for walks round and um, so there was a lot of them, er.

and in the following exchange

> DS: Did it kind of register with you at the time, because you were young, did it register that in fact it was a, a mental hospital that was being built?
>
> Anthea: Yes
>
> DS: And um, did you have any, do you remember any kind of thoughts or discussions with other people about that or what that might, might mean?
>
> Anthea: No. It didn't really because of course when the hospital was first built there were iron railings all round the wards. Patients couldn't get out (2) you see. So I mean they came out in crocodiles with two or three nurses but um, they didn't wander as they do now in the village. And in fact I remember the railings coming down, and one patient said to me 'oh dear', she said, 'now anybody can get in' (laugh).

Many older villagers have referred to this 'line' or 'crocodile' of patients escorted out of the Hospital grounds by the nursing staff, although the precise identity of members of a 'crocodile' is not entirely clear as the following extract from an interview with a respondent, who eventually came to work in the hospital, indicates:

> Henry: ...eventually, you know, the hospital got built and was very much separate from the village in my youth. I remember when the place was opened, as a schoolboy I came and was officially shown around the place. The people we were much more aware of were the Harperbury, the handicapped, because they came up in great crocodiles on a Saturday, nurses at front and back to do their shopping.
>
> DS: Right. Harperbury was built at the same time
>
> Henry: On the other bit of the estate.
>
> DS: On the other side yes.
>
> Henry: Yes, down the bottom, between here and Napsbury, yes. So one hardly became aware of it and of course the regimes I, whilst there's not a, there's not a wall or a fence round this place, there were fence, er, iron fences round certain wards. Um, they had the clever idea you see of putting the fence round our big block wards so that all the services could come into the back, and patients could go into the airing courts at the front. Well, along came of course the Fir, the Second World War.
>
> DS: Just before you come onto that, how did you know that the crocodiles of patients were from Harperbury rather than Shenley?
>
> Henry: Er (3) I suppose I saw them walking up the hill as opposed to coming out of the gates, and they were youth, of course youthful, younger, you see, younger people in the main. Along came the war...

During the Second World War many patients appear to have been discharged[8] and Shenley Hospital was used to house prisoners

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[8] It is not clear exactly *where* they were discharged to. It may be that at least some were discharged home. Referring to the impact of WWII on psychiatric services, Ramon (1986 p219) states '...no public outcry followed the discharge of many civilian psychiatric

of war as well as wounded Allied soldiers, while retaining some villas for pre-war functions. Parish Council minutes contain a single reference coming just before the war ended which suggests that some prisoners of war were having a better time than the Villagers:

> Mr Ruck asked if the Council would write to the authorities concerning prisoners of war and asked if their rations could be reduced to the same standard as civilians are obtaining. He pointed out the disgraceful conduct of the Italian prisoners of war and the young girls.

One respondent suggested that the change in function during the war helped to bring village and hospital closer together:

> Henry: Wartime of course brought a great mixed bag and vast socially, I mean the hall here (at the hospital) became the social centre of the, of the, of the village, during the war, oh yes, yes.
>
> DS: Why was that, then?
>
> Henry: Well er, I mean er, with a military hospital here, one had, and a big one, one had first class entertainment by ENSA. First class.

Following the war the size of the in-patient psychiatric civilian population began again to increase. But if the war had provided an opportunity for an improvement in relations between Village and Hospital in certain respects, and heralded cooperation and collaboration in particular projects, it also marked the recognition of the appearance of a 'problem':

> Henry: ...as far as the village, is concerned er (3) er (2) I suppose, yes, er (1.5) there started some cooperation with the village, i.e. in meeting in * after the war. Yes, and the problem wouldn't have arisen prior * so separate

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in-patients for the duration of the war, which resulted from the fact that hospital buildings were required to house wounded soldiers.'

> I can't recall a single in, I can't recall a single [incident].

The Emergence of 'Patients-as-Trouble'

The first hint of the emergence of a 'problem' concerning the behaviour of people who were patients at the Hospital came in May 1952, 18 years after the Hospital was officially opened. Headed 'Patients on Parole from Hospital', the Parish Council minutes briefly note:

> A discussion ensued in regard to complaints made by residents on the behaviour of patients from Shenley hospital when out on parole.

Here the Parish Council can be seen to have taken on the role of 'Troubleshooter' (Emerson and Messinger 1977). Although no details are included of the exact nature of the problem, the consequences were highly significant. Following a meeting, which appears from the minutes to have been the first of its kind between the Chairman and the Clerk to the Parish Council and 'Senior Medical Officers', the Medical Superintendent of Shenley Hospital wrote to the Council making certain recommendations which the Council accepted and to which the Clerk was instructed to reply with thanks for the prompt action taken by the Medical Superintendent:

1. That outside parole of both male and female patients should be restricted to the hours of 1pm to 7pm except where a patient is sent out of hospital for some specific purpose such as to return home on leave, or to make some urgent purchase.

2. That nursing officers should exercise supervision of patients on outside parole and that the hospital transport should be provided for this purpose.

3. That more adequate shopping and cafe facilities should be offered to patients within the hospital thereby giving them less incentive to go outside.

The above proposed remedies can be regarded as a 'test' of the definition of the 'problem' as defined by Villagers (Emerson and Messinger 1977 p123). The very fact that the Hospital authorities responded quickly and decisively can be read as a statement concerning the perceived correctness of the Villagers' complaint and their definition of the problem. There appears to be no controversy here, at least none that is recorded. In direct contrast to later interventions by the Hospital, the Superintendent implements severe measures. There is accord between the two parties.

However, these proposed 'remedies' to a 'problem' strongly indicate that between the opening of the Hospital and 1952, the original form of patient parole had been relaxed. This may well have been a gradual process happening by default or alternatively a conscious decision spurred on by wider processes of change within the institutions of psychiatry (see below). But there does appear to have already been a shift from the earlier routine supervision of organised 'crocodiles' of patients, to a less supervised freedom of patients within the local community.

The above steps taken by the Superintendent may then be seen as constituting a substantial curtailment in the freedom of movement of people, many of whom would have had voluntary (now termed 'informal') status as patients. The Mental Treatment Act 1930 which renamed asylums 'mental hospitals' allowed patients to be received on a voluntary basis (Rose 1986 p51; Goodwin 1990 p111).

The first item in the minutes is self-explanatory. The second led to the provision of a 'village patrol' of motorised nursing staff. The third item is particularly interesting. It clearly suggests a link between the provision of increased internal

facilities for patients and the anticipated consequential reduction of the number of patients going 'outside'.

No doubt it would overstep the bounds of credibility to see such increased internal provision as the direct result of Villager complaint, and it is possible that the Hospital authorities were already planning these developments, and that their motives were indeed at least in part therapeutic. The Superintendent may simply have been outlining to the Council the consequences for the village of action already determined. Nevertheless such detail does cast a shadow upon such initiatives. Compare for example the account provided in an article on Shenley Hospital in the Nursing Times (1977) which stresses only the 'progressive' nature of such developments.

> In 1952 the Management Committee investigated the general occupational facilities of the hospital. It found that when all the departments had absorbed their maximum number of patients to work on the land, over 100 able-bodied men were still left idle. Some hundreds of able-bodied women were in a continual state of enforced idleness.
> January 1953 saw the start of the building of an occupational centre, a vast undertaking where patients working under supervision began to erect workshops which could then provide permanent occupational facilities for an even larger number of patients. Money was made available. By April 1954 the finishing touches were being put to the completed building which has provided occupational therapy space for numerous patients ever since. More buildings have been built, the patients themselves undertaking every kind of activity necessary in their production. (Nursing Times, 9th June 1977)

But however one reads this, it is also possible to gain a sense here of the way that labour and its discipline were, and still are, considered to be forms of therapy (Wing and Brown 1970; Kendell and Zealley 1983). And at the same time it is possible to see that this enforcement of labour served to incorporate these people, to include them in the self-realization of their own discipline and incarceration, by their (supervised) help in constructing the very buildings which would house and

entertain them during the times of their enforced exclusion from the village. Indeed the very developments in the philosophy of therapeutic communities may be read, as Rose (1986 p74) suggests, as a 'profound strategy of normalization of maladjusted selves'[9].

Of course these facilities now provide patients with a greater range of options for action, and it may indeed also have been therapeutic for many people to have had the chance to do some physical work. The Hospital orchards, gardens and farmland were already being worked by the patients. The point however is to see the possibility of alternative schemes and other designs related albeit in some minimal fashion to the perceived sensitive nature of local public reactions for the Hospital authorities.

The prompt and extensive action taken by the Hospital may have assuaged local concern for a while for no further related items occur in the Parish Council minutes for some 3½ years. It looks as though many of the patients were being kept disciplined and busy building during this period.

It may have been the experimental closure of the small Village police station for a period of 6 months, as detailed in a letter from the Metropolitan Police Commissioner, 'in the interests of efficiency', which contributed to an increase in local anxieties and the subsequent further reference to the 'parole' of patients one month later in the minutes of December 1955. There followed a subsequent meeting with the Medical

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[9] Compare Foucault (1975/1979), Melossi and Pavarini (1977/1981), and on the commodification of time under capitalism see *inter alios* Giddens (1981), Lukacs (1971), E.P.Thompson (1967).

Superintendent and thereafter a statement by the Parish Council Chairman that '...there appeared to be an improvement in the control of patients in the village.'

However in April 1956 an incident is referred to in the Council minutes and is also reported in the local press. This was said to have concerned a fight between two men, at least one of whom was a patient at the Hospital, within the Village. The newspaper report is quoted here in full in order to convey its flavour, in particular its ambiguity and its emphasis upon gendered responses.

> <u>Hospital Patients in Shenley Fight</u>
>
> Frightened women locked in village shop, Parish Council were told.
>
> A fight at Shenley last week, involving a patient from Shenley hospital, and in which "a knife was brandished and frightened women were locked into a shop for safety", was described at Shenley Parish Council meeting on Tuesday by Mr E.J.Broadley, who called for greater security measures by the hospital authorities to protect villagers. "I want to withdraw my statement that there has been an improvement in the behaviour of patients" he said. It has got worse (new quotation marks missing in original). Last week there was an incident when a knife was brandished, and women got very alarmed. "The shopkeeper, Mr Maltby shut them in his shop. Apparently a fight took place between two men. One of them swept his coat off and a knife was drawn. Whether he meant to use it, I don't know, but the shopkeeper locked his shop with the women in it. I didn't see it myself but several people have told me about it".
> Mr V L V H Wild said "I had one case in my fields when I met a patient armed with a pitchfork. I was able to deal with him, but it is pretty alarming if there are any women about."
> "I found another lurking in my mother's ground at dusk. I turned him off and he was very surly. They are wandering about aimlessly backwards and forwards". (Herts Advertiser, 13th April 1956)

The Parish Council minutes are in contrast very brief, but a sense of the perceived seriousness of the problem can be found in the action proposed by the Council. Reference is made to an 'incident between patients from the Hospital, which had occurred in the Village':

> After a full discussion it was decided that the Chairman ask the Medical Superintendent of the Hospital to attend the next meeting of the Parish Council and inform him that representation have (sic) been made to refer the matter to the Member of Parliament for the district.

Both of these accounts are of interest for different reasons. In the newspaper report it is unclear whether both men are patients at the hospital or only one man is a patient. If the latter, then it is unclear who drew the knife. Allowing that both men were patients, then the starkest aspect of the report is in the contradistinction, the structure of difference, which is set up in the article, using the voices of male villagers, between 'dangerous male patients' and 'our frightened women'. The theme of 'Our Women' is repeated throughout the article. It is initially found in the sub-heading: 'Frightened women locked in village shop, Parish Council were told'; repeated through the main body of the article - '...frightened women were locked into a shop for safety', 'women got very alarmed', '...the shopkeeper locked his shop with the women in it'; and in the later reference to different incidents - '...but it is pretty alarming if there are any women about' and 'I found another lurking in my mother's ground at dusk'. This form or structure which counterposes Male-Patient-Danger-Outside with Female-Villager-Frightened-Inside can also be found in more contemporary accounts.

Also of interest here is the way that 'knowing' is introduced and raised as an issue only to be disclaimed (Hewitt and Stokes 1975): 'I didn't see it myself but several people have told me

about it'. The epistemic warrants for Village complaints indeed become increasingly thematised over time and held up to scrutiny in a way that will become clear.

The Parish Council minutes on the other hand point to a growing dissatisfaction with the Hospital's response as indicted by the summoning of the Medical Superintendent and the reference to the Member of Parliament. However, following the attendance of the Superintendent at the next meeting of the Council it appears that the situation calmed down again and no further reference is made at this time to the MP.

Some two years later in July 1958 the medical Superintendent again attended the Parish Council meeting, along with 'a large number of the public', following disquiet expressed about the 'conduct of patients in the village'. At the same time an oblique reference appeared in the minutes to a 'change of policy' by the Hospital. Unusually, the public were allowed to comment at the meeting and a letter of complaint was read from a resident of the Parish. It was later resolved that '...a letter be addressed to Dr Fitzgerald asking that a permanent patrol of the village be established on (sic) order that any patient on parole can be instructed to keep away from private property.'

The Superintendent however refused to oblige the Council and after a further exchange of letters made what appears to have been a diplomatic initiative in suggesting that '...in order to establish better understanding and confidence', the Parish Council visit the Hospital, thus also grasping the 'home' advantage. That this initiative appears to have been temporarily successful is perhaps indicated by the absence of complaint in the minutes over the ensuing three years.

A Brief Socio-Economic Excursus

The apparent emergence of 'Patients-as-Trouble' within the Village from the beginning of the 1950's coincided with the well documented change in policy within psychiatric institutions in general at this time. An 'open-door' approach, and the recognition of the importance of 'ward atmosphere' advocated by the 1953 WHO report, was widely adopted throughout the 1950's (K.Jones 1988 p130), a policy which was confirmed and promoted by the legislative reform of the 1959 Mental Health Act (Rose 1986 p75). The latter was itself preceded by the Royal Commission on Mental Illness and Mental Deficiency (1954-57) which must have played a part in creating a climate of change but at the same time also reflected a growing disquiet concerning the extant practices and conditions of such institutions. Indeed as Goodwin (1990 p88) shows, new mental health legislation had been considered by the Ministry of Health in the late 1940's in order to make it even easier for more people to receive the benefits of psychiatric treatments, but foundered temporarily for want of an administrative solution to the problem of overcrowding in such hospitals, although the official explanation for shelving the proposed Bill in 1952 was 'insufficient parliamentary time'.

Official histories often explain these changes in terms of the discovery of the major tranquillizing effects of Chlorpromazine in 1953 (Kendell and Zealley 1983) and its introduction in Britain under the brand name of 'Largactil' in 1954 (Scull 1977), or else in terms of the critique of psychiatric institutionalization (see Pilgrim 1990).

It certainly appears, as indicated above, that new administrative policies *were* being introduced in psychiatric hospitals before the introduction of Chlorpromazine. And as

Scull notes, an intellectual climate, critical of the effects of institutions, had existed for some time. Barton's work 'Institutional Neurosis' published in 1959 primarily as a handbook for medical staff, draws upon work available much earlier on the effects of institutional regimes on individuals, such as Bettleheim and Sylvester's work in 1948 on 'psychological institutionalism' although the latter are concerned principally with the plight of children (quoted in Jones and Fowles 1984). And even as far back as 1871, Williams was complaining of the negative effects of such places.

Maxwell Jones' work 'Social Psychiatry' concerning the 'therapeutic community' was published in 1952 and stemmed from his involvement during the Second World War at an establishment for the treatment of war neuroses. Thus, according to Rose (1986 p74), an attack was mounted in the 1950's on psychiatric institutions under the banner of the therapeutic community[10].

However Scull of course is intent on providing an alternative explanation which relies heavily upon a model of the fiscal crisis of the capitalist state which is said to explain the beginnings of the move towards community care (and for a critique of Scull see Matthews 1979). In his recent book, Goodwin (1990) provides a more sophisticated argument, drawing

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10 In a recent article Prior (1991a) has posed the related argument that the move in psychiatry towards community care can best be explained in terms of the development of behavioural and socially oriented ideas and discourse within the institutions of psychiatry themselves, especially nursing. Her argument is important for focusing on the way internalist (Murphy 1988) dynamics and the development of ideas influence practices, but uncoupled from its riders and disclaimers it seems to come close to yet another form of reductionism. Criticising economic and technological reductionist explanations she ends up herself with a form of idealism, failing to explain why 'normalisation' and behavioural procedures, which in her article bear the burden of explanation, were adopted by nursing staff in the first place and why social psychiatry itself came into being.

on work by Offe (e.g. 1984) and Habermas (e.g. 1976), in which the post-war development of community care policies in mental health can be seen to emerge as the outcome of a grappling by the state with a number of often contradictory problems and exigencies which include 'cost (efficiency), control (effectiveness) and legitimation (acceptability)'[11].

The precise historical course at Shenley cannot be easily determined from the material available locally, but there is certainly a likelihood that the complaints documented in the Council minutes from 1952 onwards do relate directly to a previous loosening of institutional controls or more correctly to a shift in the form of institutional control[12]. And while the 1952 tone of the Superintendent's orders to restrict patients' movements appears quite authoritarian, it did occur within a growing wider climate of change within and around psychiatric establishments which certainly pre-dated the discovery of the tranquillizing effects of chlorpromazine.

In addition, as Goodwin (1990, p84) notes, during the post-war period a shortage existed in psychiatric nursing staff in the country as a whole and many of the hospitals were becoming both overcrowded and 'old fashioned' in that they had large wards and were isolated. Shenley in contrast had been built on a 'villa' model which had been hailed at the time as progressive, but may nonetheless have shared the problem of staff shortage, and as the Nursing Times (1977) reports, while its patient population did not begin to decline until 1957, the 1953 total

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[11] Elsewhere (Southgate 1982c) I have provided an overview of the work of Claus Offe in relation to the 'state debate'.

[12] For commentary on changing forms of 'social control' especially in relation to medicine see for example Ehrenreich (1978), Lowman et al (1987), Kovel (1981), Roman (1971) and Zola (1975).

of 2300 stood very close to its peak[13]. The relaxation of 'parole' at Shenley prior to 1952 may therefore have been a result of a number of the above factors.

The Problem Continues

Over the following nine years from 1961 to 1970 a pattern begins to emerge in which an 'incident' is documented in the Parish Council minutes, contact is made with the hospital authorities, and matters improve until the next 'incident' is reported. Most of the entries are conciliatory in tone, with the occasional exception. In July 1963 for example there is talk of the 'half-hearted attitude of police and hospital authorities', while the reference in the December 1963 minutes bears recounting in full:

> A letter was received from the Hospital Management Committee to the effect that they were "doing all possible to keep incidents to a minimum".
> Mr Broadley said that events did not bear out the sentiments of the letter. He said there had been a spate of incidents recently culminating in a patient breaking into a shop at ~~10-30-pm~~ 9-30 pm (added in ink) on Saturday 7th December. Miss Boswell said that it had been her shop that had been broken into. The method showed that the man concerned is mentally unwell, which raised the question as to how he was allowed out so late, while in such a state.

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13 The 'villa system' itself appears to have been developed in the early 1870's as one of two alternative forms of workhouse design along with the 'pavilion system'. It was also known as the 'domestic system' because its basic units were built more in the form of houses than large ward blocks (Williams 1981 p118). As Williams points out these new designs contrasted strongly with the idea of the Panopticon (ibid p144). Within the new institutions, divisions were maintained by open spaces, lawns and walkways, in contrast to the hub and spokes structure of the old workhouse design. It is certainly tempting to suggest that the domestic model, with many small units separated by physical space, may have required significantly more staff simply to monitor and police than a centralised model with larger wards.

> There was very real concern in the village about the, seeming laxity, in allowing patients to wander, in and out at will.
> It was resolved the item "Shenley Hospital" appear on the agenda of the January meeting when the advisability of holding a public meeting would be considered.

By the following meeting the situation was described as 'greatly improved' after contact with the Chief Male Nurse[14].

The above account is notable for several reasons. The first is the continued (reported) cooperative tone of the Hospital authorities. The second is the dissatisfaction expressed with Hospital 'laxity' in continuing to allow patients unsupervised freedom of movement outside the Hospital grounds. Indeed there is a sense in many of these accounts in which the 'problem' itself appears to be less the Patients per se than the Hospital, rather in the manner of complaints about escaping industrial effluent, or stray dogs fouling the footpath and biting people, where the objection concerns less the effluent or the dogs, which after all might (possibly) be fine in the right place, but their controllers and keepers.

But also of interest is the decidedly strange account of the break-in. What the entry of the *text* indicates is how the poor condition of the man's mental state (and possibly his identity as a patient) is warranted; by virtue of the method used to break into the shop.

One could spend considerable time reviewing the possibilities here. What method of entry is it which can possibly indicate that the villain (or alleged 'patient' in this case), is

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[14] Note also the shift here in reference to Nurse rather than Superintendent or Doctor.

'mentally unwell', which is not based upon a simple or complicated disrespect for property?

But the principal point here is that grounds are offered at all, and that this is the *only* ground offered for imputing 'mental disorder'. The disputable nature of this account is then echoed in the next paragraph where the hospital's 'laxity' is attenuated by the use of the adjective 'seeming'. The account, then, identifies itself as controversial. In the terms of Habermas (1979, 1984) we might say that the truth claim raised in the warranting of the person as mentally unwell is then used as a platform from which a claim to normative rightness might be launched, thus: 'Because he was mentally unwell he should not therefore have been allowed out so late'. Arguably then such normative arguments rest in this context upon more than any simple and enduring assumption of a shared reality concerning mental disorder, but upon its continual reaffirmation in relation to the status of a person as mentally unwell. In other words the reality of mental disorder and prescriptions concerning behaviour have to be continually reaffirmed and renegotiated.

Some suggestion of the increasingly problematic nature of the relationship between Village and Hospital can be gauged from a lengthy article which appeared in 1968 headed 'The Village divided by love and prejudice' in a local paper and subtitled '...the Hertfordshire village with the split personality, known to some as a picturesque beauty spot and to others as "the place where the nuts come from" ' (Evening Echo 29th October 1968). Of particular interest is the way the Parish Council reacted to this article which was said to have brought up events concerning the relations between the Village and Shenley hospital which had occurred 'two or three years before',

reinforcing the sense of the politically delicate and sensitive nature of this relationship:

> Council moved a motion which deplored the article which in reference to matters which had been settled some time ago threatened the good relations between the village and Shenley hospital.

From the newspaper article it appears that these 'matters' which had been settled were related to an incident, not made explicit in earlier Council minutes, which had occurred on the local golf-course in which a woman was attacked, but in which the attacker turned out not to have been a Shenley patient. The author of the article refers here to Village 'hysteria'.

A major moment in the history of this relationship came two years later in 1970 following a reported attack on a local woman resident by a patient with a hammer on February 18th. The man also is said to have set fire to a garage. The following extract is taken from an interview with a couple who recalled the event:

> DS: You were saying about setting up the hot line?
>
> Tom: Yeah it came about, some unfortunate guy was admitted and um (2) and the laws are unless they're actually committed, they can please themselves whether they come or go and er, before they got down to any sort of treatment with the guy, he'd um, set off to go on the rampage in the, village, and er, it culminated in a fire in the er garage that I rented round the village at that time, you know.
>
> DS: A fire in the garage=
>
> Tom: =Yeah (laugh) he'd locked himself in and tried to set fire to it, oh my goodness. Only superficial damage but um. Then this, course he'd been, he'd broken in houses over here and he'd been in another house and threatened the woman before he'd decided to have a look further and er

Irene: He hit her didn't he, with a ┌hammer
Tom: └I believe that's right yeah.

Irene: Hit Mrs * .

DS: He hit her with a hammer?

I: Yeah he'd got a hammer and he hit her, yeah.

T: So he was obviously unstable because he'd only just been admitted, and, was out within hours, wasn't he,
┌apparently he wasn't
I: └That's right, yeah, same day.

T: Yeah, so I think there was a bit of, laxness there 'cos I'm sure they could have coerced him, a little bit to have sort of stayed and see what it's about, rather than go rampaging but. Then then the villagers got rather incensed and there was a meeting, public meeting called up the village hall. And um, don't know how long ago it must have been well a good 20 years ago and er (4) it, it seemed wrong that it, it needed um the public to really take, some action because it wasn't until we got together that the Council decided to, to come in at that stage. Anyway it culminated in getting a, a hot line. Well it's still in being now. (p1)

According to newspapers of the time this was the second such incident to have occurred within a few months. In December 1969 another man, resident at Shenley Hospital, was charged with 'unlawfully and maliciously wounding' a woman in nearby Borehamwood.

The Parish Council minutes record here the first mention of the 'Shenley Action Committee', the group of villagers set up to press for 'action' following the above incident, indicating some dissatisfaction with the way the Parish Council were conducting affairs on their behalf. The furore was front page news in the local press. Under the headlines 'Village in fear calls for hospital alarm' the Post reported:

Nearly 100 villagers crowded into the village hall on Tuesday to a meeting called by a band of determined mothers who want the hospital authorities made more responsible for keeping dangerous patients under control. They were led by Dr L. Payne, a local scientist living in London Road. He chaired the meeting and gave an outline of the aims of the committee.
The meeting was a highlight of a week of activity by women in Shenley who started their campaign by sending a petition to Health Minister Mr Richard Crossman. (Borehamwood, Elstree and Barnet Borough Post, 26th Feb 1970)

The petition which collected 246 signatures was said to have been started by nine women. One was quoted in the article:

> When I was young you didn't see patients in the village. We used to go for walks as children. Now you are frightened to let children go out. We never had the fear we have now.

Committee members demanded an alarm system. Dr Payne suggested that:

> A siren could be sounded as soon as the hospital discovers a patient is out, so that children can be put indoors and families prepared[15].

The subsequent meeting between the Parish Council and the Hospital Management Committee included two representatives of the 'Action Committee'. The Parish Council also resolved to keep an 'Incident' record 'of all happenings in the Village

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15 In a letter published in the Post on 2nd April 1970, Driver Giddens, of Edgware LTE Garage replied: 'Residents require protection from mental patients. What ridiculous allegations. I have never known anything so hypo-critical in my life. If anybody wants protection it is the patients themselves. It cannot be disputed, and lets be honest about it, that whenever a mental patient is walking outside any of our hospitals, throughout this country, he or she is leered at, scorned, ridiculed, call it what you like. And when they fight back it is not because of their sick minds but their self-respect.'

which were attributable to the inmates of Shenley Hospital, and that such record be checked with the Hospital records at each meeting between the council and the Management Committee.'

This call for documented evidence constitutes an effort not only to determine the extent of the 'problem', but to do it in a rigorous, accountable and calculable fashion. In measuring the problem the Council and the Villagers assert their (formal) rationality and their epistemological self-consciousness (Barham 1984 p63) while at the same time clearly outlining their interpretative schema, the boundaries or paradigm within which the 'problem' is to be measured as a 'problem': i.e. 'Patients-as-a-Problem'[16].

In addition, the fact of the resolution documents the seriousness with which the Council were taking the matter, a seriousness also explicitly shared by the Hospital authorities. A further measure of the perceived legitimacy of Village protests by the Hospital can be read from the proposals which were subsequently pursued by the Hospital Management Committee as documented in the Council minutes:

1. The Village Patrol to be more frequent

2. The Patrol to be easily recognised by the wearing of lapel badges.

3. A direct telephone line to the Hospital for immediate contact in case of emergency.

4. The use of "walkie talkie" for the use of the Hospitals Village Patrol. (sic)

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16 Compare Law's (1986) argument that the securing of control by scientists over ideas and practices rests on attempts to increase the mobility and durability of various (scientific) materials. By demanding writing (statistics), which is more durable and mobile than talk, the Village Action Committee also gain power which may be seen at least in part as an outcome of the creation of the register. See also Sibeon (1991 p44-49) and D.E.Smith (1984).

5. Increased availability of transport.

Later on that year the Hospital wrote to the Council giving the ex-directory telephone number, which came to be known as the 'Hot-Line', 'to be used in emergency'. The Council then resolved to send a letter giving the telephone number to every house in the village. Almost paradoxically however, the instigation of this new system, this technology, eventually began to further disrupt the relationship between Hospital and Village either by directly constituting a channel around which previously extant but often latent conflicts were able to crystallize, or alternatively by the direct generation of new conflicts. The particular form of this disruption is traced in the following pages.

The Hot-Line

From 1970 to the late 1980's villagers continued to complain about the behaviour of people who were patients. However, during this period the nature of the interactions between Village and Hospital underwent a subtle (and sometimes not so subtle) twist.

In the initial stage of Hot-Line use the Council minutes note the 'impressive' speed of response of the Hospital. One Councillor reported that from the time he put in the call to the time the patrol arrived was only four minutes. The Hot-Line seemed to signal the emergence of a new spirit of cooperation and understanding between Council and Hospital as the following minutes in April and December 1971 suggest:

> The chairman reported that there had been a very cordial meeting between the Council and the Hospital Management Committee, there had been no incidents in the village since the last meeting, and the hospital was congratulated on this.

and

> Meeting with SMHC (Shenley Hospital Management Committee) had been worthwhile and increased the understanding between the two bodies. The clerk read a draft letter which it was suggested should be sent to every household in the village, giving the special telephone number for use in emergencies, and asking for the cooperation of all in the village.

However by September 1973 complaints were being voiced about the working of the emergency system and the 'marked coolness from officials regarding complaints'. The minute assigns potential responsibility for the deterioration in response time to the appointment of a new 'Head Male Nurse' who was perhaps 'not as aware of the importance of these matters as was the case with Mr Vickers. It was resolved that an invitation be extended to Mr Manners to meet the Council.'

But Mr Manners only confirmed the Council's view when he failed to reply to their letter of invitation, and then gave what for the Council was a cursory reply to their second letter.

In November 1973 a letter appeared in the local press complaining about the inadequacy of the Hot-Line procedure, and by March of the following year 'a serious breakdown' was noted 'in the service given by Shenley hospital with difficult patients'. A publican is reported to have used the Hot-line but 'could not be put in touch with anyone who could deal with the matter, the result was that a very considerable time elapsed before help was obtained and the patients taken away', and in July the Council minutes note that one Villager, on using the Hot-Line, was told 'to contact the police and not to use the line.'

Reading the Parish Council minutes it becomes difficult not to draw the conclusion that the relationship between the Village

and the Hospital was beginning again to 'hot up' but this time in a manner which revolved around the 'Hot-Line' which had itself become a metaphor for, and an instrument of, both redemption and dispute.

The meeting finally held between Mr Manners and the Parish Council was open to the public. Unusually the meeting is recorded very fully in the minutes and I have included a copy in Appendix C. This document is susceptible of an extensive analysis but for the sake of economy and for the purposes of the argument proposed here, I shall only dwell on some limited aspects. First, I suggest the document provides a flavour of the sense of both promise and of disappointment in relation to the Hot-Line itself. Examples are provided of the failure of the 'device' and a clear connection is made between speed of Hospital response and confidence of Villagers. A warning is given of the possibility of serious deterioration in the relations between Village and Hospital. The tone of the case for the prosecution is one of concern for the Village and its inhabitants. There is one point when the patients' welfare is also proposed to be of concern to the Village, but this is used as a 'disclaimer' which paves the way for further criticism and blame, thus: 'Cllr Broadley stressed the fact that in general there was a very real desire on the part of the Village to help in all practical ways the recovery of those patients who would benefit by mixing with the outside world, but it did seem that many who were allowed out were in no fit state to be at large, and they did nothing in helping relations between the Village and the Hospital.'

In a symmetrical move, the Nursing Officer defended the practices of both nursing staff and patients, the former on the grounds of fallibility and the fully occupied nature of their time, and the latter on the grounds that from the patients'

point of view, things (i.e. the Village and Villagers) could be as strange to patients as patients were to Villagers. Both lines of argument are prefaced with similar statements thus; 'it should be understood that...' and 'it should be appreciated that...', which technically, in speech act terms, appear to be hedged forms of regulatives (Habermas 1979, 1984). In a less diluted form they would read as the requests/commands 'You must understand that...' and 'You must appreciate that...'. Mr Manners we might say was diplomatically invoking his power to command (cf. Murphy 1988) in respect of how the Villagers ought to think and feel.

The minutes report that Mr Manners then conjoined his defence with the Villagers' case in the following manner: 'He made no excuses, but assured those present that every consideration was given to most of the points raised at the meeting', which unfortunately for Mr Manners tends to undermine his case, obliquely attributing to it the status of 'excuse'.

Local anxieties were further increased over the following few years by the proposal of plans to establish a new 'Maximum Security Unit' at Shenley Hospital. The Parish Council minutes indicate that discussions at the Council meetings drew large numbers of the public. The meeting in January 1977 which was attended by members of the Regional Health Committee in order to discuss the proposed unit, records:

> Earnie Broadley said that with five major mental hospitals in the area it had enough and to add a security unit would be to "overload the patience" of those who live in the Village. He went on to talk about how at the moment discipline was a dirty word with those in charge. He said this was not a matter for the Council alone, and at the last Parish Meeting attende(d) by nearly 100 people it was the unanimous opinion of the meeting that every objection possible be made regarding the siting of the unit at Shenley.
> Councillor Murray said he had knowledge of patients from

> the hospital who were out late, and drinking heavily in local pubs, it seemed that the doctors were very slack on the security side.

Such protests may have had some affect and no further moves were made at the time to site the Maximum Security Unit at Shenley. But in the same year a further issue became prominent in the Council minutes for several months, that of 'Patients Votes'. This is quite an important issue which has bearing on the legal and moral status of people who are in-patients[17]. At the same time however the Council was also concerned by a proposal to demolish an old and dilapidated farmhouse on the edge of the Village, which had previously been used as a hostel for patients, and build a number of flats which would be used to house people who were at the time patients from Shenley and other hospitals. The Parish Council opposed this development principally on the grounds of 'encroachment of the green belt'.

But it is of note that this constitutes one of the few occasions when people who were patients *themselves* contributed to the debate, albeit via a 'representative'. In 1978 a letter in support of the development was sent to the Praetorian Housing Association, parts of which were published in the local press, by the Chairman of Shenley Hospital's 'Patients' Representative Group' (PRG). At the same time a hand-painted sign appeared outside the old Farmhouse which read, in capitals, 'This site is required for Shenley Hospital patients so that flats can be built and we can be discharged from hospital and become independent'. In January 1978 the M25

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17 At the time, the Council was exercised by the notion that patients at the hospital were going to be given the chance to vote in local elections. Following changes to the rules of electoral registration in the 1983 Representation of the People Act, informal psychiatric patients were able to make a 'patient's declaration' specifying an address *outside the hospital* for voting purposes. This new provision specifically excluded Parish Council elections.

appeared in the Council minutes as a further cause for opposition.

Meanwhile the Hot-Line continued to be a focus for concern, and by December 1977 the waiting time for a response from the Hospital is reported to have increased to one hour.

The sense of a reality disjuncture makes an official appearance in the Parish Council minutes of November 1979, when a reply was received from the Hospital to a complaint from the Council concerning an alleged attack by a patient in the Village. The reply indicated that the matter was 'trivial', while a press report of the time quotes a Hospital spokesman as saying 'I think 'attack' would be a strong word to use in this case, but we are nevertheless treating the matter seriously' (Herts Advertiser, 23rd November 1979). The allegedly poor response to the 'Hot-Line' was taken up in the subsequent meeting held shortly after between Hospital and Council. At this meeting it was agreed that the Council should appoint a 'liaison-person', to whom all incidents in the village should be quickly reported. This was seen as a further possible means 'to be able to judge the real extent of incidents.'

What appears to be increasingly at issue here is the rationality of the Villagers in their judgements of the frequency and seriousness or otherwise of 'incidents' in the Village, that is, of the *reality* of 'trouble' itself. In a fashion which at once confirms the changing nature of the 'problem' (i.e. as one increasingly concerning disputes over reality), demonstrates the competence of the Council's new system of reality testing, and attempts to shift responsibility for this 'new problem' to the press, the following item which appeared in the following month's Council minutes states:

Councillor Broadley said that he had had no incidents reported regarding Patients from Hospital, there had appeared in a local paper a suggestion that the Committee dealing with charges for school transport had said that there had been incidents between Patients and children in the area. This was incorrect, there had been incidents but no patients had been involved, he had written to the administrator making this point.

Two months later at the Annual Parish Council meeting, representatives from the Hospital answered Villagers questions concerning Hospital practices. This extract is taken from a press report of the meeting and indicates a significant shift by the Hospital.

> One important query was whether villagers should contact the police and the hospital or just the hospital, in an emergency. They were told that it was best to ring both because the hospital staff may be called out to deal with a patient from another hospital and that could put them in a difficult position. (Herts Advertiser, 14th March 1980).

Protests concerning the uncaring 'attitude' of the Hospital staff and Hospital security arrangements continued to be made over the following years and the Hot-Line drew regular attention. However in April 1981 the Hospital administrator took the unusual step of complaining to the Council about the press report of the Annual Parish Council meeting the previous month, in which the Hospital had been criticized for taking too long to respond to Hot-Line calls. The Council replied to the effect that it served the Hospital right for not having a representative at the meeting.

By 1983 the Hot-Line response time had allegedly increased to two hours. The Council's minute was surprisingly mild in tone, the clerk being instructed 'to obtain the comments of' the Hospital authorities in this matter. The Hospital also responded in a conciliatory manner by suggesting that 'perhaps

there had been some misunderstanding on both sides' regarding the use of the 'hot line' by a resident when reporting a recent incident.

The peak of the disagreement between Hospital and Village concerning the 'reality' of certain states of affairs can perhaps be located in 1986 and is indicated in a minute of the Parish Council which in July documented the concern of the Chief Nursing Officer at Shenley Hospital over the abortive telephone calls from landlords of Village public houses in connection with the behaviour of 'alleged' hospital patients in the licensed premises. The press report, however, although short, was more explicit and rude. Under the headline 'Just who is mad?' it stated:

> Nine times out of ten Shenley hospital staff are asked to retrieve a patient from the village they discover it is only a member of the public. That is the claim of Brent Health Authority and, at this week's meeting of Shenley Parish Council, Councillor Marion Martin announced that callers were being urged by the hospital to check that people they believed to be patients really were. Main targets of the campaign are to be the village's publicans. (Herts Advertiser, 18th July 1986).

The headline captures the irony involved here, for what does indeed appear to be at issue (in a fashion which can be contrasted to the tone and content of the debate in earlier years) is the rationality or sanity of Villagers themselves[18]. We confront here the threat of a reversal of the fortunes and

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[18] There is a sense that the press might have waited a long time for this opportunity. Compare more recent newspaper articles which trade upon the notion that the villagers/village might be crazy: 'Village barks at dirty dogs' (Herts Ad. 12/5/89); 'They are going animal quackers this week in Shenley' (ibid); 'Cage cracks up' (Herts Ad. 16/6/89). The attempted humour and irony depends for its effect upon the reader sharing a cultural understanding that 'mad' constitutes a pejorative predicate and that madness is newsworthy.

roles of the *dramatis personae* of the narrative of Village and Hospital. And not only is rationality in dispute, but there is a threat of a new evaluative and moral framework in which heroines, heroes and villains exchange parts.

The Villagers however do not take this lying down. In an article published three months later in the local press the Parish Council is quoted as casting doubt upon the Hospital's very own knowledgeability:

> Alleged buck-passing between Shenley Hospital and the police over responsibility for wandering patients has pushed parish councillors into taking the matter to the top.
> Following recent incidents of hospital patients "misbehaving", Shenley residents say that a hot-line to the hospital is not working.
> So Shenley Parish Council has decided to go to the top and is contacting health minister Norman Fowler to establish exactly who is responsible for errant patients.
> The parish council was told that one patient had been knocking on doors recently equipped with a pair of shears. Worried residents had called up the hot-line but the hospital would not acknowledge the man as a patient and suggested the police should deal with the matter.
> The police then denied responsibility and told people to contact the hospital.
> The final straw came neither the police or hospital would act after reports that patient had been jumping into the path of female cyclists.
> This week parish councillor (sic) said: "These people are put in hospital for care and to be looked after. Somebody is responsible for these poor, sick people".
> And they wondered if hospital staff were aware of who was actually in their care.
> Anne Wilson, hospital general services manager, denied that all the incidents involved hospital patients.
> "Some of the difficulties in the village relate to people who are not necessarily from Shenley Hospital" she said.
> (Herts Advertiser, 17th October 1986)

Again this article clearly indicates some of the issues at stake in the dispute. There now appears to be something more than an 'interpretive asymmetry' in Coulter's (1975) terms, in

which some objective state of affairs is acknowledged by agents but in which competing interpretations are proposed. It appears rather that a full blown reality disjuncture (Pollner 1974, 1975) has surfaced in which the very existence of the proposed state of affairs is in dispute and which is reminiscent of similar debates often found within the walls of psychiatric institutions themselves[19]. For the Hospital, arguing one would think from a position of some considerable psychiatric authority in these matters, it appears that the people who are Shenley Hospital patients are not a problem in the Village, because those people notified to them to *be* causing problems are not patients, or not patients at Shenley Hospital. For the Villagers however, insistent upon their conviction that they can indeed 'tell the difference' at least as well as, if not better than, the alleged experts, the behaviour of 'patients' does constitute a concern. But overarching this concern with patients is the meta-problem of rationality, of the question concerning whose account of 'reality' is going to prevail. And in the last extract it can be seen that further resources are being mobilized in support: the Villagers are 'going to the top'.

But at the same time a further culprit can be identified in the above article. The Hot-Line has gone wrong, *it* is 'not working'; *it* has broken down. I find fascinating the way that the Hot-Line is so easily reifiable and referred to as if 'it' were indeed an independent something which had somehow 'broken'; as if it were the wires which had snapped, or the electronic bits and pieces which had fizzled and died.

In contrast to viewing the Hot-Line simply as a mechanical thing, I suggest rather that it may be understood more

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[19] As MacIntyre (1977 p463) argues, the categories of psychiatry and of epistemology must be to some extent interdefinable.

appropriately on the one hand as a metaphor for the relationship, the link, between Village and Hospital; and on the other as embodying in its very make up and ends certain values, relationships, and social practices[20].

The social practices which are built into the Hot-Line can be viewed from several perspectives. On the one hand the Hot-Line can be said to embody a drive towards the establishment and maintenance of co-operation, co-ordination and mutual understanding, the kind of human relationship which is encapsulated in Habermas'(1979, 1984) notion of communicative action and communicative rationality. This is its positive and emancipatory side. However on the other hand the Hot-Line was set up in order that the action co-ordinated by it should be principally that of systematic control and exclusion. The communication in the end turns out not to be the encouragement of free and unconstrained debate, (for example about the ethical issues involved in certain situations) but rather a systematically distorted, or perhaps better, a systematically biased, communication oriented to systematic exclusion from the Village of Patients who are considered by Villagers to be a 'problem' (cf. Habermas 1970b). Thus it is that the Hot-Line can be seen as embodying contradictory imperatives.

And at the very least if we examine the Hot-Line we can see that as well as the human labour which has gone into the construction of its more mechanical parts, 'it' is human, in that in order for 'it' to 'work', 'it' must necessarily depend

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20 There is a wide literature concerning science and technology as the preservation of concrete social practices, from the Marxian stream of Lukacs, Marcuse, Slater, Habermas, Horkheimer and Adorno, Navarro, Figlio and the Radical Science Journal Collective, to some of the recent perspectives in the sociology of scientific knowledge such as that of Latour and Woolgar (1979), and Woolgar (1991a).

upon at least two human beings being in communicative, discursive, touch with each other. In this sense the Hot-Line *entails* a working human relationship.

Thus with the 'breakdown' of the Hot-Line is revealed the breakdown of communication, of the relationship, and the imputed 'breakdown' of its individual parts, the Village and the Hospital. Each accuses the other of not seeing, not knowing, not hearing and of being out of touch with reality. The epistemological crisis here turns out to be essentially one of human relationships[21].

In fact, in her reply quoted above (p250), Ann Wilson for the Hospital implicitly offers a mediative position, a new and 'enlarged' narrative in MacIntyre's (1977) terms, which serves to play down some of the issues and still allows for the possibility of reconciliation. Her statement is ambiguous but can be taken to read that in fact perhaps the Villagers may be able to tell the difference between people who are patients and people who are not, but may have on occasions unbeknowingly chosen to report people who are patients at another, a different, hospital.

The records suggest that the Hot-Line expired temporarily. But consistent with its ambiguous state and contradictory function it was brought to life again the next year. Headed 'Hospital hot-line re-opens', the following article details the event:

> Growing concern over the behaviour of hospital patients in Shenley has prompted the re-opening of the emergency Hotline telephone scheme.

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21 Compare Mr Broadley's reported statement at the open meeting reproduced in Appendix C, p480: 'If requests for help were dealt with promptly it would go a long w(a)y to restore confidence, but when such requests were not answered for long periods confidence was broken.'

> Businesses in Shenley are to be given the phone number which they can call if they have a problem with one of the patients.
> Councillor Bill Hogan told parish councillors this week that the so-called Hotline was once again in full operation and that the hospital would attend any incidents.
> Problems with patients have recently become a matter of great concern in the village but there was doubt over who was actually responsible. The parish council called on Secretary of State Norman Fowler to clear up the matter and issue was taken up by Shenley's MP Cecil Parkinson. The special phone line should, however, only be use in connection with patients. (Herts Advertiser 13th February, 1987)

Here the reality disjuncture spreads as it were to the Hot-Line itself which now has achieved the doubtful ontological status of being a "...so-called Hotline...".

The Hot-Line as Social Closure

As well as highlighting and accentuating the problematic nature of the relationship between Village and Hospital, being the vehicle for, and focus of, conflict, the use of such a Hot-Line has certain ethical and legal implications which have not so far been adequately explored here but which deserve comment.

The first point is that it is in fact quite unlikely that nursing staff on Hot-Line duty would know or be familiar with all the patients in the Hospital or their legal status. Thus a Hot-Line call to remove a person from the Village may very well place the nurse in a difficult legal position. Clearly if the person is not a Shenley Hospital patient the nurse has no legal right to attempt to compel him or her to go to Shenley Hospital. But equally serious is the position of the nurse in relation to a person who is an informal patient at Shenley Hospital and who has gone to the Village. For again any attempt

to compel the person to return against their wishes would constitute an assault upon that person[22].

It may appear then that from a legal perspective the Hot-Line is disadvantageous to nursing staff and patients alike. If a person is residing in the Hospital informally then we might expect that he or she has (at least formally) as many freedoms and rights as a Villager[23]. The police however, as some of these extracts imply, upon hearing that the person is (putatively) a patient at the local psychiatric hospital, are usually only too keen for the Hospital to take responsibility for the offending body. Witness the following extract from a local paper in pre Hot-Line days where a local policeman was reported as saying:

> If they were ordinary members of the public, you could whip 'em in. As it is, when you ring the hospital, they never come for them. Even if it gets to court the Magistrates seem to take a Utopian view of it. As soon as they hear someone's from the hospital, they say: "Oh I

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22 It might be objected here that even informal patients may reasonably be expected by the villagers to abide by the rules of the hospital and to return to the hospital when requested to do so by staff. And similarly it might be argued that because mental hospitals exist then the public has a right to expect patients to reside in them. But neither argument ameliorates the vulnerable position of nursing staff who must be guided by the legal framework and constraints which offer some measure of protection to patients from abuse. The second argument underplays the controversial aspects of the issue about where such people really *should* be. On the one hand the existence of large mental hospitals does tend to warp, as it were, the surrounding semantic space. On the other hand however their existence does not annul the potential or ongoing process of controversy *about* their very existence and the rights of their patients.

23 Should he or she refuse to return to the hospital when requested, the hospital authorities have the power either to discharge the patient or to consider 'formal' admission.

> don't think there's much we can do about it - send them back" . (Evening Echo 29/10/68)[24]

The implication is that this organisational procedure which revolves around the Hot-Line constitutes a form of social closure and exclusion (Murphy 1988, Neuwirth 1969, Parkin 1979), that is, a discrimination against people who are patients, although this is countered in some of the above texts by an appeal by Villagers to the welfare of patients. However these appeals themselves have rhetorical implications as I shall show in the following chapter.

A pre-eminent, important, and almost too obvious feature of the public discourse of trouble which I have begun to portray above is the way the world is divided up into two groups of people; patients and non-patients (cf. Goldie 1988). Patients in turn may be subdivided in a variety of ways which include here 'ours' and 'someone else's'. In the discourse described here patients are inevitably linked or tied to the Hospital conceptually, pragmatically and rhetorically, in a discourse and relationship in which the Hospital and Village are dominant and patients are overwhelmingly voiceless and silent.

Conclusion

In the above pages I have attempted to chart the historical development in the relationship between village and hospital. This relationship has been demonstrated to be political in that the dialogue, debate, or discourse concerning the relationship between village and hospital, local practices and patients, has revolved around the particular interests of the two principal

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[24] See Major (1991) for the recent view of a J.P. who is also the Vice-President of the National Schizophrenia Fellowship.

parties, and has excluded to large extent the voice of patients themselves. From the historical perspective presented here which draws largely upon publicly available material, it appears that villagers from time to time have attempted to close off opportunities to people who are and were patients[25]. I have argued that in the historically changing process of negotiation a principal feature of the debate has become the issue of rationality itself, not only of the people who were patients, but also ironically of the two principal parties in the discourse, and I have suggested that the reality disjuncture which emerged was connected at least in part to the introduction of a specific technology introduced to alleviate problems and tensions between village and hospital.

The dialogue between Village and Hospital which I have depicted above may be seen to mirror some of the processes which go on daily and contemporaneously between families and psychiatrists. In this scenario, where the psychiatrist is called in to sort out a problem initially felt to be 'psychiatric' in some sense by the family members (Mechanic 1962), the process of negotiation of the nature of the problem may often occur, at least in part, without the putative patient being present at all, occupying a space of an excluded middle, as in: 'Come into the next room doctor so he can't hear us and I can tell you what he's been doing.'

In the next part of the thesis I shall consider in more detail the way that villagers' talk about patients draws upon a range of interpretative repertoires in the rhetorical management of dilemma.

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[25] And of course the practices of such hospitals are also often discriminatory. As Page (1974 p16) puts it: '...there is usually a rather clear physical and attitudinal separation between staff and patient and it is not difficult to determine which group has the higher status.' Edelman (1974) has provided an astute view of the political language of the helping professions, and see also Brandon (1987).

PART THREE

Chapter 10

An Introduction to the Language of Discourse Analysis

This chapter provides an overview of the aims, methods and theoretical background of the particular form of discourse analysis drawn upon in the analysis of interview transcripts in chapter 14 below.

Background

The model of discourse analysis outlined here has drawn impetus from a number of theoretical traditions which include ethnomethodology, speech act theory, the philosophy of science, the sociology of scientific knowledge, semiotics and rhetoric as well as the work of the later Wittgenstein, and is organised to contrast with traditional perspectives in social science concerned for example with attitude studies (see Potter and Wetherell 1987). A core position, now a commonplace, is that language has more than a cognitive function, serving to do more than simply represent things in the world[1]. This model is presented not as a *method* as such but rather as an orientation to the place of discourse in social life (ibid p175). Indeed from this perspective one analytic effort is to consider how

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[1] But the metaphor of language as tool has been challenged by Gadamer (1976, p62) who argues that language cannot be picked up and put down again like a tool, but rather is a mode of being (cf. Stewart 1986).

'things in the world' are lent independent thingness by virtue of the language used to describe, debate and discuss them (cf. Smith 1978, Woolgar 1988a). In his 1987 paper, for instance, Potter provides a clear statement of the influence upon his work of literary theory, in particular that of Roland Barthes (and cf. Potter, Stringer and Wetherell 1984). In describing Barthes position Potter suggests:

> ...instead of treating "realism" as a product of acute and literal description, he treats it as a linguistic effect. The traditional question of how accurately a text describes is therefore replaced by a prior analytic question which asks how the organisation of discourse within a text achieves the *effect* of merely describing. (1987 p114)

As Potter also points out there is a strong parallel here between this poststructuralist move from resource to topic in relation to the text, and ethnomethodology, a similarity noted earlier by Lemert (1979). From the perspective of Michael Billig, and notwithstanding Barthes announcement of the 'death of rhetoric' (quoted in Billig 1991 pp2, 196), we might say that what we are engaged in here is rhetorical analysis, to be understood as the analysis of, and the joining with, argument.

It may be possible to identify continuities between the form of discourse analysis presented here and that of Foucault, for example the shared view of discourse as a social practice. Lemert (1979) for example has drawn parallels between ethnomethodology, which has informed discourse analysis, and the work of Foucault, Derrida and Levi-Strauss. But at the same time there are arguably substantial differences. Foucault's notion of discourse is wider and deeper in that he uses discourse to refer to both language and other social practices (Kramarae et al 1984 p12, Anderson et al 1986 p114,). As Woolgar (1986 p312) puts it 'Foucault's use of discourse

denotes a whole concatenation of activities, events, circumstances and objects which together make up a particular world-view'. By contrast, Woolgar (ibid p312) observes that 'Anglo-Saxon empiricism uses 'discourse' as a label for a narrow set of empirically observable linguistic activities', a position accorded to the work of Gilbert and Mulkay (1984) which is wedded, Woolgar argues, to a realist epistemology. Thus Anglo-Saxon empiricism is said to hold to the notion that: 'Objects exist independent of the observer, who strives to maximise the validity of observation by minimising his distance from the object' (Woolgar 1986 p310).

The issue of who is and who is not a 'realist' features substantially in many of the writings of Potter, Wetherell and Woolgar (see especially Potter and Wetherell 1987, Woolgar 1988a), and is often cast as part of the debate concerning social scientific methodology, reflexivity and relativism. While Potter and Wetherell (1987) move towards Woolgar's constitutive perspective, which holds that reality is constituted in and through discourse (Woolgar 1986 p312), they do not extend their analysis to the world of objects as Woolgar and Foucault do, thus: '...entities such as objects, machines and circumstances can all be treated as texts in that they too manifest a discourse' (Woolgar 1986 p312, and cf. Woolgar 1991a)[2].

In addition Foucault's excision of the subject[3] arguably runs

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[2] There may be at least two ways to understand Woolgar's claim: 1) that every 'thing' is embedded in a matrix of meaning, and 2) to view machines for example *as if* they were texts may be a useful analytic or methodological move (cf. Woolgar 1991a).

[3] See e.g. Foucault's (1980 p117) discussion of genealogy: 'One has to dispense with the constituent subject, to get rid of the subject itself, that's to say, to arrive at an analysis which can account for the constitution of the subject within a historical framework.' However, Dews (1989) points out that in his late work Foucault breaks with his earlier position by introducing a notion of the freedom of self-creation, of autonomous subjects.

counter to the social-psychological theory of Potter et al and Billig which provides room for an active subject in the process of argumentation[4].

The argument that discourse analysis overcomes some of the problems of warranting ethnographic interpretations by presenting the 'actual data' for inspection, while apparently powerful, fails to sufficiently acknowledge that in fact both discourse analysis and ethnography are hermeneutic endeavours (cf. Atkinson 1988). In chapter 11 below I attempt to tackle some of the lacunae of the discourse analytic perspective. Nevertheless I also argue that the detailed analysis of texts can offer something important and interesting to an ethnographic study. At the very least, and regardless of the slippery philosophical path here, it is possible and legitimate to read and present research material in a number of different ways as Richardson (1990 p49, and see Atkinson 1985, 1990 p168, and Silverman 1985) observes. And so in my analysis of interview transcripts and newspaper articles this means that while for much of the time I obey the discourse analytic rule of staying with the text, on occasion I disengage from this mode to enter a discussion about the implications of the analysis for the real world, in a manner informed by the universal pragmatics of Habermas.

The Focus of Discourse Analysis

A principal point of this model of discourse analysis can perhaps initially be demonstrated by an example from some

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[4] However, at least methodologically, Potter and Wetherell are 'anti-realist', that is, they do not take language as a pointer to prior events, objects, beliefs, cognitive processes, states of affairs, etc (e.g. 1987 p35, 157, 160), and do not wish to go 'beyond the text' (p49, 160), although language 'function' is regularly identified in their work with 'purpose' (e.g. p33) and goals (e.g. p137). At the same time they say they wish to resist an understanding of any particular language usage as necessarily intentional (p34).

preliminary analysis of research material. Compare the following interview extracts. In example 1 the speaker is talking about some of her responses to, beliefs about, and experiences of, people who are patients at the psychiatric hospital. On the whole this talk is unambiguously negative in its evaluation, explanation and generalised description of events. People who are patients are unpredictable and can be violent. The speaker suggests that she has become cautious because of this unpredictability and violent behaviour which is presented as a reason for trying to avoid 'them'.

Example 1

> You try to keep away from them because you don't actually know how they're going to respond to anything you may say or do to them.
>
> I think they are unpredictable in their actions and as I say you do get cautious of them.
>
> ..there have been several incidents in the road when you have had a patient who has sort of snapped and they have got very violent and vicious and we've had to call in the, you know, hospital people and the police.

In example 2 below the picture is quite different. Here the speaker proposes a positively evaluated view. In this example patients are friendly, sensible and not troublesome. There is no sense of danger or unpredictability about the patients who 'wander' around the village, and indeed there appears to be some willingness to begin to get to know 'them' albeit in a superficial manner. This speaker's use of an extreme case formulation (Pomerantz 1986), 'They're all very friendly people', seems calculated to forcefully rebut any suggestion to the contrary. As such it contrasts quite strongly with example 1. It is possible to imagine speaker 2 engaging in an argument or debate with speaker 1 on the issues involved.

Example 2

They're not as people imagine, psychopaths. They're all very friendly people.

There are several patients who come in regularly and you start to recognise them but they haven't done anything that would worry me at all. They seem very sensible in their attitudes and their manner.

> I mean the ones that are wandering around the village aren't the ones who are going to cause a lot of trouble really.

Examples 1 and 2 above appear then to contrast sharply with each other. But in fact[5] both derive from the same interview with the same person. How then are we to characterise this person? As tolerant and accepting, or as avoiding and rejecting? Do we slot her into a 'don't know' category, or dismiss one version as mistaken or invalid in some sense? If so, what kind of methodological or epistemic warrant can validly be used to achieve this?

This apparent discrepancy highlights one of the main points of discourse analysis which is an acknowledgement of the variability of people's talk according to its functional and argumentative context. Variability then constitutes a principal analytic resource for understanding the functional orientation of discourse (Wetherell and Potter 1988 p171). The suggestion here is that previous studies which are attitude or vignette-based may not be able to capture the context-related complexity of how people think, talk and otherwise behave in relation to people who are or have been patients. In the terms of Michael Billig (1987, 1989, 1991) it is possible to see talk and thinking processes as dialogically, argumentatively or rhetorically organised, so that even people whom we see as

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5 This form of presentation is used by Wetherell and Potter (1988).

holding strong views may modify their views in some manner according to the place or context of their expression, and in relation to their opponent's argumentative stance. Indeed for Billig and others (e.g. Schiffrin 1984, Knoblauch 1991) it is disagreement rather than agreement which is often a preferred activity in discourse (cf. Jackson and Jacobs 1981). Where Potter and Wetherell speak of 'variability' and 'repertoires', Billig writes of 'dilemmas', thus 'The dilemmatic nature of ordinary thought might be said to reveal that people possess contrary repertoires for talking about their social lives (Potter and Wetherell, 1987).' (Billig et al 1988, p143).

This view of language use and its related notion of functional, argumentative and context variability has considerable implications for the way interviews are or should be conducted. For rather than trying to pin our respondents down to one consistent response or belief expression, we should be attempting to generate the conditions under which the kind of variability which it is possible for the person to exhibit is allowed to emerge. This is the approach advocated by Gilbert and Mulkay (1983, 1984), Potter and Mulkay (1985) and Potter and Wetherell (1987). And consistent with his rhetorically informed position, Michael Billig (1987) suggests that interviews should be carried out argumentatively. That is, once we see 'views' as rhetorically and dialogically organised then it is beholden upon us, if we want to witness the range of views, to encourage the argumentative context out of which they can emerge. Potter and Mulkay (1985 p269) for example suggest 'Once the analyst has come to use the interview as a way of exploring participants' variable interpretative practices, there is every reason for her to engage actively in the interview so as to extend the range of interpretative work carried out there.' From this perspective, interviews which contain an internally consistent set of responses are seen as relatively uninformative.

This position also has the effect of making quite clear what is now a commonplace, that all interviews are inherently joint creations (see Mishler 1986 for a good account of interviewing as dialogic construction). Once seriously acknowledged this also has implications for the presentation of research material, which as far as possible should show the part played by the interviewer.

In addition to the functional variability of accounts and an emphasis upon the constructive use of language, Potter and Wetherell follow Gilbert and Mulkay in adopting the analytic tool of the 'interpretative repertoire'. The building blocks of accounts, repertoires may be defined as registers of terms, descriptions and commonplaces drawn upon to characterize and evaluate actions, events and other phenomena. They often utilize distinct grammatical structures and styles, and may often be signalled by certain rhetorical tropes (Potter and Reicher 1987, Potter and Wetherell 1987, 1990, Wetherell and Potter 1988, Yearley 1985)[6]. An end point of discourse analysis can be seen as the identification of such repertoires together with their management devices, and an examination of the discursive functions which the differential use of repertoires serves to perform. The overriding concern here is often to do with how respondents' practical reasoning may serve to maintain asymmetrical power relations within society (Wetherell and Potter 1988 p173), and defend existing social institutions against criticism (Wetherell and Potter 1989 p218). The view provided here is not unduly voluntaristic, for as well as being used by actors, discourse is seen as constraining and enabling

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[6] This is quite a wide definition of interpretative repertoire which is not entirely dissimilar to the notion of discourse register as used by Fraser (1988). Compare also discourse theme (Agar and Hobbs 1982, Agar 1979), and dilemmatic theme (Billig et al 1988). Brewer's (1990) use of 'discourse vocabulary' is also similar to interpretative repertoire.

action. Indeed the relationship between actor and repertoire is quite close to that of action and structure in Giddens' (e.g. 1984) sense, where structures, i.e. rules and resources, are seen as instantiated in action. As Potter, Wetherell, Gill and Edwards (1990 p213) put it 'Put simply, discourse analysis studies how people use discourse and how discourse uses people'.

Nevertheless one criticism which might be levelled at the approach presented here from the view of social and political theory concerns the apparent lack of any analysis of power, ideology, and social structure. The work of Billig et al (1988), which is concerned to detail the way that 'the dilemmatic ideology of the Enlightenment' still influences people's discourses and lives, goes some way towards remedying this, although the meaning of ideology is not addressed from the position of the critique of political economy.

Chapter 11

Theoretical and Practical Problems: Beyond Potter and Wetherell?

In the preceding chapter I presented a brief 'official' version of discourse analysis; what it is and what the analyst does. In this chapter I want to look in a little more detail at the specifications of a discourse analysis as outlined above, and in particular the three central features with which analysis is concerned: 'variability', 'interpretative repertoires', and 'function'. The following comments have derived from my efforts to *do* discourse analysis and so the clarification of these issues has constituted a practical problem which I have had to tackle. The following may be termed an immanent critique of discourse analysis, in the spirit of a constructive and reflexive criticism (Atkinson 1990, Steier 1991, Woolgar 1988b, Thompson 1990). There are, I suggest, a number of lacunae in the work of Potter, Wetherell (and Reicher), which I attempt to clarify here, with the aim of reformulating the discourse analytic project.

Variability

The suggestion here is that researchers should be alive to differences and dissonances (cf. Ward and Werner 1984) in their research material. For Potter and Wetherell such variability is, it seems, a self-evident affair. As in my own example provided above, 'variability' is offered up to the reader as in need of no further support beyond that of the evidence

provided in the text itself. Further, the suggestion is made that variability indicates that different things are being done in different contexts.

In their 1988 paper Wetherell and Potter suggest:

> ...our point is that variation has a crucial analytic role. As variation is a consequence of function it can be used as an analytic clue to what function is being performed in a particular stretch of discourse. That is, by identifying variation, which is a comparatively straightforward analytic task, we can work towards an understanding of function. We can predict that certain kinds of function will lead to certain kinds of variation and we can look for those variations...(p171)

And in their 1987 work the authors clearly see the identification of variability as a first phase analytic task, and the identification of function coming later on (p 168). It appears that although the authors see variation (variability) as pragmatically linked to function, for the purposes of analysis variation is lent a certain analytic privilege in that it is to be identified prior to function. Again, for the purposes of doing analysis there are I think two issues here. The first concerns the general problem of determining meaning. The second concerns the analyst's differentiation between different types of difference.

The authors seem to propose here that variation or difference is readily identifiable 'in itself' and analytically separate from its functional correlate. They therefore play down the way difference comes into analytic being by virtue of the analyst's selection and argument. This may be surprising in view of their antipathy to 'realism', their social constructionist orientation, and their criticism of the way others illegitimately select or ignore 'data'.

While 'good' and 'bad', for example, may be easily read as lexical items with opposing meanings (although a certain usage may yet bring their meanings into line), it is less clear where the analyst stands in relation to more complex 'distinctions' such as 'good' and 'not bad' in terms of a) whether this is an example of variation, and b) if it is, whether it is a significant variation. Of course to give them the benefit of the doubt the authors may simply assume that everyone understands that there is no available algorithm for the identification of meaning and difference.

Clearly the analyst plays a central role here. And in their 1987 work Potter and Wetherell do suggest that the analyst should be constantly asking 'why am I reading this passage in this way? What features produce this reading?' (p 168). But *pace* Potter et al, a central point is that while variability might signify function, a preliminary anticipation, determination or reading of a specific function by the analyst may be involved as a prior or *simultaneous* step in determining and identifying variability and difference.

On the other hand it is no doubt prudent to resist any suggestion that meaning might be reducible to function because such a reduction would render any search for discrete semantic variability, redundant. Yet such resistance also has a logical correlate and indeed it is clear that figurative language itself depends upon a distinction between literal and metaphorical meaning, as Culler (1981 p41) for example points out[1].

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[1] In other words the notion of 'literal meaning' is something we implicitly rely upon in our everyday use of language, even though the meaning of each word can vary according to its use. And see Searle (1979) who argues against the idea of literal meaning as implying a zero or null context; also Richards (1936/1971).

The issue here is an old one concerning the indeterminacy or otherwise of meaning. There appears to be a dichotomy between a semantics which promotes literal and independent meaning, and a pragmatics which emphasises its contextual dependency. Although separate, each however can be seen to depend upon and point towards the other, and it is arguably out of this process, this dialectical movement, that understanding comes (if it does).

If we allow for a dialogic (Gadamer) or argumentative (Billig 1991 p31-56) theory of meaning, then the analytic task of discourse analysis is perhaps more accurately described as a dialectical or hermeneutic, rather than linear, process. The authors come close to this view when they note that 'We can predict that certain kinds of function will lead to certain kinds of variation and we can look for those variations...' (Wetherell and Potter 1988 p171), although the emphasis still remains in their work upon identifying difference in the text before hypothesising function, in the practical business of analysis. Arguably then their linear analytic movement captures only one part of a larger process in which the analytic priority they give to variability collapses.

The problem of understanding the meaning of abstracted parts of discourse may be less of an issue in face to face interaction in which meaning, while still dialogic and discovered anew, in the terms of Gadamer, may yet be hammered out to some mutual agreement and understanding. Schegloff (1984) has discussed this issue of meaning in terms of the 'overhearer's problem' and ambiguity:

> It is because actual participants in actual conversations do not encounter utterances as isolated sentences, and because they do not encounter them in a range of scenarios, but in actual detailed single scenarios embedded in fine grained context,...that most

> theoretically and heuristically depictable ambiguities do not ever arise. (p51)

Although a central theme of discourse analysis is that interpretations of differences and functions can be displayed in the final text so that readers can decide for themselves upon their validity (Potter 1988), the analyst's task is different to that of the 'final' reader, for as well as identifying variability, he or she must, as I have noted, also decide which textual differences make a difference - which to leave out and which to include in the final document. If the analyst's selection is likely to be linked to his or her theoretical and other interests, in other words with what the analyst-reader brings to the text, as for example hermeneutic 'reception theory' in literary criticism suggests (Eagleton 1983 p74-90, Polkinghorne 1988 p96-99), then some form of analyst's (reflexive) autobiography should perhaps also be included in the text (cf. Söderqvist 1991)[2].

Interpretative Repertoires: Warrants

Once we have justified 'seeing' variability, then it seems reasonable enough to attempt to impute pattern to it. In relation to ethnography for instance, Ward and Werner (1984) talk of the identification of difference and dissonance as opening 'epistemological windows' leading to a more fundamental level of analysis in which discrepancies become resolved.

It is arguably the case that the imputation of pattern via the identification of repertoires shares the problems identified in 'Variability' above, but this time in terms of seeing or warranting pattern at a meta-level, instead of imputing variability at the first level.

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[2] I have attempted in Part One to give a brief account of my own interests and background.

How is it then that the textual material can be warrantably differentiated into discrete repertoires? For example at precisely what point does one cut into the text with the analytic scalpel? How often does a pattern of words, tropes, etc have to be seen in use in order for it to be adjudged a repertoire? Can one continue to break down a repertoire into sub-repertoires and at what point should one stop? These kinds of questions must be addressed in the process of identification of variability, repertoire and function.

Because at the time of writing there is no detailed and lengthy elaboration of a research project available which shows how these questions are answered, my discussions below must have recourse to arguments presented in short papers[3].

In their 1988 paper Wetherell and Potter offer three prime warrants for the definitions of the examples of repertoires furnished in their text (p178):

> What grounds have we for defining three different interpretative repertoires (here)? In this analysis we used three central kinds of evidence for this. Firstly, as we will show, there are inconsistencies - noticeable to *both* analysts and participants - between the different forms of account. Secondly, these forms of account are generally separated into different passages of talk so that inconsistencies do not become a problem for participants to deal with. Thirdly, on these occasions when the different repertoires *are* deployed together, participants display in their talk an orientation to the potential inconsistencies, or the variation is organised for different functions - one repertoire presented for disclaiming, for example.

The warrants presented here can be read as ex post facto supports. First they suggest there are inconsistencies

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[3] Gilbert and Mulkay's (1984) study of scientists' interpretative repertoires also fails to address these issues fully.

(variability) between the different forms of account which are noticeable to *both* analysts and participants. However they fail to note the extent to which this occurred, or what their position might be if this does not occur. That is, if the inconsistencies are *only* noticed by the researcher, then to what extent should they still count as valid pointers to repertoires?

Secondly, they suggest that different forms of account (i.e. repertoires) 'are generally separated into different passages of talk so that inconsistencies do not become a problem for participants to deal with.' But uncharitably one might say that if inconsistencies are not a problem for respondents to deal with because they are kept separate, then how is it that we can say respondents 'notice' inconsistencies? If 'notice' means the use of a meta-comment then this would only serve to draw attention to an inconsistency *as* a problem. The analysts' ability to locate competing accounts in different parts of the text does not in itself mean that such variability has been noticed by respondents.

Finally Wetherell and Potter tell us that when 'different repertoires *are* deployed together, participants display in their talk an orientation to the potential inconsistencies, or the variation is organised for different functions - one repertoire presented for disclaiming, for example' (ibid). This warrant, however, like the two above, presupposes the prior identification of repertoires. However it is possible to read it in two ways. First, that disclaimers (and other reflexive displays) can be used in a deductive fashion as a test of the validity of previously identified repertoires. In other words, that once identified, the validity of repertoires may be judged by the way they are 'managed'. Or second, that repertoires may be identified *via*, amongst other things, the prior

identification of the rhetorical trope, prolepsis, which is what the authors suggest elsewhere (Potter and Wetherell 1987, Wetherell and Potter 1988 p172). However if the latter is the case then it may seem unreasonable to use the same prolepsis as a test for validity. In other words there is a potential contradiction between these two readings, which *both* appear to be advocated by the authors (but which are kept separate in different parts of their texts!).

These proposed warrants only rather weakly answer the question of how it is that one set of 'terms, descriptions and commonplaces' may be initially preferred by the analyst to another, in order to resolve the 'problem' of variability. As I suggest below I think this is inevitably a complex hermeneutic *process* involving function, repertoire and variability.

And indeed Potter and Wetherell do talk about the long and complicated procedure of following hunches and testing out ideas. For example in their 1987 work, while they begin by arguing that coding, which functions to 'squeeze an unwieldy body of discourse into manageable chunks' (p167), is 'quite distinct from doing analysis itself', a few lines later they acknowledge that on occasion the process may be 'a cyclical one, moving between analysis and coding' (ibid).

Interpretative Repertoires: Two Approaches

The analysis of problems concerning interpretative repertoires may be extended by the comparison of two papers. In Potter and Reicher (1987) and Wetherell and Potter (1988) we find what appear to be arguably two different approaches to the definition and naming of interpretative repertoires.

In the 1987 paper Potter and Reicher set out to examine the range, features (p27), facets (p27) and themes (p27) of what is called the 'community' repertoire, in the context of the aftermath of the 'St Paul's riot', with a particular focus upon the way conflict is represented in talk and text. This repertoire is given its name by a process of analytic fiat which appears to have taken place before the analysis. In this case 'The entire body of transcript and copies of newspaper articles were read and all instances of the terms community, communities and communal were noted' (p27). In other words the authors set out to provide empirical support for their idea that there is such a thing as a 'community repertoire' organised around the lexical items 'community, communities and communal' which is used differentially in different argumentative contexts. Note here that there is said to be only one repertoire defined as a range of terms, tropes, etc, from which people 'selectively deploy' (p38) parts, thus:

> Overall, then, two opposing ways of representing and evaluating the role of the police and the nature of conflict have been described. In each case, the same linguistic repertoire is drawn upon - that of community. But the repertoire is deployed in such a manner that the evaluative implications are markedly different. That is, different selections are made from the various lexical items and tropes in the repertoire to formulate actions and events in contrasting ways. It is important to emphasise again that the repertoire is a set of *available* resources - we are not suggesting that the entire repertoire will be somehow present in every use of 'community'. (p37)

In this analysis the notion of 'community' is demonstrated to be generally positively evaluated - as demonstrated by a list of sample predicates - but its differential thematic and grammatical usage is shown to have variable consequences.

In the 1988 paper on the other hand, the identification and labelling of the repertoires, also concerned with racial discrimination but in the context of New Zealand culture, is portrayed as taking place after or during the analysis. Here coding does not alight simply upon references to 'Maori', in the pursuit of the range of the 'Maori repertoire', but instead upon discourse topics, thus:

> The first goal in a study of this kind is to perform some preliminary coding and thus sift out a manageable subset of data from hundreds of pages of transcript. We selected out from the interviews all passages of talk relating to our topic of models of 'race' relations. This included all material relating to the respective places of Maori and European culture in New Zealand - issues such as integration versus separate development or assimilation, the teaching of Maori language, reactions to attempts at a renaissance in Maori culture and so on. (p177)

The analysis in this short paper yields an identification of three 'dominant repertoires', which the authors, following their analysis, labelled 'culture fostering', 'pragmatic realism' and 'togetherness'.

Now it is arguably the case that although the repertoires identified above in the 1987 and 1988 papers were arrived at in a different manner via different coding methods and with arguably different labelling techniques, they do in fact share something in common. This commonality is given by the definition of the repertoire as a 'limited number of lexical items' which make up a set. The items in the set of each repertoire can be seen to have a family resemblance (Bloor 1983, Sacks 1974) according to their conventional social use.

Thus, in relation to the 'community' repertoire, as noted above, community is defined and used in different ways by different people but is given, in its use, an overwhelmingly

positive evaluation. The predicates 'friendly', 'warm', 'happy', 'harmonious', are all seen as being part of the same family of 'positive connotation'. 'Community' is by all accounts a good thing. 'Culture fostering' for example, in the later paper, while having different 'facets', has a consistent theme of 'advocating multiculturalist social policy and the importance of Maori culture for New Zealand society' (1988 p178). In other words there is an overarching sense of *coherence* to an interpretative repertoire as described above. But where then we may ask, is *variability* in the 'community' study?

In the 'community' study, variability is located in the way 'community' is related to different 'facets' and 'themes' (p27-28), such as the theme of the temporal existence of community. Varying the temporal accent then changes the impact of the use of the community repertoire. In addition, variability is located in differences in syntax as for example in their identification of the putative nominalization 'community relations' (p32), whereby a description of action is turned into noun form thereby obscuring agency (see also Wetherell and Potter 1989 as well as Kress and Hodge 1979, Seidel 1985, Thompson 1984, Fairclough 1989).

In the 1988 paper on the other hand variability is depicted as occurring in, is located in, the usage of different repertoires themselves, and their juxtapositions and combinations. Indeed in this later paper the repertoires are conceived of as 'constituted out of a restricted range of terms used in specific stylistic and grammatical fashion'. On this definition the use of a nominalization around the word community, such as 'community relations' in the 1987 work (p32), should have constituted a separate repertoire.

This brief examination of coding, analysis and naming of repertoires suggests that methodologically this process is, to a degree at least, an open one, and one that is perhaps still in the process of being clearly articulated. Probably the most extensive account of the method of analysis is to be found in Potter and Wetherell (1987). Here coding is depicted as being 'quite distinct from' the analysis itself. The point of coding as in the 1988 paper is to 'squeeze an unwieldy body of discourse into manageable chunks' (1987 p167). However while the authors suggest that on occasions coding might be straightforward, as in the Potter and Reicher study, they do allow that at other times 'the phenomenon of interest may not become clear until some analysis has taken place and a number of attempts at theoretical interpretation of the data. In these cases, as noted above, the process will be a cyclical one of moving between analysis and coding' and the authors give the New Zealand study as such an example (p167).

In relation to my own study, the *anticipation* of potential repertoires has derived from a number of different stages in the research. It must be remembered that a participant-observation study took place over a long period of time; that I had interviewed respondents and corrected transcripts and so on. Ideas were being formulated at quite an early stage and have been honed down or elaborated over time, and in the preparation of discussion papers and presentations. However in apparent contrast to the account of the 'community repertoire' by Potter and Reicher, the full range of potential repertoires was not readily apparent to me before beginning the research project.

Interpretative Repertoires: Status

A further potential problem with interpretative repertoires concerns the relationship between their analytic and ontological status. According to Potter and Wetherell (1987) the interpretative repertoire is seen as an analytic tool, a 'summary unit' (Wetherell and Potter 1988 p172) which is useful principally in lending form to, or conceptually organising, the apparent variability of accounts. This analytic device then in turn facilitates the hypothesising of different discursive functions. So far so good. This elucidation of function 'is one of the endpoints of discourse analysis' (ibid p170).

Yet at the same time interpretative repertoires are characterised as having some kind of real existence which appears to be independent of their analytic function. In other words Potter and Wetherell portray interpretative repertoires as having quasi-independence, as being existentially available in some fashion for people to draw upon. Witness their use of the metaphor of 'building blocks' in describing repertoires (Wetherell and Potter 1988 p172).

In their 1987 paper Potter and Reicher talk of the (community) repertoire as a 'pre-existing interpretative resource', and 'The concept of repertoire is an initial attempt at characterising certain pre-existing organisations of discourse' (p38). It appears to be in this sense that a further end-point of the analysis is justified: the identification of the range of interpretative repertoires available for use. The problem then is that if such repertoires constitute an analytic tool on the way to the explication and elucidation of discourse function, it may be difficult to see how they can also constitute an end-product, a result, of the analysis.

This has implications for the organisation of this research document as well as the internal coherence of the methodology, for if repertoires are an end-product then they might best be positioned at the end of the research text, in the way that results might come after analysis. However if they constitute an analytic tool, then one would expect interpretative repertoires to appear towards the middle but before the explication of function.

This problem may be tackled in a similar manner to that of 'variability' discussed above. As noted above it is clearly possible to 'find' all kinds of sets or registers of terms, descriptions and commonplaces, according to the researcher's interests at the time. The text can inevitably be parcelled up in a host of ways[4]. Now it seems quite likely that while the identification of function may be based on the researcher's use of the analytic tool of interpretative repertoire, the identification of the latter may depend in turn upon some prior or simultaneous understanding of the functioning of particular parts of the text. As Culler (1985 p293) comments in his critique of Habermas, 'to understand sentences is to understand how they might function in purposive activity'.

And it is in this way that the above 'problem' might be solved, for methodologically it is arguably the case that the 'identification' in the text of variability, repertoires and functions all proceed apace in a way in which all are mutually informing. Where the analyst may be struck for example on one occasion by a contrast or seeming contradiction, out of which one may designate repertoires and functions, another tract of text may promote the initial sense that something of interest is being done discursively (i.e. that the text is functioning

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[4] Yet, following Eco (1992) for example, one may argue that there are *limits* to the interpretation of texts.

in an interesting fashion), which may in turn lead to the elaboration of repertoires, and so forth (cf. Potter and Wetherell 1987 p167).

Methodologically therefore the process of discourse analysis can best be seen as an hermeneutic process, as I have argued above. Existentially, the repertoires may be seen as instantiated in discourse, so that their 'existence' is 'virtual' and not independent of the practices which draw upon them. This is of course similar to Giddens (e.g. 1984) notion of 'structuration'.

To repeat the main point here, at the end of the day the endpoint of discourse analysis becomes the elaboration of *both* repertoire and function, with 'variability' taking a backseat as an analytic conceptual tool. Interpretative repertoires are then both an end-point of analysis as well as an analytic tool. However, alternative analytic schemes are not excluded as Potter points out. For example one may be more interested in exploring the kinds and range of discursive methods used to generate a factual account (cf. D.E. Smith 1978, Potter, Wetherell, Gill and Edwards 1990), rather than specifying repertoires.

Function

I have already touched above upon some of the problems with the authors' use of 'function', but a central issue remains; their general lack of clarity concerning the kinds of function that might be referred to.

Clearly there are many ways of using the term 'function'. How it is defined, as Mishler (1986 p108) argues, may reflect assumptions about relations between language and meaning.

Within the domain of linguistic theory, 'function' has a long history, as Halliday (1978 /1979 p47) points out. Writing from a position of interest in the social use of language, Halliday proposes a model of three major generalised functions[5], and the meaning of language is defined in terms of function. At the same time Halliday makes a distinction between function and use, with the latter understood in an informal multiplicitous everyday manner, and the former in terms of a discrete and well defined system (1978 p46, 187 and cf. Georges 1969 p319, 327). In other words we can regard 'function' in terms of local, variable and multiple use, or attempt a kind of meta-functional classification.

In his model of communication, Jacobson (1960) described six functions that messages can perform: the referential, the emotive, the conative (to move to action), the phatic (to express sociability), the metalingual, and the poetic (the message as center of attention). For Jacobson the meaning of a transaction between sender and receiver resides in the total act of communication and not solely in the message itself (Polkinghorne 1988 p34).

And from speech act theory it is possible to see language functioning in terms of constatives, regulatives, expressives and so on (Austin 1962/1989, Searle 1975a), while in Habermas'(1979) universal pragmatic terms, functions can in a very general sense be said to relate to three different worlds in the raising of validity claims of normative rightness, sincerity and truth. In his *Theory of Communicative Action,*

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[5] The ideational (comprising the experiential and logical), the interpersonal (language as action), and the textual (language as a texture, in relation to the environment) (1978/9 p187). According to Mishler (1986 p77) the latter function refers to 'how parts of the text are internally connected through various syntactic and semantic devices.'

Habermas refers to the three general functions of language in terms of mutual understanding, social integration and the coordination of action, and socialization (1987a p137), which coincide with his understanding of the structures of the lifeworld[6].

In their 1988 paper, Wetherell and Potter appear to use the lexical items 'function', 'use', 'effect', 'purpose' and 'consequence' interchangeably, thus:

> Talk...can be analysed in terms of discursive functions and effects...(p170)
>
> Essentially, discourse analysis involves developing *hypotheses* about the purposes and consequences of language (p170)
>
> (In discourse analysis) the search for regular pattern (gives) way to the formation of hypotheses about that pattern of repertoire use (p177-8)

In effect however they appear to looking for functions which 'go beyond' (p170) the meaning immediately given by the text, thus:

> As we have seen, discourse does not usually come ready labelled with the functions neatly displayed on show, so that one kind of form is always an accusation, or always marks out a rationalisation, or always suggests consequences which we could describe as ideological in their effect.

Notwithstanding the important point that all discourse, spoken or textual, cannot fail, as Ricoeur (1981 p201) says, to be about something (apart from the few sophisticated texts 'where the play of signifiers breaks away from the signified' ibid),

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[6] For commentary upon the relation between the structures of the lifeworld and Habermas' three world concepts, see p138 above, note 6.

it seems fairly clear here that in spite of their bid to stay with the words on the page, Wetherell and Potter also enjoin us to deviate from this path in the definition of function.

In their 1988 analysis of putative functions of the repertoires outlined above, Wetherell and Potter are clearly inclined towards a speculative assessment of the implications of differential repertoire use for the maintenance of relations of domination, that is, the structured relational inequalities of power between Maori and European people. I suggest that as it stands this approach is incomplete. The reason is that in order to present the repertoire use in this fashion the authors must make use of a prior (or simultaneous) understanding of the particular relations of power at issue. In other words because they already know that discrimination occurs, they can therefore hypothesise about function in the way they do. Alternatively, in the absence of a prior understanding the authors might be said to be building an argument *de novo*, but this may lack persuasion.

As I have shown, the authors do note that the kind of functions they are interested in do not come complete with labels identifying them as such (1988 p170). Discrimination/domination in the form of perlocutionary action, or concealed strategic action in Habermas' (1979, 1984) terms, cannot easily be read off from the text in any simple fashion. And even for open strategic action (eg 'A woman's place is at the sink'; or in the context of this project 'A patient's place is in the hospital') to be understood as discriminatory, one already has to have some awareness of discrimination/domination as an issue; there must arguably already be at least the possibility of a meta-discourse concerning domination. And of course in addition the identification of discourse function in no way explains *why* kinds of talk occur in the way they do.

This absence of any critical socio-historical analysis of structures of domination in their work (although to be sure there is scarce room for this in short papers) therefore arguably detracts from their analyses by leaving their interpretations of function ungrounded (cf. Thompson 1984, 1987, 1990).

In this research project I have attempted to integrate a discourse analytic perspective with an historical analysis and a participant-observation study which is framed by the theoretical orientation of time-geography[7]. In the analysis of discourse I have used the term 'function' in a similar wide-ranging way to that of Potter and Wetherell, but have also drawn upon the work of Habermas (1979, 1984) and Billig et al (1988) in attempting to understand the social meaning of the use (function) of interpretative repertoires. By locating the analysis of function within a formal pragmatic framework I have configured talk as thematising 'validity claims' which could be argued out further in a 'discourse' or 'critique' in which reasons are offered and evaluated (Habermas 1984 p42. See also ch 5 above).

Conclusion

In the above pages I have addressed some practical problems with this particular version of discourse analysis. I have portrayed it, much like my earlier view of ethnography, as an ongoing (critical) hermeneutic process[8]. In this manner,

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[7] Elsewhere (Southgate 1992b) I have addressed the relationship between village and hospital, and attempted to reframe the dilemmas of villagers, in terms of Habermas' analysis of lifeworld and system.

[8] This is 'hermeneutic' in a double sense; first it refers to the 'circular' process in which repertoires etc may be identified from the text, and second, it refers to the way that the text itself is

ethnography and discourse analysis can be brought into methodological line (cf. the view of ethnography of Ward and Warner 1984), rather than being portrayed as competing research orientations as in Potter and Wetherell (1987).

However the critic may well ask about the point or coherence of portraying discourse analysis as a separate method from ethnography if the two are 'really' similar. The answer is that discourse analysis does have something extra to offer if not always for the reasons provided by Potter and Wetherell. While both may be hermeneutic endeavours, the close analysis of interview (and other) transcripts allows more readily for the illumination of the argumentative nature of the provision of facts, opinions, feelings etc; emphasises the way that language has more than a referential function; may enable a greater reflexivity in that a part of the researcher's work can be openly displayed to the reader; and provides for a preliminary specification of often subtle aspects of discourse which may be tentatively configured as discriminatory.

On the other hand the *theoretical* presentation of ethnography may easily be divorced from its *textual* presentation, so that what is given as theoretically interpretative or dialogic may turn in the text into a realist tale. This can then be counterposed to the more explicitly rhetorical analysis of

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an outcome of a joint effort involving researcher and interviewee. I have left to one side for the moment the way other factors impinge upon the text and its interpretation. In addition one question which may be raised concerns the status of repertoires as 'artifacts' or 'analysts' constructs'. I have discussed this above to some extent. But my general position, which I have explicitly articulated in Part One, is that we have no unmediated access to reality (*pace* conversation analysts, and cf. Atkinson 1987 p460), and that the objects sociologists present to their readers are *always* in some way jointly constructed. This does not mean however that we should not be oriented to the 'truth', and the discourse-analytic perspective has the advantage that its workings can be inspected by the reader.

discourse which illuminates the ways that this resultant reality comes into argumentative being, so that the two textual orientations may be seen in counterpoint to compliment each other (see ch 6 above especially p130 *ff*).

This leaves me with the issue of how the process of discourse analysis, which has involved the reading and re-reading of texts and the refining of ideas over a long period of time, might be telescoped into comparatively few pages in this text. To this end I have adopted two methods. In chapter 14 below I introduce the range of repertoires which I argue is 'discoverable' in the text. I then work through the processes of discovery in order to show how my preliminary ideas about repertoires and function were amended and refined, and the anomalies and interpretative difficulties encountered along the way (cf. Bloor 1978).

In relation to what Bloor (1978 p547) has called 'the hoary old problem of drawing the correct inference from all the competing inferences that could be drawn from one's data', I have suggested that the discourse analytic method advocates the presentation of detailed transcripts to the reader in a way which may not always be done in for example an ethnographic or participant-observation study[9]. This does not however solve the problem of the possible accusation of 'verificationism'. Unfortunately it appears that the only way around this is either to become an explicit falsificationist or to present all the material for inspection by the reader. Neither is a viable option here.

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[9] Although it may be said that the detail provided here is not as fine as that found in 'conversation analysis' transcriptions; nor is this kind of detail *necessarily* excluded from ethnographic studies.

Yet the hypothetico-deductive approach is clearly not without its own problems. In this respect it may be worth quoting Peirce: '...All the ideas of science come to it by the way of abduction. Abduction consists in studying facts and devising a theory to explain them. Its only justification is that if we are ever to understand things at all, it must be this way.' (quoted in Hanson 1958 p85)[10]. And in Hanson's words: 'The H-D account tells us what happens after the physicist has caught his hypothesis; but it might be argued that the ingenuity, tenacity, imagination and conceptual boldness which has marked physics since Galileo shows itself more clearly in hypothesis-catching than in the deductive elaboration of caught hypotheses' (1958 p72).

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[10] I might like to amend this in the following manner: 'Abduction consists in studying implicitly theorised facts and devising an explicit (and perhaps different) theory to explain them.' In a recent book Thomas Joel Scheff (1990 e.g. p31) commends Peirce's concept of abduction as an analytic method for understanding meanings in context.

Chapter 12

Prolepsis and Dilemmas

The present chapter sets out to describe and develop the themes 'prolepsis' and 'dilemma', in anticipation of their central analytic importance in chapter 14 below.

Prolepsis

The analysis of variability, function, and interpretative repertoires may be aided by the results of previous work which has shown how particular rhetorical tropes or schemes may be implicated in their constitution and management. A number of studies of racial discrimination have for instance shown how such figures of speech are used to mitigate potential accusations of racism (van Dijk 1984, Cochrane and Billig 1984, Billig et al 1988, Potter and Wetherell 1987, Wetherell and Potter 1988, 1989). One central device is known within the tradition of rhetoric as 'procatalepsis[1]' (Nash 1989 p180), or in shortened form 'prolepsis'; the anticipation of objection, complaint or accusation, which has come to be known in social science as a 'disclaimer' (Hewitt and Stokes 1975, Billig 1987).

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[1] Etymology: *pro, Gk*, before in time or position, *katalepsis, Gk*, a seizing, from *kata*, down, and *lambanein*, to take or grasp. Thus: 'to seize before'. Interestingly 'Catatonia' is a (now rarely used) term in psychiatry to describe the rigid posturing of patients, and 'Catalepsy' is a term used in neuropharmacology to refer to rigidity in rats. 'Prolepsis' has a similar derivation: *pro* + *lambanein*.

There are many ways to do a proleptic manoeuvre. A principal feature of a prolepsis is the combination of a position on a topic (e.g. "I'm not against the patients") with a reflexively linked comment ("but I don't think they should be allowed out at night"). The two parts to the manoeuvre react upon each other, and the speaker can be seen to be commenting upon his or her own comments. This reflexivity may be implicit as in the example above, or explicitly and immediately meta-discursive as in "I don't like to say this, but..." (Schiffrin 1980). Very often the link is made by the use of a strategically placed 'but', although (!) this is not always the case.

The scheme of Hewitt and Stokes has been expanded by McLaughlin (1984), following Mura (1983) and Brown and Levinson (1978/1990), to specifically include anticipation of complaints over potential alleged infringements of Grice's Cooperative Principle[2]. For example the reflexive comments "...to tell the truth..." , and "...that's just a guess...", which modify another discursive item, tell others that in spite of any appearances to the contrary, the speaker is actually orienting to the maxim of quality; is concerned, that is, with being truthful. McLaughlin terms these 'licenses'[3].

McLaughlin has coined the term 'Preventatives' to incorporate both disclaimers and licenses as outlined above. Thus 'Preventatives ... are disclaimers and licenses aimed at protecting the author of a potentially troublesome speech act from negative characterization of him as an unthinking,

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[2] 'Make your conversational contribution such as is required, at the stage at which it occurs, by the accepted purpose or direction of the talk exchange in which you are engaged.'

[3] Compare Habermas on 'avowals', the paradigmatic speech act form of the validity claim of sincerity as in "I must confess to you that..." (1979 p57-8).

irrational, or irresponsible member of society and/or as an incompetent communicator who either doesn't know the rules or doesn't care about them' (1984 p207). While preventatives may then be seen as devices of impression management (e.g. Goffman 1959) it is clear that they also suggest other functions of language as I argue below. In contrast to McLaughlin I shall continue using the word prolepsis to cover all preventatives for the reason that the concept 'preventatives' unduly limits the pragmatic and rhetorical implications of such manoeuvres.

Pace McLaughlin I suggest that the use of a proleptic manoeuvre serves to implicate several potential discourse functions. For it is not simply that the 'rules' remain as an unproblematic backdrop against which the actor must adjust his or her discursive garb, as McLaughlin's dramaturgical definition implies, but that the backdrop itself may also be spotlighted in the process as something potentially in need of repair.

This matter may be addressed from the perspective of Habermas' theory of communicative action and universal pragmatics. Habermas has extended the concepts of rationality and social action beyond the dramaturgical. Following Habermas (1979, 1984) we can say that in every instance of communication a number of universal validity claims (reciprocal demands) come into play, although often only one is thematic. Language is seen here as the medium which interrelates three 'worlds': the 'objective' world of existing states of affairs and facts, the world of normatively regulated social relations, and the inner 'subjective' world of the speaker's intentional experiences (Roderick 1986 p96 and see chapter 5 above). For Habermas, in the process of reaching understanding and coordinating action via communication, we cannot avoid raising the validity claims of comprehensibility, truth, normative rightness and sincerity (Habermas 1979 p2).

From this view, therefore, dramaturgy is seen as a limited account of social action. While a proleptic manoeuvre can be seen to have impression management effects, it may also serve for example to throw light upon, to comment upon, the world of social relations, of normative rightness. Indeed we can say that a prolepsis may act as a spotlight which highlights or points to particular validity claims concerning several worlds which are problematic and indicating controversy, ambivalence and dilemma (Billig et al 1988, Schiffrin 1980).

In everyday life when a problem in communication arises, then any or all of these claims may be thematised, that is, action may switch to argumentative speech and the discursive examination of problematic validity claims (Habermas 1979 p4, 1984 p42[4]). In terms of normative rightness, validity claims may be thematised at two levels: a) the justification of action by reference to established norms and b) the thematisation of the background consensus itself. What the proleptic manoeuvre can be said to achieve is to point the way to those claims which are arguably shaky and problematic. It points to a potential problem in the background consensus.

However Habermas further points out that while talk oriented to communication raises the whole range of validity claims, only the claims to truth and normative rightness may be discursively redeemed. That is, the dramaturgic aspect of sincerity may only be redeemed in action. I am judged to be

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[4] His 1979 account of the thematisation of problematic validity claims as 'discourse' gave way in his 1984 (p42) work to reference to 'discourse' and 'critique': The latter is to be used '...when arguments are employed in situations in which participants need not *presuppose* that the conditions for speech free of external and internal constraints are fulfilled.' 'Discourse' is to be used when participants can suppose (via the conceptual force of the meaning of the problematic validity claim) that a rationally motivated agreement could be achieved in principle.

sincere by my actions, but judgements of truth or normative rightness spring from justifications and warrants in discourse.

Thus the proleptic manoeuvre may act both to uphold and challenge claims to normative rightness (and truth) as in the following extract taken from van Dijk (1984 p65, and quoted in Billig et al 1988 p108) in his research into racial discourse:

> I have nothing against foreigners.
> But their attitude, their aggression is scaring.
> We are no longer free here. You have to be careful.

The two parts can be said to co-exist in uneasy tension, while the whole acts to both uphold anti-racist normative rightness and at the same time to undermine and challenge it. A prolepsis then, at one and the same time, both anticipates and attempts to block criticism and the thematisation of validity claims while also inviting precisely such thematisation.

Billig et al (1988) have characterised this kind of talk as dilemmatic (see below). The authors criticize van Dijk (1984) for portraying such talk as a conflict between the interviewee's *real* attitude and their desire to create a favourable *impression* upon the interviewer (p108). By contrast Billig et al argue:

> One must ask why respondents assumed that the utterance of racist comments would make such a bad impression. Evidence suggests that the respondents were not paying lip-service to norms of politeness, which were foreign to themselves but which they knew the interviewer held. Instead, these were norms which they themselves shared. (p109)

In other words the real meaning of a prolepsis is said to lie less with 'I don't want you to think I'm prejudiced because I don't want you to think badly of me' than with 'I don't want

you to think I'm prejudiced because I think it's wrong to be prejudiced'. For Billig et al, the prolepsis signals dilemmatic thought, a kind of dual or rhetorical consciousness. We may ask however what kind of evidence supports this assertion. Billig et al, for example, argue that studies which catch respondents talking relaxedly amongst themselves suggest that this ambivalence or two-handedness[5] is still present (ibid p109). Nevertheless we cannot easily dismiss out of hand the notion that people do try to impress others, and say what they think others want them to say; and that in the everyday world people do continually try to persuade others to say what they want them to say. My argument here is that the kind of extension of the action framework proposed by Habermas allows us more easily to see that in spite of a person's intentions, their talk has normative as well as truth-related and dramaturgic implications and that all may be highlighted by the proleptic manoeuvre. In this sense the framework provided by Habermas lends some theoretical support to the position of Billig et al. It may then be possible to imagine, in a situation in which there is sufficient freedom for relatively unrestrained discourse, the normative and truth components being further thematised and debated.

On the one hand then the use of prolepsis itself constitutes 'reasonable prejudice' in the terms of Billig et al[6]. We see

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[5] We could perhaps say that Billig emphasises the 'two-handed', rather than the 'two-faced', nature of argument.

[6] Scambler (1989 p56) also speaks of 'reasonable' discrimination in relation to people with epilepsy; for example bans on driving trains, etc. This is rather different to Billig's notion of 'reasonable prejudice' in which the outcome is more a disguised prejudice, dressed in 'reasonable' terms, and thereby, for Billig, signalling dilemmatic thought. Much of Billig's work is to do with race, and the issues concerning discrimination are perhaps clearer or more fully debated there than in relation to people who are psychiatric patients. Wall (1986 p1262) has referred to this form of talk in relation to people with learning disabilities as a 'proxy for prejudice'.

how discourse may deplore, deny and at the same time *protect* prejudice. And in order to be reasonable, arguments have to be built and reasons proffered (and see Southgate 1992c). In this process 'reasonable prejudice' requires its unreasonably prejudiced and irrational Other (Billig et al 1988 p114-5, and see ch 14.8 below).

On the other hand, the use of prolepsis constitutes a moment in the pointing towards, the instantiation of, a window of opportunity by way of which debate can be further conducted, a debate about *whether* certain prejudice is *in fact* 'reasonable'. In other words the prolepsis signals dilemmatic thought, although the opposing themes which go to constitute the dilemma may not be equally balanced (ibid p144).

Thus these issues could in principle have been further pursued by those involved in the performative attitude within the interview world thereby 'deepening and radicalizing' (Habermas 1984 p130) the communicative context in a manner which is open to all 'social-scientific' laypeople[7].

At the same time, the degree to which we regard such a debate and agreement as rational will depend upon our understanding

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[7] There are limits to the extent to which issues can be pushed within interviews. We might say that the interactional fabric of the interview world may not be strong enough to contain the degree of pressure needed to substantially 'radicalize' its communicative context. Thus the opportunities for the kind of critical approach organised around the thematisation of validity claims *in situ*, provided for by Habermas' formal pragmatics, and oriented to the counterfactual reconstruction of generalizable interests, are also limited in the practice of interviews. But we can still of course engage with, and interrogate as it were, interview *transcripts*, which is what I attempt to do in this chapter, thereby identifying retrospectively some of the validity claims which appear problematic for respondents (and myself), and thereby further raising issues concerning discrimination and discourse, in a manner still oriented to Habermas' model (cf. Habermas 1976 p113).

of the structures of power within which participants will be located. In this manner Habermas' analysis of the relationship between system and lifeworld precisely addresses the socio-historical possibilities of rational agreement.

Dilemmas and Ideology

In their 1988 work, Billig, Condor, Edwards, Gane, Middleton and Radley have shown how it might be possible to configure the social meaning of interpretative repertoires in terms of their instantiation of competing 'ideological' themes and dilemmas. In this section I want to pursue the notion of ideological dilemma and consider its relevance for the present project and the social significance of interpretative repertoires.

From their concern with what they call 'liberal' or 'Enlightenment' ideology, the above authors locate the dilemmatic nature of this ideology in its reproduction 'as an incomplete set of contrary themes, which continually give rise to discussion, argumentation and debate' (p6). The philosophical concepts of liberalism are said to appear in everyday contemporary discourse, often with complex and contrary meanings (p4). Fundamentally, 'dilemma' and 'dilemmatic', which are used variously as predicates with 'common sense', 'situations', 'thinking', social beliefs', 'concepts', entail *contrary themes*, although one theme may be dominant in particular discourses (p144). These themes are often posed as ostensible opposites such as 'freedom v. constraint', 'internal constraint v. external constraint' and so forth. Such themes may, they suggest, be uncovered by the analysis of implicit meanings via a hermeneutic process: 'Discourse which seems to be arguing for one point may contain implicit meanings which could be made explicit to argue for the counter-point' (p23).

Thus for Billig et al 'The dilemmatic nature of ordinary thought might be said to reveal that people possess contrary linguistic repertoires for talking about their social lives (Potter and Wetherell 1987)' (1988 p143). There is still the problem however of what precisely constitutes contrasting themes[8]. 'Contrast' can mean many things. The authors suggest that the presence of contrary themes in discussions is revealed by the use of qualifications, so that 'The unqualified expression of one theme seems to call forth a counter-qualification in the name of the opposing theme' (p144).

To be sure the dilemmas posed here are complex. As Billig argues, if poles of each dilemma are equated with particular ideological positions, for example if the pole social order, control, authority and tradition are taken as central planks of conservative thought as for example in the work of Edmund Burke, they nonetheless arguably contain within themselves the seeds of their opposite. This dialectic can be presented in several ways. For example, from the position of the lived functional demands of liberal capitalism, order, security and discipline, while necessary elements in the maintenance of class society, may also act as constraints upon accumulation. As Stephen Spitzer (1987 p48) has observed:

> And if capitalism requires uncertainty for its development *as a system*, but individual actors and organizations need to reduce uncertainty to operate and profit, then security clearly stands in a complex and contradictory relationship to capitalist vitality and growth.

Or from a more abstract viewpoint, 'society', while not merely a sum of its parts, would simply not exist without its individual elements; while the individual in turn needs society

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[8] Compare this with the problem of identifying variability and interpretative repertoires discussed above.

and the social structures which constrain but also enable him or her to act.

The notion that ideologies are by no means univocal or consistent but contain, sometimes implicitly, opposing themes concerning for example issues of freedom and constraint, individual and society is not therefore exactly novel. Marxian theory is predicated upon real and lived contradictions wherein ideology is anchored. However the benefit of the account by Billig et al is their explicit attempt to link action and society, as the following gloss suggests:

> In contrast to the cognitive psychologists, we stress the *ideological* nature of thought; in contrasts to theorists of ideology, we stress the *thoughtful* nature of ideology (1988 p2)

And so in common with a number of other recent works (e.g. Donald and Hall 1986, Eagleton 1991, Thompson 1984, 1987, 1990 p8) ideology is seen here as a matter of discourse rather than language. To paraphrase Eagleton (1991 p9), ideology is less a matter of inherent linguistic properties, than a question of 'who is saying what to whom and for what purposes'. As he puts it:

> Ideology is a realm of contestation and negotiation, in which there is a constant busy traffic: meanings and values are stolen, transformed, appropriated across the frontiers of different classes and groups, surrendered, repossessed, reinflected. (1991 p101)

Stuart Hall (in Donald and Hall 1986) has argued for example that 'liberalism' itself has contained radically opposed strands such that Paine's radicalism and Burke's traditionalism were both premised upon the liberal principles of political

economy (p57), while the recurring contradiction[9] in liberal thought between liberty (freedom) and equality persists today (p41).

These authors also prefigure Billig et al in the way they discuss the process of thinking, so that like Billig et al, Donald and Hall argue that these political concepts and languages tend to flow through and structure our thought:

> We swing, in our actual thought, from 'liberal' to 'conservative' to 'collectivist' arguments as we move, episodically, from one area of thought or practice to another. We get a kick out of our ancient and revered institutions, believe fervently that every person must be free to maximise his or her self-interest, and see ourselves as responsible and 'caring' members of society - without experiencing much more than a tiny, involuntary hesitation as we shift gears through these conservative, liberal and social-welfarist discourses which consistently 'map out' political thought in British society. (1986 pxii)

The point to be made here is that while the dilemmas which villagers face in respect of people who are patients can be configured as local and discrete, they may nonetheless and at the same time also be patterned by wider social discourses. The interpretative repertoires which are displayed here arguably share in and recreate wider ideological dilemmas in Billig's terms. However it is one thing to portray talk as dilemmatic and another to read into this a fractured ideology, and there are passages in their book which methodologically seem very naive (e.g. Billig et al 1988 p3-4).

A further problem here lies in the way that the very dilemmatic nature of ideology takes on a neutral quality such that

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[9] An alternative view might recast 'contradiction' as a 'plurality' of ideals.

domination often appears to take a back seat as Spears (1989 p284) suggests. While the claim concerning the universal status of argumentation is well founded, Spears notes that:

> ...people's capacity to generate such dilemmas may also be related to the time and scope for such deliberation that their place in the order of things affords...In these terms it could be argued that it is precisely when the contradictions relating to unequal power relations are *not* articulated in 'ideological dilemmas' of people's everyday thinking, that 'ideology' in its critical sense is most evident. (p284 emphasis added)

This leads back to the old issue of reflexivity and the kind of question which asks how a theory of ideology may avoid the type of accusations which its own analysis raises. In this case perhaps we could say that the dilemma the authors face is between a sanitised view of ideology, or ideology as domination; or, to the extent that their own thought is also necessarily ideologically dilemmatic, whether it can remain coherent. The issue of the extent to which such a theory might be able to 'ground' itself could I suggest be tackled via the work of Habermas[10].

Another way of understanding some of these issues is to ask whether the 'dilemmatic' nature of people's responses to patients (and elsewhere for example to matters of race and gender) constitutes their 'real' position, or whether this dilemmatic mode itself constitutes a verbal smoke screen behind which people shelter other views, or a screen by which social science itself once more hides the 'real' issues. However, the point about a prolepsis is that while it no doubt shelters, it identifies itself as doing such sheltering. People *may* adopt

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[10] There is lacking here a sense in which ideology, as something people do, as grounded in the practices of ordinary people, connects up to the present day social structures, mechanisms and dynamics of our society. See note 7, p285 above.

this device strategically but at their own risk. Prolepsis points to problems.

In the following pages I refer to the dilemmatic quality of villagers' talk about people who are patients, a quality which I suggest is signalled by the rhetorical structures of their responses. It may also be the case that villagers' talk displays the same kinds of dilemmas which can be read into bourgeois-philosophies and I shall briefly consider this further below, although the 'ideological' nature of everyday dilemmas is not pursued here as a central theme.

Chapter 13

Interviews and Interviewees

Numbers

A total of 37 interviews were conducted with people who lived in Shenley village (32) and others (5) who had an interest in the village, such as the doctors of the local G.P. practice, present and former hospital staff and the manager of the Praetorian Housing Association. Most interviews took place during the years 1989 and 1990.

Of the 32 interviews with villagers, 27 were tape-recorded[1]. These recordings lasted up to 1½ hours in length. One person was interviewed and recorded on two occasions, the first on his own and the second together with a friend. On another occasion I realised over half way through the interview that the tape recorder had not been running.

One tape-recorded village resident was also employed at the time at the hospital. Five tape-recorded residents had previously worked at the hospital in capacities which included domestic (2), clerical, shop assistant, medical secretary and gardener (one person had held two different jobs). One tape-recorded resident had worked as a nurse in nearby Harperbury Hospital. Two other tape-recorded village residents were actively involved with the Shenley Hospital League of Friends.

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[1] From the perspective of Wetherell and Potter (e.g. 1988 p173) this constitutes a substantial sample.

A number of the recorded interviews with villagers (8) involved more than one interviewee, so that the total number of villagers involved in the recorded interviews was 34, bringing the total number of villagers interviewed to 39.

Excluding interviews with people who were Shenley Hospital patients or former patients[2], altogether 30 interviews were tape-recorded (27 villagers, 3 others). These recordings were completely transcribed. Constraints of time allowed 20 of these transcriptions to be corrected and analysed in detail. The remainder were then partially corrected and analysed according to a refined analytic focus. Of the 34 tape-recorded village residents, 14 were male and 21 female. The large majority were over 42 years of age (0-21:4, 22-31:1, 32-41:3, 42-51:8, 52-

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[2] I also conducted interviews with 27 people (17 men and 10 women) who were patients or former patients. The 'former patients' interviewed (9) lived in the Praetorian Housing Association houses on the edge of the village. Of this latter group, most had been patients in Shenley Hospital, with one exception. These people were interviewed either on their hospital ward, or at their house. On one occasion I interviewed a group of three men together, and on another I interviewed two women together. The remainder of the interviews were conducted with individuals. Thus 24 interviews were conducted. On the majority of occasions (17) I tape-recorded the interview. For the rest I made detailed notes wherever possible. One person refused to speak to me at all after I had begun the interview and he is not included in the figures. The age distribution was as follows: 32-41:3, 42-51:6, 52-61:8, 62-71:8, 72+:2. These patients were identified for me by hospital staff and villagers as being people who were known to go into the village and make use of some of its facilities. In order to interview patients on the hospital ward I had to secure Parkside Health Authority Ethics Committee approval. I also agreed to use a consent form. This was a useful exercise on at least one occasion when someone whom I had finally persuaded to talk to me was able to use his reluctance to sign the consent form to avoid being interviewed. See Appendix D for patients' voices.

61:5, 62-71:8, 72+:5)[3].

The detailed transcription of tape-recordings is a formidable affair which is extremely time consuming. Following transcription, the texts needed to be corrected and I also included in the first 20 texts the fine detail of hesitations, overlaps, etc which had not initially been incorporated[4].

Coding and Topics

I have already argued that coding has constituted a process in which themes have become progressively modified and refined by way of a continual shuffle between coding and analysis, a continual process of testing and 'theoretical' elaboration in which the definition of repertoires and their functions has

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[3] These details are included only for the information of readers. It is not my aim in the following pages to compare the responses of men with those of women, young with old etc, nor to suggest that one 'group' or person is more tolerant or intolerant than another. Indeed my argument is that it is often difficult to characterise individual respondents as *unambiguously* or explicitly prejudiced from their talk, which within the interview world displays variability, ambivalence and dilemma. Rather than attributing prejudice to individuals I have attempted to highlight some dilemmas which villagers appear to share, together with the functions of particular kinds of talk. However at times of course we may wish to explicitly characterise individuals as holding strong views (cf. Billig 1989) or as being prejudiced. In which case we also build arguments based upon a range of reasons and evidence, both discursive and extra-discursive, and on occasions I have referred to certain patterns of talk as prejudiced.

[4] Transcription conventions in relation to tape-recorded interviews are to be found in Appendix A. Unfortunately first transcriptions were made using a type-writer rather than a word-processor, and I later decided to use a scanner to import the material into my computer using the Omnipage programme. This process was further complicated by the fact that the Hatfield Polytechnic scanner was linked up to a Macintosh system, which was incompatible with my own, thus requiring further translation of computerised data.

been open to revision. In terms of the philosophy of science this has perhaps as much or more in common with Kuhnian hermeneutics, Peirce's 'abduction', or Hanson's (1958) elaboration of 'retroduction' as it has Popper's deduction and falsificationism (and see Bulmer 1979 for a discussion), while within sociology in this sense its procedures are congruent with those of participant observation and also have some loose affinity with 'analytic induction' (see Hammersley 1989, Hammersley and Atkinson 1983, Bloor 1978), and stand close to the 'constant comparative method' of Strauss (1987).

All interview transcripts were read and in the first 20 interviews all references to 'patients', 'mental disorder' and their synonyms (e.g. 'them'; 'mental illness') were coded. In addition the texts were extensively marked according to a large range of other categories of interest which included 'metaphor', 'history', 'blame', 'argument', 'contradiction', amongst others. Following an initial and preliminary analysis of these interviews, the coding focus in the rest of the interviews was narrowed to include, in particular, 'stories' told in relation to patients[5]; text relating to stigma and discrimination in general terms; and potentially controversial topic areas.

Topics and related discourse have included a) the hypothesised siting of a psychiatric hostel next door to the interviewee, b) the closure of psychiatric hospitals in general and Shenley Hospital in particular, c) the topic of patients' freedom within the village, and d) the question of whether patients can

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[5] One possibility I have not pursued is the separate analysis of respondents' stories about patients. However a particular story provides a focus for my paper presented at the BSA Annual Conference (Southgate 1991).

or should be able, and be allowed, to join in local activities such as clubs and societies. These questions were included in the interview schedule in order to attempt to stimulate debate but also in part because of their intrinsic interest. I wanted to see how people would respond, whether they would adopt rigid and defensive positions or whether respondents' talk would illustrate more than stereotypical responses.

These are not, however, the only topics to generate debate. Indeed in the interview setting and guided by a loosely structured interview schedule, it became virtually impossible to suppress discussion and argument. Sometimes the debate was carried out between the parties present on those occasions when there was more than one interviewee. And on other occasions it became clear that a single interviewee was engaged in the expression of what appeared to be an internal debate. At other times the discussion took place principally between the interviewer and the subject. The topics of debate in fact varied widely.

Nevertheless the particular topics upon which I attempted to focus do smack of contention and again my understanding or presupposition of this fact is symptomatic of the way that social research relies upon often unarticulated and taken for granted assumptions (Garfinkel 1967, Warnke 1987 p77). And in this way social research can be seen to constitute the outcome of an interrogation of both the culturally located author and his subjects, by the author, in conjunction with his or her subjects (Hammersley 1990 p9).

In the following pages I have tended to draw upon interviews with couples because this has often better exemplified the argumentative flow.

Respondents

The proper names of interviewees have been changed to maintain anonymity. In addition I have made minor adjustments to occupational details and ages where it seemed that explicit and precise description would render identities transparent. Where respondents have been residents in the village I have indicated the length of such residence.

However where names have appeared in publicly available documents such as newspaper articles or Parish Council minutes, I have not changed them[6].

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[6] To my deep regret two villagers died following my interviews with them (not, I hope, a case of *post hoc ergo propter hoc*). Another person whom I had interviewed and who in various ways had been very helpful to me in my research endeavours suffered a bereavement and shortly afterwards left the village. Yet another interviewee, a former patient, was knocked down by a car and killed.

Chapter 14

Arguing About Madness

1: Interpretative Repertoires: A Preview

In this chapter I show how I came to identify a range of interpretative repertoires which refer to the relationship between residents of the villager and people who are patients and former patients, and I hypothesise about the functions the use of such repertoires perform. In addition I consider the discursive means whereby villagers account for 'telling the difference' between patients and others, and also provide an analysis of what I have called 'Balancing Devices', by means of which villagers shrink the discursive distance between themselves and patients.

The two central repertoires recounted here have been named 'Own Interests' and 'Humanist Concern'. I suggest that these may each be regarded as possessing two parts which I later elaborate[1]. The other repertoires which I have identified have been named 'Relative Balance' and 'Local Identity'. As analytic tools the configuration of such repertoires enables us to lend some structure to the analysis of function within interview talk. As 'virtual' entities they may be read as resources which villagers draw upon in arguing a case within the interview world. But at the same time they rely for their 'survival' upon being used.

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[1] In the process I occasionally talk of 'themes' when referring to repertoires and their parts.

The number of repertoires identified here was not pre-ordained. It may have been possible to have written of just one 'Patients' repertoire with many parts, but in its generality something would have been lost. And unlike the 'Community' repertoire of Potter and Reicher discussed above, the meanings which attach to 'Patients' within interview transcripts are variable as I shall show.

It may be possible to further break down the repertoires depicted here into more parts. The reader may well read other patterns into the texts[2]. Yet arguably there is a limit to the kinds of repertoires which would be acceptably identified in this context (a thesis) and within the framework of this kind of discourse analysis. For example, to identify a repertoire as consisting of the sequence 'and the', simply because this sequence reappears regularly in the texts, would not be an acceptable version of a repertoire relating to patients and villagers. But at the same time 'acceptability' is itself something which has to be located within the traditions of social science, and for which I must also attempt to provide locally occasioned warrants.

The first three repertoires identified in the following pages, 'Own Interests', 'Humanist Concern', and 'Relative Balance' refer, as I have suggested, to the relationship between villagers and patients but also contain, as it were, a sense of what patients are like as patients. 'Local Identity' also implicates the relationship between village and patients but arguably in a more complex manner. In the section below entitled 'Other Times, Other Places, Other Persons' I argue that the notion of a local village identity may be taken as a resource but at the same time rhetorically managed by the delimitation of boundaries with others, *including* patients.

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[2] See the arguments in chapter 11 above.

In the following section I show how a sense of the two central repertoires may be initially gained via the analysis of proleptic manoeuvres in 'on record' public talk.

2. Competing Accounts

The two major repertoires can be approached via an old extract from Parish Council minutes[3]:

> '(Councillor Broadley) instanced a case at the King William IV public House (sic), and cases of intimidation by patients to housewives, and cases of indecent behaviour in the Village and its surrounds. He thought that not enough attention was being given to the very real concern of the Villagers when faced with these problems. Councillor Broadley stressed the fact that in general there was a very real desire on the part of the Village to help in all practical ways the recovery of those patients who would benefit by mixing with the outside world, but it did seem that many who were allowed out were in no fit state to be at large, and they did nothing in helping relations between the Village and the Hospital. Shenley had had the Hospital in its midst for so long that it was accepted as part of Village Life, but there were limits and if they were exceede(d) there could well be a serious deterioration in those relations which would not be for the good of the Hospital or the Village.' (Minutes of Shenley Parish Council Open Meeting, 9/4/1974)

The message in the above extract is clear. In the text the speaker, a villager, portrays the behaviour of some patients as posing a threat. Talk of 'indecent behaviour' and 'intimidation', coupled with later references to customers in the pub being 'seriously upset', and 'the possibility of children being frightened or interfered with', all point to a serious worry or concern which is primarily to do in this extract with the protection of bodily integrity, and the defence of physical and social space (cf. Lyman and Scott 1967, Goffman 1961/1968, 1971, Sommer 1969, South 1987). The sense here is more than one of patients simply being a 'nuisance',

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[3] The whole of this official minute is reproduced in Appendix C. This extract has been corrected for spelling mistakes.

or of villagers being 'fed up' with their behaviour. Rather the dominating linguistic repertoire has a more ominous ring which can be characterised as one of danger, threat and fear.

As I have already shown in chapter 9, the precise reality of local life, which can include the level of danger involved in living near a psychiatric hospital, is one which is open to dispute and negotiation. And the organisation of the above text must be seen in the context of the part it was designed to play at the time in the open meeting with the hospital authorities, and the villagers' desire to present their point of view with maximum effect. The point however is that the kind of account offered here, in relation to the behaviour of patients and the feelings of villagers, is acceptable as an account in this instance, even though elsewhere villagers' efforts at accurately identifying patients is held in doubt, and their rationality impugned in the process. To paraphrase Collins (1983, p72) this understanding allows the researcher to identify the kind of account which counts as an adequate account[4].

The dominant linguistic theme in this extract can therefore be seen to combine a presentation of 'many' patients as threatening and dangerous[5], together with villagers' concern for their own safety and protection. I have configured this pattern as the repertoire 'Own Interests'.

But at the same time as invoking this major repertoire, the extract above draws upon another important theme. Both are

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4 Or by corollary, the kind of context which would be needed to allow a particular account to be taken as acceptable.

5 For discussions of the dangerousness of patients and their 'fitness' to be allowed out of the hospital see chs 4 and 9. These are clearly contestable issues.

articulated in the context of a variation upon the rhetorical figure 'prolepsis'. Two sentences in the extract demonstrate the same construction; first, the positive message, then the warning, revolving around the word 'but'. As I have shown in chapter 12 above this is a way of forestalling anticipated criticism and can be seen to juxtapose competing discursive themes which run through much of the talk about patients in the village context, by using one moderate or positive theme to pave the way for a criticism or some form of potential social 'offence' (cf. Brown and Levinson 1978/1990, Billig et al 1988, van Dijk 1984).

A second major theme, derived from merging the first parts of each proleptically organised sentence above, contains 'very real desire...to help', and the hospital as an 'accepted part of village life'. It is a positive 'caring' theme which locates the Village and Villagers within a tradition of humanism[6] (see e.g. Soper 1986). I have therefore called this the repertoire of 'Humanist Concern', which also has two parts, as I shall later show.

In building his argument, grounds or reasons are provided by the speaker to support his conclusion: '...but it did seem that many who were allowed out were in no fit state to be at large'. The minutes then proceed to document examples of this absence of 'fit state'. The theme here, which clearly coincides with

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6 In these allegedly 'postmodern' days this term is often viewed with suspicion, see Foucault (1961/1971, 1975/1979), Connolly (1987 p104). For a discussion and Foucauldian critique of 'the paradoxical nature of humanist caring' in relation to social work, see Rojek, Peacock and Collins (1988): 'In determining the needs and rights of citizens, humanists are said to install new and extended patterns of surveillance and control which unavoidably limit the freedom of the individual.' (ibid p115)

the theme of 'Own Interests', has two aspects, one related to 'fitness' and the other to 'place'.

There are several ways of interpreting this. First, that some patients should not be let out because they are not fit to be out (because they cause trouble, or constitute a problem); or alternatively, that some patients should not be allowed out because they are not well enough to be out. While the first version coincides with the Own Interests repertoire (as in 'they should not be let out because they are a danger to others'), the second could be seen as part of the repertoire of Humanist Concern (as in 'they should not be let out because they need the proper care and help'). This latter aspect is common and has already been seen in use in chapter 9. For example in the following extract already quoted on p250 above:

> This week parish councillor (sic) said: "These people are put in hospital for care and to be looked after. Somebody is responsible for these poor, sick people." (17/10/1986 Herts Ad.)

This passage which bespeaks concern, worry and disquiet, hardly needs elaboration. This theme can also be illustrated by additional extracts from local newspapers reporting the comments of Parish Councillors, over a number of years, as follows:

> Parish Councillor William Hogan said at one incident he attended when an elderly woman patient was taken from the village pond it was a full ten minutes before a hospital representative arrived. "People were very concerned about the attitude of the hospital because the officer did not go in the ambulance with the patient", he said. (20/3/1981 Herts Ad.)

and:

> Councillor Marion Martin told members she had received many comments from members of the public concerned at the unsuitable dress of many patients.

> She said patients, some of whom were elderly, could be seen wearing only thin cotton smocks and slippers on the coldest of days (20/1/1984 Herts Ad.)

By contrast the repertoire of 'Own Interests' focuses upon the position of villagers, and examples of their concern about the protection of their space, property, and selves can be found sprinkled throughout chapter 9 above. Sometimes the concern is stated explicitly as in the following further extract[7]:

> (Councillor Ernie Broadley said) "The hospital ought to look after the interests of villagers by taking more care over which patients it allows out of its grounds." (23/11/1979 Herts Ad.)

Similar repertoires are used by hospital staff in their defense but with a different weighting. For example in Appendix C the hospital representative also refers to the welfare of patients and in addition defends the interests of the hospital staff. In the following extract for example the then hospital Administrator stated:

> ..."It would be inhuman to confine a person in a ward for 24 hours a day." (20/3/81 Herts Ad.)

In the following pages I intend to trace the way that the two central repertoires glossed here, which I have named 'Own Interests' and 'Humanist Concern' jostle continually, as it were, for place within the texts of interview transcripts. However, within the interview world their argumentative expression often appears more sophisticated and complex, and the clear themes, especially those of danger and threat, often give way to milder forms. Thus I show below how the repertoire

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7 Interestingly the word 'care' is also used here but in terms of an imperative about the kind of action the hospital should take which would demonstrate that it cared about *villagers*.

'Own Interests' possesses a strong and a weak form in interview transcripts[8].

Although these repertoires are not logically contradictory, nevertheless their use has a certain dilemmatic quality, and arguably illustrates a central dilemma for local people which is occasionally commented upon explicitly. This dilemma can be caught in the first extract above, and is evident in interview transcripts in the way that one repertoire can be seen to give way to the other within the argumentative context (cf. Potter and Wetherell 1987, Billig et al 1988). It is possible to tentatively reformulate this dilemma in different terms. Both repertoires have an interest in control but from different perspectives; one emphasising the social good in terms of the importance of constraint and discipline, defence of property and order; the other the welfare of individual and 'generalised' patients. Social defence is pitted against the benefits to patients of having the freedom of the village. Individual and society become, to an extent, counterposed. This polarity becomes clearer with the elaboration of these repertoires and the introduction of others.

It is already clear from chapter 9 that talking about patients in the context of public debate and complaint often involves the attribution of blame and responsibility, with the hospital and its staff as the frequent focus. This also occurs in interview texts. However, as I have indicated, the latter

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8 Note that I am not yet arguing that one context allows the more 'accurate' expression of the 'real' opinions, feelings or beliefs of villagers. Although we may wish at other times to attribute accuracy to accounts of others' (or our own) feelings and thoughts, this again would itself take place within an argumentative context of a different kind. Here I am arguing only that people's accounts (about patients) vary according to the argumentative context.

display talk which is often much more subtle and varied and often implicates third parties other than the hospital as I shall show.

In chapter 9 villagers were portrayed as actively participating and intervening in the real world. Those villagers quoted by the press and in the Parish Council minutes were clearly interested we might say in directly altering their world in some way. Regardless of the justifications for their arguments and complaints, we may feel confident in suggesting that a large turnout at a public meeting is indicative of controversy, dispute and complaint, with feelings often running high. This was largely in contrast to recorded interviews, where respondents were sometimes reluctant and perhaps not necessarily motivated to expound in a mode of high dudgeon, and indeed sometimes implied that they did not want to 'stir things up again' at least on this occasion[9].

Public statements and meetings have, we might say, constituted occasions at which explicit 'boundary work' (cf. Woolgar and Pawluch 1985) can be clearly witnessed. At these times of complaint the argumentative (rhetorical) delineation of boundaries and categories (e.g. 'village', 'villagers', 'patients', 'hospital') may be especially transparent. This work is also instanced within the interview world but again often in a more subtle and complex manner as I show below.

This may go some way to explaining some of the differences in the exhibition and use of repertoires in the interview world. Basically we may hypothesise that the interest matrix of villagers differed on these different occasions. This argument

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[9] It should be born in mind that during the period in which most interviews were conducted, in the years 1989 and 1990, the village was facing the projected closure of the hospital.

is consistent with the premises of discourse analysis which maintain that the language used will differ according to the argumentative context[10].

While blame may be one specific function of villagers' discourse (on conversation analytic perspectives of accusation and blaming, see e.g. Drew 1978, 1988, Watson 1978, Pomerantz 1978, Molotch and Boden 1985), this chapter continues the argument that in the process of discussion and debate the villagers are actively (re)constructing their own identities as reasonable, rational and sane people (Garfinkel 1967, Shotter and Gergen 1989, Goffman 1959), together with the identities of patients as patients; and that they are simultaneously recreating culturally furnished norms together with the truth or facts of the matter (Baxter 1987, Habermas 1979, 1984, Potter 1987, D.E.Smith 1978).

In terms of its overall structure, this part of the thesis may be read as displaying two positions. Its main thrust is to provide an elaboration of, and give substance to, the discursive, interpretative repertoires of madness - that is, those culturally furnished resources which people draw upon in talking about mental disorder, madness, mental illness, and above all 'Patients'. It aims, in other words, to illustrate repertoire content.

However, in addition, it also focuses upon some of the rhetorical moves implicated in talk about patients, and provides space for the analysis of the interpersonal and communicative effects and functions of repertoire use. In this

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10 The functional variability of repertoires often seems more evident in public documents whereas on occasions within the interview world it has not been possible to discern precisely what function a particular repertoire might be performing.

sense then it attempts overall to link content with form, or to explore the relationship between interpretative resources and situated talk (Edwards 1991 p517).

In the following pages the examples used are derived primarily from interview transcripts although newspaper excerpts are used on two occasions in order to reinforce a particular point.

3: Strange Alliances; Danger, Nuisance and Concern

As I have presented it so far the repertoire of 'Own Interests' organises the idea of villagers' defence of their village realm against perceived threat, understood in a strong sense to imply danger and violence. It is clear however that although danger and violence reappear throughout the interviews, there is also a competing theme of 'nuisance', a word used in relation to patients on numerous occasions. Here, villagers are still concerned about their own interests, but the concern and the interests are to do more with defending their physical, social and property space and labour time, as for example in the anticipation of requests to 'look after' patients.

The following extracts are taken from one interview with two respondents, Nancy and Ralph. Ralph, a retired craftsman, has lived in the village since childhood, and his friend Nancy, a 'housewife' in her 50's, has been resident there for 15 years. The extracts have been chosen to illustrate first the way that the themes of danger and nuisance, as well as concern for patients' welfare, are often intertwined in talk; second, how temporality is used to discursive effect; and third, how Ralph's acknowledgement of dilemma concerning a controversial issue gives way to a different position in a different argumentative context.

My question concerned whether patients should be allowed out of the hospital in order to go into the village. Ralph's answer at first seems certain but he goes on to modify it by way of an interesting prolepsis-like manoeuvre with a particular kind of content, which I refer to as a 'balancing device' (see section 10 below):

Ralph: At one time when it was, when it was first there you'd get about four nurses, coming up the road with about a dozen or dozen and a half patients and they were allowed in the shop two at a time and the nurses were there and then they walked back again. But now they walk all over the place.

DS: They're allowed out all over, anywhere?

R: All over the place

Nancy: There's no gates, no gates.

DS: What do you think about that?

R: Well, to my mind I think it's all wrong but er, I, I'm not a medical, man. I know psychiatric people down there, I think they're as mad as the patients, quite a few of them.

DS: What, staff you mean?

R: Yeah. Well the patients, some of the patients are a damn sight, saner, than what they are I think. But they say no you can't keep em closed in. Well (2) they've got a few, yards of open space there that they walk around in without coming into the village and I, well a, a mate of mine saved one woman from throwing herself in the pond, it took us a hell of a while. All these sorts of things happened. And they walk in front of cars and get knocked over and killed.

N: Several isn't there

R: Been several accidents happen like that. Well, it's their life I know it's their life, but er, it's the p-poor old motorist really I mean (2) (p7)

In the above extract Ralph appears to be saying that patients should not be allowed out because they are a danger to themselves - talk which can be read as displaying an instance of the repertoire of Humanist Concern.

At the same time the reference to 'the p-poor old motorist' (who may not just be a villager) and '...it took us a hell of a while', suggests that he is also referencing here the Own

Interests repertoire. However the threat to villagers is not to do with patients being violent towards villagers, but is related rather to upset and the extraction of labour time.

Intriguingly, one of the few putative references in the interview transcripts to 'Patients Rights', as in 'Well, it's their life I know it's their life, but...' is used to raise the idea, immediately disclaimed, that they have a right to die in that manner. To be sure an alternative reading of this sentence can be made but it would be distinctly less charitable, as in 'Well it's only *their* life I know but...' i.e. '*they* don't matter, but what about the motorist'.

A little later in the interview Ralph provides another example in the form of a story[11]. As part of his construction of 'patients as nuisance' this particular patient is portrayed as deviously attempting to exploit Ralph, and later flaunting this intent. However the coda to the story contains a brief prolepsis which points to the dilemmatic nature of the topic and of 'nuisance' itself:

> Ralph: ...there's one chappie, I ain't seen him for ages but he'd 'Have you got a shilling, for a cup of tea?' 'Oh get back down the bloody hospital. Get one for nothing there.' And I walked in the toilet, public toilet one dinner time on me way down the village and there he was, sitting in the bloody, on the floor of the toilet, trying to scrounge, money. And I was just walking in the [King Harry] one day and he stopped me, I said 'I've told you time and time again, get back down the road, you'll get a cup of tea for nothing.' He followed me in the pub, fetched out a fiver and and said to old Clive, the barman, he said 'Got change for a packet of fags?' (2) And I said 'You scrounging', I said, 'get out of it', I said, 'You stopped me outside (laugh) wanting a bob for tea.' It's

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11 I have not attempted an exhaustive analysis of this story here. Elsewhere (Southgate 1991) I have provided a framework for the analysis of respondents' stories drawing in particular upon the work of Polanyi (1979, 1981, 1985) and Linde (1986).

> something and nothing really but it, it does aggravate you, you know... (p9)

The dilemma here relates in part to whether patients should be allowed out into the village, but also to the issue of how villagers should react to patients who are allowed out[12]. Another way of putting the point is to say that in these extracts Ralph expresses disapproval but in a manner which displays the dilemmatic nature of the subject.

In the following passages Ralph, Nancy and myself pursue the issue of whether patients should be allowed out. These are notable for the way the themes of danger and nuisance, past and present, are intermingled in such a way that it becomes virtually impossible to disentangle the facts of the matter.

> Ralph: Oh used to be gates, yeah. And there used to be gates down Radlett Road and they, and a chap called King used to live in that lodge. And he was responsible for shutting them and undoing the gates, in the morning and night.
>
> DS: So the railings and the gates would have kept a lot of the patients in?
>
> (jumble of talk)
>
> R: I say, at one time you never saw patients walking about, but now of course they they go in the pubs and er, in the shops and they create a nuisance sometimes [to] themselves. And er some of them are quite light fingered (2) And well, although the general public don't say much they're not very happy, are they really.
>
> Nancy: No. * I'm glad my children when we moved here, that they were (2) 8, 8 and 10 weren't they. I'm glad they were that age. I didn't like them you know, there was quite a

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12 This may be read in at least two ways; as a dilemma about how one should respond to a patient *qua* patient, who is being a nuisance; and second, as a dilemma about whether one should consider this behaviour of sufficient 'nuisance' to become 'aggravated' about in the first place.

few patients then. Going back 15 years there was quite a few. You couldn't, you had to know them, to know what they were going to do. One or two were a bit=

R: =There was lots of things really. People wouldn't take any notice much of it today, but going back, there was two old ladies there, they must have been there years and they'd just stand on the pavement open their legs and pee (2) And even now the men do that. Some of the men do it. * Pass water on the pavement. Don't matter who's about..
(p8)

In this section the past is presented as both bad and good, while the public is depicted as both unhappy with patients' behaviour ('...the general public don't say much but they're not very happy,..') and also unconcerned or dismissive of it ('People wouldn't take any notice much of it today...').

While Ralph plays down danger and focuses upon nuisance, Nancy's talk is perhaps most readily understandable if the reader adopts the culturally available frame of 'patients as danger'[13]. Here patient identity as 'psychiatric patient' is already given, so the question becomes 'what is it in the text which allows us to read 'danger' in the absence of explicit reference?' I suggest the key lies in the reference to dislike, together with the line 'you couldn't, you had to know them, to know what they were going to do', which suggests a certain unpredictability, conjoined with reference to children. Danger and threat are located by Nancy in the past, when '...there was quite a few patients...'.

However some time later on in the same interview a significant change of tone can be detected in the context of the topic of the proposed closure of the hospital:

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13 Compare D.E.Smith (1978 p23); 'the structure of the conceptual scheme 'mental illness' which the reader uses in recognising 'mental illness' is isomorphic with that organising the text', and also D.E.Smith (1984).

DS: So you'd prefer the hospital to stay, would you? If you had a choice?

Ralph: Yes it wouldn't worry me in the least, wouldn't worry me in the least.

DS: That's in spite of the patients or?=

R: =Well, you see (1.5) you learn to live with these things.

Nancy: They've got to go somewhere haven't they? Otherwise they'd be on the road.

R: And I think the type of patients you've got in there now (2) are pretty harmless really (2) At, I mean, at one time they were compulsory patients I should imagine, I don't know. But now it's all voluntary patients. That's why they're allowed to walk about I suppose. But er (2) I don't think, I'd sooner it was a hospital than (2) the houses. The amount of money that's been spent on that road. It's um, a sheer waste of money.

DS: I suppose it will make a difference, quite a big difference to the village?

N: Well you see that will near enough join it to Radlett, you see. We're nearly joined up with Borehamwood now. So a village=

R: =I mean you're, you're, you're only about 300 yards without a house between here and Borehamwood. And er, when Elstree Rural Council decided, won the honour of becoming a Borough it was the worst thing that ever happened, 'cause Elstree Rural Council was a, good Council. (p21)

In contrast to the previous section there is no reference here to patients as 'nuisance', and in proposing 'otherwise they'd be on the road', a charitable reading of Nancy's assertion suggests a Humanistic Concern for patients' welfare. Ralph too, in fending off my reminder of previous talk about patients being a nuisance, tells us that '...you learn to live with these things', thereby invoking a temporal continuum or

process, a projected history within which villagers have become more or less tolerant and accepting[14].

Ralph goes on to describe patients as 'harmless', which, while not incompatible with 'nuisance', plays down what has previously been defined as a potential problem.

In what amounts to a defence of the patients in support of his own cause, it would be simple to argue here that Ralph, in order to mount such a defence, is forced to play down the idea of patients as danger and as nuisance. This is not correct however for there would be nothing to stop Ralph in theory from arguing that the hospital should stay *in spite* of the danger and nuisance of patients; that the housing development might prove more of a danger and a nuisance in terms for example of increased traffic flow. There is therefore nothing necessary about Ralph's argument. Rather, it constitutes one available option open to him.

One way of reading this section is in terms of patients constituting a danger in the past but no longer in the present, as previously suggested by Nancy. This reading relies upon understanding 'compulsory' as relating in some way to 'harmful' (the opposite of harmless). Ralph can be seen as trying to provide grounds for his position that patients are now harmless i.e. the reason they are allowed out now is *because* they are not 'compulsory', hence not dangerous.

Ralph's assertion that the fact that patients are allowed out is evidence for their harmlessness, appears to clash with or contradict Nancy's earlier suggestion of implied danger which is linked to 'quite a few' patients being around 15 years ago.

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[14] Compare the discussion in section 8 below.

It is interesting to see here how temporality is used across the range of extracts and with different effects. Ralph and Nancy use time to locate danger elsewhen. Time here is comprised of discrete packages. There is now and there is (in the present) then, which serves as a contrast structure within which one can make a particular point. At the same time, Ralph implicates a continuum notion of time to argue that 'you' and by extension other villagers, 'learn to live with these things', thereby rendering villagers as presently tolerant. In terms of the way its constitutional makeup is discursively varied, time can perhaps be seen as relative.

In this final extract it is possible to see how Ralph constructs his position by (a) converting the nuisance and danger of patients into harmlessness (b) locating danger in the past and (c) recreating villagers as tolerant, with assistance from Nancy who (d) expresses concern for patients' welfare. The outcome of this is the co-optation of now harmless and vulnerable patients to the cause. Patients become allies in the voiced opposition to the housing development and the local Borough becomes the other 'Other' upon which complaint is focused.

The above sequence of extracts illustrates, I suggest, a number of points. First, that 'nuisance' competes with 'danger' as a central theme of the interpretative repertoire Own Interests. 'Nuisance' reappears throughout the interview transcripts and is evidenced in many of the extracts which appear in later pages. I have chosen to include it in the Own Interests repertoire instead of creating a separate category because it shares the central tenet of the Own Interests repertoire, i.e. defence by villagers. I shall refer to this aspect of the repertoire as Own Interests (Nuisance) or Own Interests (Minor) or simply 'Nuisance', but point out that it is intended to

illustrate a particular meaning of the relationship between villagers and people who are patients.

Secondly, the above analysis shows that such repertoires are drawn upon in different ways in different argumentative contexts and with varying discursive results; and thirdly, that the intertwining of alternative repertoires possesses a dilemmatic quality which finds expression in a sense of uncertainty in relation to contentious topics, and which arguably possesses an ideological correlate in so far as their themes embody an opposition between social order, constraint and control, and individual freedom and expression.

4: The Rustle of Danger

In the previous section I showed how Ralph proceeded to discursively neutralize patients-as-danger with the effect that patients were co-opted to his cause. Danger became converted into harmlessness and villagers' fear into concern and tolerance.

Danger and threat have indeed proved to be continual themes throughout the interviews. One moment they rustle in the background, lurking, half articulated and hinted. The next they rise to the surface of talk and display themselves, so to speak, to use a structuralist metaphor. And indeed it is possible to see how the psychiatric hospital itself helps to perpetuate this undercurrent.

In this section I will show how danger, threat and violence can be conjured into being out of nuisance and even out of reason and reasonableness itself, often with the discursive assistance of Humanist Concern.

From Reason to Danger: The Paradox of Normality

The following extract is taken from an interview with Andy, a 40 year old man who had a managerial position in a local company who had lived in the village for most of his adult life.

> DS: Suppose somebody said, one of the patients came to you and said - I'm interested in being on the committee of the Village Society. What would happen?

His response was long and complex and I have included only the latter part of it below:

> Andy: But um, no, I think most people are tolerant. Yes, what if someone came up and asked me?
>
> DS: Would you consider it?
>
> Andy: If they seemed reasonable and they had a reasonable point of view, of course you would, because you can't see any reason against it. It would only make you wonder what on earth they were doing in a mental hospital, you see (Andy's laughter). I don't know, they, they could be a psychopath (Andy's laughter). But, no I think the worst people are locked up. I think mainly the people out there are just just genuinely harmlessly mad. You know, for various reasons. (gap) Normal people just had their lives ruined. ** (p17)

Andy's laughter in this passage coincides with a temporary change of frame (cf. Schiffrin 1984[15]), from stated acceptance to doubt and back again.

It may be possible to view this laughter as exhibiting a kind of 'troubles-resistance' in Jefferson's (1984) terms, whereby in the course of telling about a trouble the speaker demonstrates that he or she is coping with the trouble. And to the extent that my question itself constitutes 'trouble' for Andy, this may be the case.

Andy had been floundering somewhat in answering the question. His immediate reaction was 'Ah, I don't know. I've no idea, it depends who it was.' He eventually proceeds to work his way reflectively through stages of argument pausing for a moment with an answer which twice articulates the lexical item 'reasonable' and once that of 'reason':

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15 Drawing upon Goffman (1974/1986), Schiffrin refers to 'frames' through which levels of seriousness in conversation are negotiated. Thus speakers as said to 'break frame' from serious argument, to jointly gloss disagreement as non-serious.

> If they seemed reasonable and they had a reasonable point of view, of course you would, because you can't see any reason against it.

Andy tells us that no reason can be found to oppose the reasonable. But then immediately Andy 'sees' a reason against it. And this reason is the very reasonableness of the person him(her)self. From the perspective of the semantic and symbolic sway of the mental hospital, a socially shared affair, there is no demeanour, no behaviour, no reasonableness, according to Andy's argument, which cannot itself be taken as evidence of mental disorder; while the very absence of problematic behaviour constitutes the most extreme evidence of one extreme case of such disorder. The very fact that someone is a patient in a mental hospital, in Andy's talk, is sufficient to imply threat and danger irrespective of the person's behaviour; and the more 'reasonable' the person is, the more he constitutes a potential threat.

There is indeed a certain paradoxical logic here which Andy reflects, for surely, the reader might object, a person who is a patient in a psychiatric hospital *ought* to appear odd and so forth, and not completely reasonable. And yet clearly it is possible to imagine such circumstances; for example where someone has 'recovered' in hospital, appears 'normal', and is seeking some social stimulation while awaiting rehousing.

Andy's articulation of the problem may be fleshed out via Foucault's (1978/1988) analysis of the way the medico-judicial category of the 'dangerous individual' came into being via the notion of early 19th century category of homicidal monomania; the 'zero-degree of insanity' (p130), the psychiatric entity of 'a crime which is insanity, a crime which is nothing but insanity, an insanity which is nothing but crime' (p132).

Foucault argues that 'the great unmotivated crimes' posed a problem for the judiciary from the very fact that 'reason', 'motive', could not be established: 'Now that the reason for the crime had become the reason for the punishment, how could one punish if the crime was without reason?' (p138). In the following process, he argues, modern law has come to allow for society's right over the individual because of what the individual *is*, not what he or she *does*. The establishment of motive therefore becomes pre-eminent, and psychiatry becomes the specialist in motivation (p138).

In this analysis of the psychiatrisation of crime within a framework of the management of threat (danger) to the social body and public hygiene, Foucault details how the concept of 'dangerous individual' was enlarged by penal law from the 'monomaniac' to everyday figures by way of a perpetual interaction between the judiciary and medico-psychological knowledge, out of which a set of objects and concepts was born (p149): 'Nineteenth-century psychiatry was a medical science as much for the societal body as for the individual soul' (p134).

This figure of homicidal monomania can therefore be seen to have played a part in the elaboration of psychiatry's functions; the control of the dangers hidden in human behaviour, and so the functioning of modern psychiatry is linked to this kinship between madness and death (p135).

There is a picture here of the way that danger and madness have been historically elaborated, with the assistance of homicidal monomania, a category which, although now discarded by psychiatry, nevertheless still holds some symbolic sway. This figure suggests that at the ultimate boundaries of insanity lie violence and crime, a violence all the more dreadful because

it gives no hint, no sign, until it explodes into being. This is insanity in its most harmful form; a maximum of consequences and a minimum of warning, as Foucault puts it (p135)[16].

What can be seen in the brief excerpt from the interview with Andy, I argue, is the way that danger emerges from discourse, framed in laughter and joke, only to sink back again in the further light of reason. The traces of danger and threat nevertheless remain. In terms of the effect of this discourse or its function, it can be seen that while rational consideration suggests that at least some patients should be allowed into local organisations, it is still possible to find a trace or a hint of danger and threat even in those most reasonable of requests, a trace which could be used to rationalise decisions to discourage patients from applying to join local societies.

Andy's laughter in the above extract can also be said perhaps to comment upon or capture this particular sense of paradox involved in arguing about madness, a paradox also noted by other villagers. Put another way, it can be said to offer the opportunity for a laugh or a joke. For example in my lively discussion with Anne and Arthur a couple in their mid 50's who had lived in Shenley village for 20 years, I asked:

> DS: What would have happened if someone you knew was a patient had come along and said they wanted to join the W.I?

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16 Ramon (1986) has argued that the category of psychopathy was 'rediscovered' in Britain during the Second World War, and functioned after the war to explain residual anti-social behaviour in the context of new welfare state stereotypes of the poor, the criminal or the ill. And see Blackburn (1988) for an examination of practices of classification of psychopathic personality within the professions of psychiatry.

Anne: If they had enough, if they had enough sense to come and say they wanted to join and er=

Arthur: =They wouldn't be in Shenley Hospital (their laughter)

Anne: No, erm. Then, good luck to them. I mean as long as they weren't disruptive I suppose. (p16)

From Nuisance to Violence

The following extracts illustrate further the discursively contingent nature of danger, violence and threat, and the way that their factual status is constructed in discourse. The extracts are taken from an article in the Herts Advertiser, which is reproduced in full in Appendix B. Although a complete analysis needs to locate the extracts in their relation to the whole, it is arguably the case that these parts are of intrinsic merit.

Talking about 'a young hospital patient' who had sat in the car of some friends, Mrs Gee said:

> "If he had sat in a less patient person's car or if he had confronted someone violent, this could have been a very serious problem indeed",..
>
> and
>
> "This latest event was potentially a nasty situation. It is something that could happen in the village but we felt that if someone had lost their temper they could have hurt the patient", added Mrs Gee. (Herts Advertiser 4/9/1987)

The police eventually came to help after a 999 call was made.

The contingent nature of violence and danger arises in the sense that violence is discursively conjured out of thin air, when little or no warrant exists for it in terms of the

recounted actions of the patient himself. What might otherwise have been taken as an instance of 'nuisance' becomes transformed into something more serious. Nobody in this account, nor in the complete account, was violent (although the identified patient did allegedly swallow a cigarette butt). Violence, rather, somehow appears as if from nowhere and becomes attributable in a very speculative fashion to hypothetical and generalised 'others'. No-one acknowledges that *they* were violent or even feeling vaguely violent. And yet violence has been raised as a truth claim in Habermas' terms.

My initial response to this extract was to see it as an effective way of objecting to the behaviour of patients, any behaviour within limits, that people found objectionable. All one has to do is say 'other people are less patient and may become violent'. In argument one can of course dispute this and say 'well then that's their responsibility, not the patient's'. And indeed this kind of argument can often be found within the auspices of psychiatric practice itself when interested parties may demand the removal of the (putative) patient because they feel that the patient is at risk of violence from others, including relatives. This comprises a reversal of the discursive use of danger and threat as described above, but it invokes danger, threat and violence none the less.

At a theoretical level the above passage may be seen to relate to the practical dilemma which centres upon freewill and determinism. In his 1974 discussion, Strawson contrasts two opposed but not exclusive reactive attitudes of everyday life, the 'participant' reactive attitude and the 'objective' reactive attitude (p9-10). While the former is concerned with the expression of a range of reactive feelings and attitudes which belong to involvement or participation with others in inter-personal human relationships -feelings and attitudes such

as anger, resentment, gratitude or forgiveness, the latter involves seeing the other as something to be taken perhaps precautionary account of; as an object to be treated, trained, managed, handled or cured[17].

His central argument concerns the importance that people attach to the intentions of other human beings, and the great extent to which our personal feelings and reactions depend upon, or involve, our beliefs about these intentions (p5). The argument is that if we experience or understand another's harmful act towards us as being intentional then we will respond differently to a situation in which we believe the other was in some sense 'determined'[18].

Strawson distinguishes between two groups here. The first concerns situations in which the agent is granted autonomy but in which the action was 'determined', for example in which he or she had no choice, couldn't help it, was pushed, made a mistake, did it by accident and so forth. The second group concerns not the action but the actor, and Strawson again separates out two sub-groups. In the first we may be able to

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17 In so far as this articulates with issues surrounding social action and rationality then it has links with a whole range of sociological theory. Compare for example the distinction in Habermas between communicative and instrumental/strategic action, the associated work on the attitude of natural science and the discourses of medicine by e.g. Mishler (1984), Scambler (1987).

18 Another way of addressing this is to say that we can *dismiss* threats to our self and our world-view, mend the fences which delineate our notions of the moral order, and the order itself, *by* strategically attributing madness to the other. As Wagner (1980) shows, once people are regarded as mad then this may allow for continued co-presence without the consequences of engaged interaction. Like the marriage where partners accuse each other of being mad, this may allow the couple to remain together (unhealthily we might say), to occupy the same space, without having to engage with each other.

ascribe a temporary state in which the person's identity is not permanently spoiled (Goffman 1963/1968), as in: 'He's been under great strain recently' and 'He wasn't himself'.

In the second subgroup the actor is presented as psychologically abnormal or as morally undeveloped: 'the agent was himself, but he is warped or deranged, neurotic or just a child' (p8). His argument is that when we see someone in this latter light 'all our reactive attitudes tend to be profoundly modified' (p8) and shift from the participant to the objective reactive stance.

Emerging from the discourse analytic frame for a moment, it is possible to understand that the people involved in this example may have felt angry that their property had been invaded, (from the suggestion that 'others' could become violent), but because the man had been identified by them as a patient from the local psychiatric hospital, as someone therefore who simply 'couldn't help it', they may also have felt constrained in terms of the socially acceptable alternatives for action open to them. The people arguably faced a dilemma about how to act.

To acknowledge one's own anger towards someone who is a patient constitutes a problem in two ways. On the one hand one may be seen to be in violation of a putative normative code to the effect that one ought not to be angry, resentful and so on towards people who simply and genuinely 'can't help it'. On the other hand, in the case where someone *is* openly angry or expresses resentment towards a patient, the implication could be that the patient is accountable for his or her actions, or that the angry person is not him or herself being fully rational. In either case the actor who expresses anger or resentment in such circumstances is in a potentially difficult position which may invoke criticism from 'normal' peers and contemporaries.

Of course, that a participatory reactive stance *could* still be retained, and often is retained, can be seen from the way people often react in relation to objects in the world, for example a Cleesian whipping of the car which 'refuses' to start. In such a case we may anthropomorphically attribute agency and freewill to some thing which in calmer or less poetic moments we may view as inert (cf. Woolgar 1991). Clearly then it is still possible to attribute freewill to people who in other contexts we may see as not responsible for their actions. But there may be costs in so doing, for example the image Cleese casts as Basil Fawlty of being very close to the edge of sanity.

In everyday life this issue is a practical, contingent, difficult and complex one. There are occasions when it is both morally and technically right to attribute responsibility to someone who is a patient in a psychiatric hospital, depending upon a variety of factors which include the nature of the offence and the degree of mental disorder. Psychiatric nurses for example regularly and inevitably rely in a practical way upon being able to make this distinction (cf. Bott 1976, Erikson 1957).

At the same time however it may be that the dilemma described here about whether or not to attribute agency to another is not necessarily ahistorical as Yearley (1985) appears to suggest in his discussion of Strawson's work. At least in terms of content it can be seen to relate to particular times and kinds of property and power relations (and see chapter 8 p199)[19].

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[19] In other words the attributions of responsibility and insanity are themselves conditional upon historically and geographically specific social relations.

But from a discourse analytic perspective it is neither necessary nor warrantable to impute motive and sentiment. Rather the aim is to stay with the text itself as far as possible. Indeed, as noted, the speaker does not acknowledge that anyone felt violent. And from this position two dominant themes emerge: the hypothesised threat of violence by a villager or other non-patient, and concern about the welfare of the patient. The provoking action is nothing more nor less than 'sitting in (someone else's) car'[20]. The text suggests that patients may be at risk from certain impatient or violent people. Who are these people? We are not told. In what way is violence raised as an issue?

The extracts arguably work in three main ways: First, a contrast structure is set up between concern and violence. This becomes particulary clear in the full text which begins with several statements of concern about patients' safety. This very concern then appears to justify or provide for the raising of the theme of violence, as one more thing about which there should be 'serious' concern in the first place[21]. Second, a further contrast structure is created between those tolerant, patient and understanding people involved i.e. the speaker and friends, and intolerant, impatient and violent 'others'. Third, the event is temporally located as the 'latest' in an undisclosed number of prior events, stretching into the past

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20 One the one hand this is an innocuous enough and everyday affair. On the other the uninvited nature of the sitting renders it unusual.

21 It should be noted that there is nothing necessary in the relationship between violence and concern. Many people enjoy violence in one form or another, and many (without necessarily being classifiable as 'psychopathic'), may also demonstrate little concern for its consequences for others or themselves.

and projected into the future as 'warning'[22]. In this way, what would otherwise have been a legitimate complaint about 'nuisance' is converted discursively into the more serious issue of violence and danger[23].

In terms of putative function the article extracts quoted above arguably act as a warning to patients, villagers and the hospital authorities, that something nasty could happen unless something is done. There is also a possible and implicit interpretative line that patients *may be responsible for* others' losing control. That is, others who are 'less patient' may simply be pushed over the edge into anger and violence by the behaviour of the patient him or herself (even though the patient 'can't help' his or her behaviour)[24]. Of course if the text allows this reading then it also allows for the possibility of villagers and others, by implication, becoming patient-like, i.e. by losing control of their actions.

The use of the repertoire of Humanistic Concern together with the contrast structure between speaker, friends and violent others, functions to present the speaker and her friends as caring people. These villagers are discursively recreated as interested, concerned, patient and tolerant in contrast to violent, impatient, others. And obviously the complaint or warning of genuinely concerned people should be heeded.

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22 Reference to time is also found in another part of the article in terms of the duration of the event itself, 45 minutes, which can be seen to support the contention that this was a serious, because lengthy, incident.

23 In the article this theme is in turn played down by both the Parish Council members and the Hospital Administrator.

24 Or, perhaps better, villagers may be pushed over the line by the coincidence of patient behaviour and lack of assistance from the hospital.

Yet there is more involved here than impression management (corporate or otherwise), warning and complaint. And it also involves more than the discursive production of the facts of the matter. For what we have here in the article, in the twin themes of violence and concern, in the intertwining of the repertoires of Own Interest and Humanist Concern, lies arguably a dilemma about how to act. In formal pragmatic terms we might say that the validity claims to normative rightness which are raised here are problematic. The article contains as it were a moral debate or 'moral work' (Jayyusi 1984) about correct behaviour, in terms of property rights and reactive positions to disabled others. The Violence which is raised, with the help of Concern, although purveyed as morally wrong, is presented as understandable, and thereby almost allowable[25].

Supreme Acceptance

I have suggested that danger is a continual theme in the interview transcripts and have shown above how it can appear suddenly as if from nowhere, thereby assuming a predictably unpredictable status, and 'polluting' the majority of texts (transcripts). There are no texts which do not at some point refer to danger or threat.

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25 However in so far as the claims of psychologistic science are granted legitimacy here, then a further validity claim concerning truth is implicitly raised in relation to the technically correct way of responding in such a situation. There is a potential here for the ideology of science to undermine or at least complicate the moral problematic in the way for example in which Habermas (1971) spoke of the 'technocratic consciousness' closing off moral-practical discursive spaces. In his later work Habermas (1987a) talks of the 'fragmentation of consciousness', rather than ideology, in which the development and retention of knowledge in expert cultures may prevent the mobilization of resistance to life-world colonization. And compare e.g. Mishler (1984) on the dichotomy in medicine between humanness and efficacy (p191), and his 'voices of the life world' and the technical-scientific assumptions of medicine.

Mary, aged 89 years, who had lived in the village for most of her life, had been intent upon avoiding casting any aspersion upon anyone, patients and hospital included, and in this respect was unusual. Witness for instance the way she talks about patients she has known using an extreme case formulation:

> DS: I was just wondering how you knew who the patients were?
>
> Mary: Well they used to come in for a few buns, stale buns and that sort of thing and you got to know them and. There was one old chap, he used to bring me, when they used to throw the hydrangeas out in pots, he'd bring me some of those to put in me garden, you know. Because I let him have a few, * day-before buns and that sort of thing.
>
> DS: I mean I wondered if you've, ever mistaken somebody for a patient in the hospital who later turned out, not to be. Has it ever been difficult to know?
>
> M: No I don't think so, no, no I don't think I did (2) No, I don't think so. They were all quite nice. They got to know me more in the shop you see. (p4)

Mary maintained her position of acceptance and harmony for most of the interview, yet on one or two occasions the hint of possible threat appeared:

> DS: ...What would you think if um, if you got a letter from the Council saying that they'd bought up this bit of land next door and they were going to build a hostel on it for people who used to be patients at Shenley?
>
> Mary: Well, I'd have to put up with it wouldn't I (laugh). Can't help these things, they come, don't they.
>
> DS: Would you object to it?
>
> M: Well I'm not much of a one for voicing my opinion at all. (Laugh). I'm very easy to get on with (laugh). So long as they don't interfere with me I don't mind (laugh). (p7)

And in the following excerpt I had been asking Mary how she thought others would hypothetically respond to her if she had a 'nervous breakdown':

> DS: ...Would it alter the way that they reacted to you d'you think? Would it change anything?
>
> Mary: I don't think so. Well it all depends how it affected, me, wouldn't it be. If I was aggressive, they'd want to get rid of me quick wouldn't they? Cos I mean you can't help how the mind goes, can you? (p15)

I have been arguing above that danger, threat and violence are everpresent, if sometimes implicit, themes in interview transcripts (and including one newspaper article), themes which may be brought into being with the assistance of the repertoire of Humanist Concern. I shall continue by considering those occasions in which these themes occur in a more explicit manner.

5: The Odd One: The Display of Danger

I have been arguing above that danger, threat and violence are continuing and ubiquitous themes which are present in the majority of interview transcripts, often entwined with Humanist Concern. I have also suggested that on many occasions the main interest of villagers is less to do with their physical safety than with 'nuisance'. I have shown above how threat and violence may be discursively referenced even in what might otherwise be taken to be unthreatening situations, or situations of 'nuisance', and in a reverse fashion, how in the process of argumentation and in conjunction with the expression of concern, danger can be suppressed and converted to harmlessness (in Strange Alliances p320 above).

Danger and violence can of course also surface in a relatively explicit manner and yet the way in which this is done continues to be of considerable analytic interest. In the following example I had just asked Kev, a 23 year old man who had lived in the village for just over 3 years and who worked in a Shenley pub, how he would feel about a hostel being built next door:

> Kev: Oh (3) As I say if it's somewhere like Shenleybury where they can look after themselves and if you like aren't violent or whatever, I don't think, I wouldn't complain or anything. If it was right next door I suppose, and you've got say people from the flats who started to, I don't know, get petitions going up or something like that, I mean, you might get people doing that sort of thing. But I mean I'd never do anything like that. (p14)

In this account, violence is raised as a central theme. Kev is saying that he would not complain as long as the former patients were not violent (in which case we may assume that he

might complain). But his expressed tolerance is buttressed by his assertion that 'others' might well complain even about non-violent former patients. In relation to 'others' the precise truth of this matter is not at issue here - and indeed we none of us could say for sure whether the residents in the flat really would complain. Rather, what is important is the way Kev argues his point and makes claims for himself by invoking 'others' who are depicted as morally suspect. In the terms of Habermas, the central validity claims raised here are sincerity and normative rightness.

In addition however another mention is made of patients which does not immediately fit either the Humanistic Concern or the Own Interests repertoire. This is Kev's reference to the possibility of patients being not-violent and being able to look after themselves. In many interviews this often reads as a hypothetical concession to the argument, based around the form 'if...then', often acting as a disclaimer. And yet it still raises the possibility, the theme, of former patients acting autonomously. I shall have more to say on this point later in the chapter, but for the moment wish to stay with the theme of violence, threat and danger.

The following excerpt comes from an interview with Penny, aged 36, who was born in the village, and worked in the store. Her objection is related directly to fear but in a less unambiguous fashion:

DS: Patients wander round the village don't they, and er, unaccompanied. Do you think, that's OK?

Penny: No, not all [the time]. Um (2) Not at night. I don't think they should be roaming round. I think they should have gates, on there and they should keep them. I mean they've got some nice grounds in there, you know, and they could keep a check on whether they were coming home. When you think some of these patients that they find dead and that, they've been gone for sort of four or five days

and no-one knows about it. You know, if they locked, I think they should have a bit more security, like checking the wards, making sure they're all in, and locking the gates.

DS: Why at nights especially?

P: Yeah I think they could frighten people, you know, frighten like the young girls, getting off the bus and that at night. And, for their safety, you know. And like they could, the way they could sort of cause accidents, I mean you'd never know, a couple of people have sort of said when Joyce died, someone was saying about he was driving along and he could see that this patient was going to step out in front of him, and he said he slammed his feet on the brakes and stopped just in time, you know. Um, so for their safety as much as anything really. (p13)

Penny swings here between the expression of Concern for the welfare of patients and the expression of anxiety and apprehension. In this extract the frontier which Penny is defending extends through time to include in particular the night (see especially Melbin 1978, and also Lyman and Scott 1967), an anxiety which can also be found in other transcripts[26]. The conjunction of fright, young girls getting off the bus, night-time, and psychiatric patients, coupled with references elsewhere to death, acts as a powerful focus which may suffice to key the listener/reader into images of the (male) Boston Strangler or the (male) Ripper. And yet this is prefaced and followed by concern for the safety of patients. This extract therefore conjoins the interpretative repertoires of Humanist Concern with Own Interests in a powerful argument to the effect that patients should not be allowed out, especially at night.

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[26] Consider Irene: 'Don't like it when it's night time, if it's dark. I think there should be some way of them being in when it's dark. I do really. Day time it doesn't bother me.' (Irene and Tom p1), and Val: 'But I've noticed the elderly people who I've dealt with are suspicious of the patients. We've got to know some of the older ones but you can sense the nervousness now regarding them going out of a night...' (Val p1)

Finally I want to consider another response to the question of patients' freedom which displays violence and danger in a different but no less interesting form. Brenda, aged 38, had been living in the village for 15 years and at the time of interview also worked in the village store.

DS: They're free to wander around and er, do you think that's alright? Are you happy about it?

Brenda: Yes, it du, yes it du, doesn't bother me. Well, there's only one particular patient and that was um, a young man (2), he must have been 18, I don't know. He was (2) He never actually done anything but, you, you felt as though you really had to be (2) you know cautious.

DS: You had to be careful?

B: Very careful.

DS: Because, what, what would have happened?

B: I don't know, it's just stories you hear about him, you know, that he's violent and er. If you upset him he can just, flip.

DS: Right, so, so you felt a bit apprehensive **

B: Yeah. Just that one.

DS: Um, and that would have been because, d'you think it was because of the stories you were told about him? Or do you think it would've been, also about something about him himself?

B: There was something about him as well. It's just the way he walks, and stands, and looks (3) That's the only er. I've never had any experience of him.

DS: So he's never actually done anything?

B: No, no, but I've heard people, I mean especially in the pubs, that he's wiped the counters clean of glasses when he's (3) you know, gone into a rage (laugh).

DS: I see, yeah, yeah. Does he still come into the um, ⌜store?

B: ⌞I haven't seen him for a while. No, but apparently they have to keep him under control.

D: I see. He's a young chap?

B: Very young chap, yeah (5 secs)

DS: So he's the (2) he's the main one then that you've you've had anxieties about.

B: Yeah. Just that one.

DS: In, in all those years, just that one? I mean that's interesting isn't it?

B: Yeah, mm (3) Yeah, I mean, none of the (2) No I can't say really, really. I can handle most of them that come in the shop. (p7)

There are two central points to note about this passage. The first is that Brenda has not herself witnessed the man's violent behaviour but warrants her belief initially by reference to stories that she has heard, going on to use my prompt to invoke the notion that there is also something about the man himself which is disquieting. The initial warrant is quite legitimate and comprises an account of a discursive form of knowledge, of 'coming to know'. Brenda knows the man is violent because she has heard stories about him. This is in itself unremarkable.

My defence of the man is met by Brenda by a reiteration of her point and a brief précis of the stories. Brenda is unwavering about her conviction.

Secondly, what I obviously saw at the time as being of major interest was how Brenda could apparently only quote, or only wished to quote, one instance of concern over all the years she had been in the village. The interview was a difficult one. Brenda was hesitant. Perhaps she had been holding back or felt too anxious about the interview to say more? But a further reading provides a possible explanation.

By redirecting our focus upon the potential *functions* of the discourse it becomes possible to see something of interest. For although propagated by myself, the seeds of the argument and prime function already lie in Brenda's first paragraph.

> Brenda: Yes, it du, yes it du, doesn't bother me. Well, there's only one particular patient and that was um, a young man (2), he must have been 18, I don't know. He was (2) He never actually done anything but, you, you felt as though you really had to be (2) you know cautious.

Brenda has said it does not bother her whether patients wander around the village. This is a brief statement of generality in which patients constitute an undifferentiated mass. She is, she says, only concerned about a particular case. And it is this particular case which is sufficient to cast *doubt* upon the correctness, rightness or sensibleness of the general - that patients should have freedom to enter the village. The seeds of doubt are sown here. That the majority of patients may in fact wander meekly around the village no longer matters; the one counter-example challenges the tenor of the text, undermines the general and promotes the particular. The 'doesn't bother me' becomes subordinated to the emphasis upon, and worry about, the particular case. And again moving frame away from the text alone, it seems that the history of the relationship between village and hospital is, at least in part, one of a kind of lurching from crisis to crisis of imputed danger or nuisance; of the occasional particular within the general.

It is possible therefore to see how violence, threat and danger may contaminate a text. In this form of accounting, which displays a kind of crude falsificationism, just one instance suffices to falsify, or at least cast strong doubt upon, the hypothesis. And it may be that the form of the account is congruent with its content. For where violence is concerned it

arguably only takes one episode or instance to shake confidence and undermine trust[27]. If the content in the above passage were reversed, for example, so that the mass of patients were seen as violent and the odd one was portrayed as harmless, the effect might be different.

This passage again illustrates the omnipresence of anxiety about violence, such that even when presented as exceptional it comes to dominate the text. This can also be seen in the following passage where Irene, in response to my question about a hostel next door draws upon an incident which had been recounted by herself and her husband earlier in the interview (and presented in chapter 9 above, p238-9), but which actually occurred almost 20 years previously. This one incident has cast a long shadow:

> Irene: But if it were for bad cases I would say, well, I wouldn't be very happy. I mean if it's someone that was gonna break out and, club you one with a hammer or break in the house. (p15)

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27 Although this may not be the case in cultures where physical and 'unpredictable' violence is not only expected but valued. Consider, for example, the account of 'Going mental with the hard core', in Hobbs and Robins' (1991) discussion of football violence.

6: Discursive Dependence and Relative Balance

In the previous pages I have shown how danger, threat, violence and nuisance are recurring themes, often linked to the expression of concern for patients. I have summarised these linguistic sets as the interpretative repertoires of Own Interests (Major and Minor) and Humanistic Concern, and have configured these two major repertoires in terms of the expression of dilemma. I have also noted how there is occasional reference to patients as autonomous beings and I shall further track this motif in this section.

The title of this section 'Discursive Dependence' derives from the way the phrase 'It depends' is used in villagers' talk about patients in the context of potential controversy. It is, to be sure, a common enough phrase which is used not just by villagers, but which has applicability in every walk of life. Yet the very commonality of terms or phrases can sometimes conceal their intrinsic interest and their functions.

And it is arguably an analysis of the common sense, practical, everyday phrases, terms or maxims that can point us towards the 'ideological nature of thought' (Billig et al 1988 p2, Donald and Hall 1986, Fairclough 1989, Thompson 1984, et al) as well as the dilemmatic nature of ideology which can be seen to contain contrary themes (Hall 1986, Billig et al 1988, and see chapter 12 above)[28].

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[28] There is an extensive literature on ideology, its link with common sense, and the issue of the way ideology embodies contrasting themes which is too large to reference here.

In the process of analysing transcripts I was struck by the frequent use by respondents of 'It depends' and variations such as 'Depends', 'Depending on', 'It would depend' and so forth. This may be seen as a cousin of the discursive strategy 'on the one hand...on the other hand' which Billig et al (1988), drawing upon van Dijk (1984)[29], have linked to prolepsis and dilemmatic thought. These authors suggest that if someone uses the terminology 'On the one hand...on the other', in a particular context, we may expect to hear a dilemma in the form of two competing themes. At the same time these themes may often not balance out (Billig et al 1988 p109); that is, in its proleptic mode the two handedness may serve the purposes of one hand, as in 'On the one hand we've nothing against them but on the other hand they take our jobs' in which a critical comment is facilitated (and see chapter 12 above).

If someone begins their statement with 'It depends', we may immediately look forward to the possibility of hearing at least two positions[30]. On occasions the 'It depends' is implicit while the statements follow a similar form, usually revolving around 'but', and often couched in the form 'if..then, but, if..then'.

Essentially 'It depends' signals the undecided or pending (hanging, from *Lat: pendere*), nature of a situation, phenomenon, course of action etc. The decision is suspended to be finalised in the future. It may be finely balanced or not but 'it' remains to be seen. This is probably the semantic core of 'It depends'. Something, we may say, 'hangs in the balance'. 'It depends' then connotes both 'waiting' and 'weighting'. In

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29 There is also a passing reference in van Dijk (1984 p48) to 'It depends'.

30 Of course 'It depends' may be used to imply more than two alternatives, and may even suggest the rejection of *any* fixed meaning or truth; an overarching uncertainty.

this sense we can see doubt and equivocality which takes the place of a 'yes' or 'no' answer[31].

In the abstracts below, 'It depends' is used primarily and explicitly to refer to 'types' of patient. The evaluation or judgment depends upon the type of patient who would for example be placed next door in the mental health facility. This seems fairly clear. Yet the passages often also possess a dilemmatic quality such that the respondent appears to find it difficult to know how to respond to the question, as in Irene below (p354): 'Well I don't know...' . In addition such passages often possess a proleptic form such that one part can be said to dominate another. In this sense 'It depends' may indicate uncertainty and possible dilemma.

At the same time, like 'On the one hand...on the other', or 'Don't think badly of me, but...', 'It depends' also suggests a balanced thoughtful view, a rational and reflective form of discourse[32]. In a later section I provide an account of a number of different kinds of 'balancing devices' which achieve various balancing effects. For the moment I am interested primarily in the content of the competing repertoires which 'It depends' signals.

In the context then of a potential controversy, 'It depends' both reinforces the topic as one of controversy while providing for the resolution of uncertainty. It acts to show how the problem or uncertainty is 'worked out' in practice.

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31 In an earlier draft I provided a more extensive analysis of 'It depends' but to reproduce it here would be to overburden the text.

32 As noted earlier, Billig et al (1988 ch 7) have coined the term 'reasonable prejudice' to describe the style by which prejudice is at once denied, deplored and protected.

The abstracts which display talk in this way are numerous but a few examples must suffice. These examples illustrate the way 'It depends' reflects reluctance, controversy and possibly dilemma; is linked to talk about 'types' of patient; and implicates a variety of repertoires. In particular the following examples have been chosen to illustrate further the range of interpretative repertoires involved. In the language of discourse analysis we can say that 'It depends' is a figure of speech which signals the utilisation of competing interpretative repertoires within an argumentative context.

Irene is a 68 year old retired woman who has lived in the village for over 30 years. She was interviewed with her husband, Tom, also retired. Irene had worked as a sales assistant in several village shops. In response to my question about how they would feel if a hostel were built next door, she replied:

> Irene: Well, I don't know (2) Um (2) I don't think. It depends on what type of person they would put into it. (DS: Yeah) For instance if it were just the normal depressions, nervous break-downs, things like that, I think probably you'd accept it. But if it were for bad cases I would say, well, I wouldn't be very happy. I mean if it's someone that was gonna break out and, club you one with a hammer or break in the house. (p14)

The form here is clear. Two positions are linked by a 'but'. And these positions are illuminating because they refer explicitly to two 'types' of patient, a common differentiation which I shall explore in more depth later. Here the 'normal' (normal depressions, nervous breakdowns) is contrasted with 'bad cases' (cf. Goffman 'Normal Deviants' 1957/1967). The latter position which Irene says she would not be happy with, is clearly an example of the repertoire 'Own Interests' (Major). But what of the first part? It is unclear here exactly which repertoire this relates to.

The second example is taken from the interview with Penny:

> DS: Imagine that erm you got a letter from the Council saying that um they planned to build a, a mental health hostel next door to you, what would you think about it? Gonna house about a dozen, dozen former patients?
>
> Penny: We've talked about this before actually. (DS: Probably I might have asked) No not, not with you. It's a friend, friend of my sister's. It's, it's actually happened to her, right next door to her house you know, and she's sort of unsure, um, how she feels. It depends what sort of patient you're going to get in there, do you know what I mean. I mean I wouldn't want, people peeping over the, you know some of them peep over the fence and, I think that would be, I don't think the kids would like it.
>
> DS: So it would depend on the type of patients that they had (4) So you could imagine, that it might be alright, if they were all **?
>
> Penny: If they were all. Yeah, if they were like that, I mean I don't see anything, anything wrong in it really. If they all know how to, to cope and to look after themself and they're not ones who are going to sort of go mad and start putting bricks through your, your windows and that. (p13)

Again the argument contrasts 'sort(s)' of patient. Both aspects of the Own Interest repertoire can be seen in Penny's reference to nuisance (people peering over the fence) and violence (putting bricks through your windows). But in addition we can see a reference to a different 'type' of patient corresponding perhaps to Irene's 'normal' patients. These are people who know how to cope and look after themselves and who at the same time are neither a nuisance nor violent. To extrapolate beyond the interview text it may be that these 'types' constitute 'types' in a Schutzian sense of the typifications which structure everyday action in the village life-world.

In a different part of the interview Penny and I had been talking about whether patients should be allowed into village pubs:

> Penny: Well I know it sounds horrible but they smell a bit. You know you get the ones that smell in there and they start coughing and choking with their cigarettes. You know, I mean, some of them they're alright but I can remember going in myself and thinking, you know, they shouldn't be allowed in here. You know, you go out for an evening you don't really want to sit and listen to that. As I say, some of them, again it depends what they're like. (p20)

In this context 'it depends', which again implicates the possibility of different 'types' of patients, is dominated by the preceding negative evaluation in which patients constitute a nuisance, and appears to be an afterthought, but one which allows for the potential redemption of patients.

References to such people, hypothesised patients or former patients who have some ability to manage their own affairs, can be found in various parts of the transcripts. The following two extracts have the same form as those above but the 'It depends' is, I suggest, implicit. I have drawn upon these to illustrate my reasoning concerning the development of another repertoire.

The following extract is taken from an interview with Anthea, a 68 year old retired woman who has lived in the village all her life. I had just asked her how she would feel about a hostel being built next door:

> Anthea: I don't think I'd like it (2) Well, I wouldn't want anybody to build *anything* anywhere near me (laugh).
>
> DS: * If it's possible to separate the two, the building and the um, the issue about having, people who were patients [here]? (2)

A: Well, I, I think you'd have to um (2) give them a chance, wouldn't you. But I mean, if they weren't able to cope and the place was dirty and it was out of hand, that's what I would be apprehensive about. But I mean if they could if they could look after themselves and keep the house and themselves clean um providing they're alright, I don't think, I don't think there's any difference. (p16)

Again it is possible to see the backwards and forwards argument, this time revolving around two 'buts', and suggesting both an ability and inability to cope as well as an implicit 'nuisance'.

In the next extract the coping patient is contrasted with explicit concern about other patients who are unlikely to be able to cope, and is taken from an interview with Karen, aged 28, and employed as a P.A. in a local business, a relative newcomer, having been resident in the village for only 2 years. The extract takes the same form but instead of 'it depends', is headed with: '...I think there are two things'. Lines have been numbered to assist analysis.

1 DS: Closing down the big institutions. Do you have any thoughts on that?

3 Karen: Um (1), I think there are two things. Um some people I think will probably benefit from it say perhaps the younger ones, the ones who are (2) are just a bit confused, you know, there's nothing, dangerous about them or anything. Um, where my parents live just up the road
8 there's a large house been converted into little flatlets
9 and little bedsits, um where half a dozen of these people live. You know, it doesn't make any difference. That's fine. I mean they're there in the community and I know one of them gets on the bus and goes off to * That's fine, they're obviously leading more of a life than cooped up
14 in a big hospital. But, when you get the elderly patients that've been there all their lives, which, you know, from the few that I've seen I, I tend to think [as] that what they are. You don't see many young patients or I don't, you know I dont, I don't, I'm not involved in the hospital so I don't really know what's *. The people that I've seen wandering about all seem to be quite elderly, and I would

have thought um that if they've been in there all their lives it's home to them, and to suddenly say Oh we've got this brilliant new idea, you're going off somewhere else, I should think it would frighten and confuse them even more, personally. I mean I'm not a professional, I don't know. I presume the psychiatrists know what they're, you know, ┌know what they're doing, or maybe they don't I dont know
29 DS: └Know what they're doing, or maybe they don't.

K: But it just seems logical to me that if somebody thinks of a place as home and they're used to it, they know every inch of it, go to the village and they've got a routine. Suddenly pack them up and ship them off somewhere else
34 when they *are* so confused, * (p14)

The first point to note about this extract is that on the surface we might say that it has a liberating aspect in that lines 3-14 appear to acknowledge that many patients have a potential for autonomy, for self-determination, and should be allowed out of hospital. In its second part (lines 14-34) it recognises that other patients are vulnerable and should be allowed to stay in hospital. The tone of the extract is one of 'concern' by the speaker for patients' welfare, and criticism of the hospital authorities.

In terms of its rhetorical structure the extract can be divided into two parts, joined together with a 'but' in line 14. In the first part Karen tells us that the 'younger' patients who are 'no danger' may be allowed out. The 'older' patients referred to in the second part are ascribed feelings of fright and confusion at the prospect of being moved somewhere else. The sequential order of the two parts is important and asymmetrical. If they were to be reversed then the emphasis of the passage would change. The first part can be read as having the function of 'feeding into' the second, of setting it up as it were. In this sense it is not independent of part two. In its rhetorical form it is close to a disclaimer or prolepsis.

In addition the grammar used in part one is arguably patronising. The use of diminutives in lines 8 and 9 portray a sense of these people as children. The syntax transforms and transfixes any other potentially radical meaning; the patients being discharged have shrunk descriptively and morally to the size of children and hence still need attention, albeit not in hospital.

We might also add that the division in the above text between young and old people acts as a supposedly self-evident explanatory and supporting mechanism. But again, although *we* might think that older people might not want to move home, this may in fact not be the case at all. The feelings attributed to patients are presented as causally independent of the patients, stimulated by the environment, feelings over which patients have little control. There is no suggestion that patients might actually *want* to move out, or that they could be consulted about moving. In this sense, in which patients are not granted a capacity for choice, the message dominating the account is that patients should be looked after.

Finally there is mention in the account of younger patients who are not dangerous, in a way that suggests that somewhere else 'other' patients may be dangerous. The text does not tell us where these others are. The reference to danger is an aspect of the 'Own Interests' repertoire previously identified.

I want to suggest that the extracts presented in this section point towards the delineation of a further repertoire which incorporates references to patients' (sometimes limited) autonomy. This fails to fit easily into the other repertoires already identified. It is not readily congruent with villagers' expressed concern for their own interests which is linked to patients as either dangerous, threatening, violent or a

nuisance. Neither does it fit easily with the repertoire of Humanist Concern, with its stress upon caring villagers and sick or ill patients who need to be helped, looked after and cared for, especially in hospital (although it could be made to fit these).

I have therefore named this the repertoire of Relative Balance and I have shown above how it may be modified by particular grammar, and used in conjunction with, as a quasi-disclaimer, other repertoires with various effects (and cf. Kev in 'The Odd One' p344 *ff*).

The naming of this repertoire in fact went through several stages, beginning first with 'Coping Patients' and moving to 'Quasi-Autonomy'. I felt however that these names did not really capture the relationship between villagers and patients. The name Relative Balance incorporates a number of references:

a) Like the preceding names it suggests that there are for villagers different types of patients, and that some may be more balanced or stable than others, as Mike, aged 16 and born in the village, suggests:

> DS: ...What would 'fitting into society well' mean for you? What would they, need to do or not do, to fit in? (4)
>
> Mike: I think they'd have to be of a, a more stable character. Not so unpredictable as some patients can be. (p15)

b) It touches on the idea that there could be a change in status involved in discharge into the community so that patient-villager statuses could become relatively balanced. This was suggested by Anne in discussing the possible siting of a group home next door:

> Anne: Erm (6) Let me think, I can't think. (Arthur interjects) Well, providing they *are* in the category where they can look after themselves. (Talking over each other) It's just like another householder isn't it, just like another house (p18)

c) 'Balance' is related to rationality as in a) but also refers back to villagers' balancing devices (see below) which allude to further evidence of villagers' rationality in their transcript texts.

d) Finally it also hints at the relationship between rationality, realism and relativism which this thesis has also addressed.

Discursive Dependence, Qualified

In the previous section I argued that it is possible to identify a repertoire of 'Relative Balance' which is drawn upon in the expression of 'discursive dependence'.

We also saw above in the extract from the interview with Karen that a diminutive 'little' was used with the effect of challenging the status or autonomy of discharged longer stay patients[33]. This word is used occasionally in other interviews in relation to patients, as in the following excerpt from the interview with Mrs and Mrs Green, Harold and Wendy. This retired couple had lived and worked in the village for approximately 40 years:

> DS: Did you make friends with patients yourselves?
>
> Harold: Oh yes=
>
> Wendy: =Well, only through business really

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[33] Van Dijk (1984 p137) also mentions the use of 'paternalistic diminutives' by his respondents.

H: Not, not, not er personal friends, no. I mean we, there's one that is there at the moment, a very intelligent um man really. I mean he, been there 40 odd years and er, er but um he obviously was the type that couldn't, be outside the environment of the hospital. As soon as he went out he was sort of in a phobia that he'd got to be back and er. But he was working there, and (1.5)

┌translating=
└

W: └He run a newspaper

H: =He run the newspaper and he translated Russian. He was very good at Russian and he used to do this translation and er, he had his own little, room and did that and he was musical and very good. And he was the patients' representative on the, League of Friends. (DS: I see) But um then unfortunately he was told that you know he was one of better ones and he would probably have to go out, and he's gone back er in a very bad state.

DS: He's still in there is he?

H: Still in there, yes I'm sure. Yes cause we were talking about him recently. (p2)

And

DS: So that wouldn't be very popular, if they were rehoused next door?

Wendy: No, I don't think. I mean, I'm saying if, I mean they haven't tried, well they have tried a few but I mean not generally speaking in the village. They've taken them out=

DS: =I know there's some down the bottom of the hill

W: Oh yes, well of course there's their own little

Harold: Yes they are eh=

W: =** (p7)

The next extract is from an interview with John and Susan Smith, another retired couple who had moved to Shenley over 50 years previously, and who initially lived within the hospital grounds. When I met them they were resident within the village.

In this excerpt 'little' is used in relation to patients in a way which conveys poverty, paucity and dereliction:

> Susan: It's like they are in London now. A lot of those patients are there with their little boxes, ┌they're sleeping in the park. I=
>
> John: └Well you dont know it (laughter)
>
> Susan: =don't know it but my mind tells me that er that's where they are, a lot of these patients, in their little boxes. That's my little section of the pavement. But yeah, they've got to go somewhere haven't they? (3) And I think its dreadful. (p7)

The effect of a diminutive may obviously vary according to the context but often appears to transform the subject or object to which it is attached into something or someone not quite complete, or unimportant. In my reading it is patronising. Occasionally too the connection between patients and children is made explicit[34].

In this next extract from an interview with Jean, a 21 year old villager, born and bred, the comparison with children is made explicit. I had asked Jean whether any patients would be allowed to join the local carpet bowls club. Her reply, which began with an 'Um, depends who it was I think', meandered through different arguments to finish here:

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[34] The connection between mentally disordered people and children is one which has a long history, see e.g. Platt and Diamond (1965). In her interesting book in which she considers the grounds upon which madness may be said to 'exculpate', Radden (1985) draws parallels between the 'unreason' of children and that of madness (ch 10), via a consideration of the work of Piaget. Mad people and children, she argues, share a similar lack of reason. This notion of madness as '(Exculpating) Unreason' (rather than, for example, disease) better allows us to regard madness as ordinary and everyday, less obscure, puzzling and less *different,* she maintains, without rendering it identical to sanity (p53). The psychoanalytic tradition also establishes other kinds of links between madness and childhood.

DS: Um, I mean if somebody turned out to be quite good at the bowls, would he be allowed?

Jean: Probably yeah. Yeah, if he wasn't any problem and he was quite good at it. Did as he was told, then yeah (6). It's like with the young ones, there are, I think the youngest one there's now is 15. There's a new girl started, I think she's about 10, and they used to be younger. Used to be quite younger and it's just the same children, init, a lot of the patients. As long as they do as they're told and are quite good. Know what they're doing (7) (p10)

And later in the interview Jean had been talking about how she had once worked at the patients' shop within the hospital grounds:

> Jean: ...It was quite funny actually, I was scared at first serving the patients. In the end you just do it. You don't worry about it, you have a chat with them all as well. I found it hard to serve the normal people if you call them normal people. Nurses and that. Didn't know how to speak to them. Cos you're so used to the way you speak to patients you know. Some of them you speak to like children. Some of them you have to respect as well cos they get angry with you (laugh). You never even used to know, sometimes you didn't know which were patients and which were nurses. Some of the foreign ones you couldn't tell. (p4)

In the interview with the Greens the same identification can be seen:

> Wendy: ...As we always said the patients are no more trouble than, most of the public are quite nice but you get them, some of them that you see them coming and they're all a damned nuisance. There's no difference really is there? We always said their money was as good as anybody else's and they needed um kindly treatment and er, generally speaking, not all of them but some treated as children. Some are highly intelligent and of course it's the highly intelligent one that can be very sarcastic at times to you. (p4)

7: Humanist Concern: Help and Care

I have shown above how the interpretative repertoire of Humanist Concern has been used in conjunction with other repertoires in the production of particular discursive effects in the context of debate and argument. In this and the subsequent section I intend to show how this repertoire may be elaborated.

I indicated earlier (p308) that the repertoire of Humanist Concern has a number of different facets and it is to this range that I shall now turn. The extracts presented below inevitably also display the repertoires Own Interests and Relative Balance, for in the large majority of interviews all three are drawn upon, in different combinations and with various discursive effects.

These different aspects could, to be sure, be portrayed as repertoires in their own right but I have chosen not to do this in the interests of economy and textual management.

This section is concerned principally with a major distinction which can be made within the Humanist Concern repertoire, between the notion that patients should be 'looked after', especially in hospital, 'cared for' in their 'proper place'; and the suggestion that patients might or should be 'helped'. Both parts express Concern but with a different emphasis. A reference to villagers' desire to help patients can be found in the extract from Parish Council minutes presented on p311, as a first part of a prolepsis:

> Councillor Broadley stressed the fact that in general there was a very real desire on the part of the Village to help in all practical ways the recovery of those patients who would benefit by mixing with the outside world, but...

The focus upon 'help' is often oriented to the notion that patients or their conditions may improve, whereas being looked after, or cared for, may suggest that no improvement is possible. These two parts of the Humanist Concern repertoire are not mutually exclusive however. Clearly it is possible to talk of patients being 'looked after' at the same time as being 'helped' towards, for example, greater autonomy; or to see being 'cared for' as, *eo ipso,* 'help'.

In fact direct references to 'helping' patients are few and far between in the transcripts, and when used they are often accompanied by signs of doubt and dilemma. The following extracts were taken from an interview with Lou, aged 17 years and still at school. She had lived in the village for 5 years and worked from time to time in the local store:

> DS: Supposing then in, in the context of the hospital closing down, supposing um the planning authority came to you and said um, well actually Mr and Mrs [Blackwell] and family, er we have plans to build a mental health hostel right next door here to [your] cottage. What would you think about that? (2)
>
> Lou: Um (2) I don't know **
>
> DS: Would you have any objection to it?
>
> L: Um (4) Not really, well (3) In a sense yes and in a sense no.
>
> DS: Do you think you could explain that? In what way would you have objections and in what way wouldn't you?
>
> L: Um (5) I'd mean to help them (9) They'd be new people. Um (3) (p8)

Later Lou elaborated upon her doubt:

> DS: You were saying yes and no and I'm trying to get at what the dilemma might be, about.
>
> Lou: People who didn't know the area and they came to visit us and they realised that you were living near patients. Some people would resent it and they wouldn't return because they'd think it would be (4) * and they wouldn't like it.
>
> DS: Do you mean friends of yours?
>
> L: Just general people who aren't used to living near psychiatric hospital or anything. They've never met anybody like it and they're terribly unsure. They'd still be unsure 'til they got to know some of them. They'd soon change their mind. (p9)

The reference to misguided outside 'Others' is ubiquitous and will be analysed in detail in the next section. In the present extracts the message is explicitly one of uncertainty, with the interviewee drawing upon the Humanist Concern (Help) repertoire to reference her own position. In another passage, Lou again speaks of her desire to help people who are patients, this time in the different discursive context of working in the store, and in a more positive manner.

> DS: You were saying that you'd miss the patients because they're characters? (5)
>
> Lou: A lot of them have very strong characters.
>
> DS: Characters, character could be positive or negative presumably. It could be nice or nasty? Presumably you see them as positive characters?
>
> L: Yes (2) There are a few that you'd miss. They don't, they're very, shy and they don't feel like talking * because you're trying to get them to talk and when they do talk, they do talk (laugh). Rather a long time. And they, I'd miss having the chance of being able to help them regain their self confidence * speak to other people.

DS: Do you see that as one of your jobs in the store?

L: No I enjoy it actually. It's not exactly part of the job but it's, because they, if I'm wandering round the village they sort of recognise and they actually come up and talk to me. In the beginning none of them knew me and they just walked past. And at the beginning none of them knew me, or, they weren't, they weren't too sure, but now they talk to me. You know they meet the family occasionally if I was out with my mother * go up and talk to them and introduce them to * (p15)

And

DS: How does that feel, that they want to talk to you?

Lou: Um (3) Well I'm very glad that they want to talk to me. At least they want to talk to somebody. They talk to quite a lot of people but they have to know them well and know they can be trusted and know they, um, have people behind them that are going to make them talk and make them realise that *

DS: So it's good for them and presumably

L: Me as well

DS: Is it good for you as well?

L: Yes. It gets me to talk to people which I could do anyway, but. You know you feel there's something there when you talk, when you manage to get somebody to talk who's shy. (p15)

This notion of discovering 'something there' when talking to patients is repeated on occasions by other staff who work in the store and provides an interesting commentary on the fundamental importance of communication.

Lou's strong message of explicit help stands alone amongst the interviews, however. In another interview with Mike, an articulate 16 year old, doubts were again expressed, following my lead,

DS: A hypothetical question. If you were in charge of the store instead of [Brian] would you ever consider employing a patient? (4)

Mike: Mm (2)

DS: Or would you have doubts about that? (3)

M: I suppose they'd be understandable doubts to have about employing a patient. If there was, you know certain patients who by the hospital's recommendation, *were* more ready for outside life, especially if they're being moved into you know the homes for the rehabilitation into society, then I think there would be a space for employing a patient on a small part time basis, to, you know, enter them back into society. Um, whether taking someone on, because I'm not too quite sure about their you know, the intellectual capabilities. There are limits to what you can give them anyway. But I think if you had certain peop, patients who were trying to be rehabilitated then yes.

DS: So you'd prefer to have some kind of endorsement from the hospital?

M: If the hospital gave recommendation, yeah. I wouldn't, you know, I wouldn't do it without finding out from the hospital who, who were the more (4) the better patients who were more in society. (p13)

Mike's talk provides for the possibility that he could, in the appropriate circumstances, help patients, although the 'space' to which he refers, 'small part-time basis', seems quite restricted. In terms of the structure of his reply he uses the form 'It depends' to refer to particular kinds of patients, which I have argued has a dilemmatic quality. In addition Mike provides us with a reflexive meta-comment. Following my lead he does not simply admit to having doubts but modally suggests that in this context, doubts 'would be understandable'. My argument is that this reflexive comment, expressing as it does a direct comment upon his own understanding or understandability, performs a certain and interesting function. First of all it challenges any suggestion that doubt may be an indication of something not-understandable, that is, as not

rational. In this sense Mike is discursively recreating a view of himself as a rational and accountable actor. He is raising a validity claim about himself, his inner world, and those of similar others. But in addition this reflexive meta-comment provides a commentary upon how people like him may be expected to reply to this kind of question. In particular it can be seen as a commentary upon the normative rightness of his assertions in the interview context so that he thereby states that doubt is not normatively wrong to be expressed here. In a later section below (p430 *ff*) I shall elaborate upon the functions of reflexive comments in interview texts.

In contrast to the display of a desire or willingness to help people who are patients, the expression of Concern that patients should be looked after and cared for is regularly found in transcripts and more clearly overlaps both conceptually and functionally with the use of Own Interests, as I have shown in the previous sections. In other words although retaining different foci, both Own Interests and Humanist Concern (Care) conceptually incorporate the idea that psychiatric patients should be looked after, preferably in psychiatric hospital, and the two are often employed together with functional effect. In contrast, the emphasis of the repertoire Humanist Concern (Help) is more compatible conceptually and functionally with the repertoire Relatively Balanced, which I have argued allows for the possibility of patients being semi-autonomous and 'coping' outside the hospital.

But while sharing as it were the same territory of Humanist Concern the two aspects of Humanist Concern (Help and Care) described here may in addition each be used to counter the other; that is as a resource for an argument against the other, as the following extract with Wendy and Harold Green begins to show:

Harold: Well I think the hospital was there for the, the mental pa, was built for the mental patients and as I say these have been institutionalised all these years and to go out into the outside world, erm they're going to be lost er and I think that there'll still be people needed, mental care. More so with the stress of the erm world today really. I think that er you know you need a place like that and I think a purpose built place like that, they'd be far better looked after even if they were only there for a year or six months and then go out rather than sort of sending them out now into homes where they've got to try and go to the market place and people are going to be taking advantage of them. I mean because I'm sure people would do, really.

Wendy: I can't see them living in the community, I mean I may be wrong, but everybody I've spoken to said, em everybody I've spoken to said, that if they put four in the house next door, we wouldn't, em, I mean we'd speak to them obviously, but we wouldn't ask them into our house, sort of thing. And we wouldn't really expect to go in and look after them if they needed to be or if we saw their dustbins all filthy and, and they weren't looking after themselves. (p7)

The message here, which actually contains a number of fascinating and subtle parts, is that patients cannot cope 'outside' and should be looked after in hospital; and that arguably because of this, neighbours of patients rehoused in the village would not expect to help out in certain ways.

This extract could be said to blend the repertoires of Own Interest and Humanist Concern in a manner which functions to justify the unwillingness of the speaker, (and via an extreme-case formulation, other villagers), to provide support, strike up friendships, help out and so on. Here, Humanist Concern (Care) is used affirmatively and Humanist Concern (Help) is disavowed. And it is in this precise context that the intervention by Harold some 5 minutes later in the same interview can be understood.

Wendy: If they want to go and they can be seen to be looking after themselves I suppose it would be a shame to stop them but, I dont know *

Harold: I mean I was speaking to a nurse who was erm on the League of Friends, she came from the Brent area, and she got put onto accepting the patients from the hospital and sort of caring, seeing they were alright when they got out into the world. And I met her at a meeting in July and said how was she getting on and she said Oh oh very, very well. Erm, it was in the Ruislip area and the [peop], the patients that had gone there they'd got in a house and the neighbours were accepting them in, very well and they were looking after, you know keeping an eye on them and things like that. And she felt that the group she was looking after, they, they, they were progressing alright. But er I don't think that'd apply, you know I feel they'd be finishing up at er, under the bridge at Waterloo, like, and er=

Wendy: =I suppose, I mean you probably know this the ratio of how many going out, how many are living happily, but how many are sort of ending up in prison or doss houses and such like places, or are, I dont= (p8)

Harold, perhaps initially surprisingly, provides an account of a conversation in which a group home was said to have been working well in a different area with the support and help of neighbours, but, in an argument which is congruent with the position proposed by his wife, tells us in effect that these neighbours and the professionals were, or are, misguided; they do not essentially *know* the patients. This can be viewed as a variation of the Reality/Appearance device described by Potter (1987) and Potter and Wetherell (1987), originating from Eglin (1979, and compare Pollner 1974, 1975). The message implicitly suggests that the appearance of positivity portrayed by the account of the discussion is belied by the essential reality of the situation. The appearance must therefore be discounted. Regardless of the truth of the recounted discussion the (implicit) 'R/A' device can be seen to mediate between the repertoires already raised and conjoined by Wendy in the previous extract, which for this reader left a sense of

unfinished business. Harold's intervention may be read as an effort to clear up this business. Its effect is to challenge any thought that the couple were themselves being uncharitable in some sense, for the couple can see beyond the appearance to the reality thereby concealed.

This extract, then, has considered how the available repertoire Humanist Concern (Help) may pose a problem for respondents (via its disavowal) and need discursive mediation or management. That it may also be an asset can be seen from some of the first extracts in this section. 'Helping', certainly in its use here, has a positive evaluation, providing an instance of moral repute which cannot *itself* be easily or seriously challenged on its own grounds. As in the case of Wendy and Harold, challenge may be achieved via the transformation of the area of validity claims raised. The Greens were not challenging the moral correctness of helping per se; only its factual correctness - they can be said to be engaging a technicist or instrumental discourse about the correct therapeutic method in the circumstances (cf. p341 above), in which the validity claim of truth takes precedence.

The above extracts from the interview with Wendy and Harold are also of interest however for the way they illuminate the themes of inside/outside, whereby a stressful outside world is recreated in which patients will be 'lost' and taken 'advantage' of. To be sure Harold's later account of helpful neighbours somewhat complicates his position, but illustrates again a central point of this thesis, the variability of discourse in argumentative context.

A different interview also provides an example of the way patients are spoken of as needing to be looked after in the hospital in a way that also implicates an interesting

distinction between inside and outside. The context is Hostel talk. The extract is included here in part because of the difficulty involved of working out just exactly what had been going on within it. It is taken from the interview with Jean:

DS: Part of the reason for this study that I'm doing is uh, is because a lot of the hospitals are closing across the country. It's not just Shenley. It's a nationwide, international thing really. Have you had any, did you know about that?

Jean: Yeah, yeah.

DS: Do you have any thoughts about it?

J: Well as long ago, as long ago when I was 14 when I first started there that's when they first started sending people out, they were trying to get them to live in the community. Giving them houses, living together and that. But, a lot of them used to go out and I remember seeing them coming back ten times worse, you know. Used to be in terrible state when they came back. They *always* came back though. Hardly any of them went out and stayed out.

DS: So what will happen then when there aren't, these big hospitals, when they're all shut? They won't be able to go back to Shenley because Shenley won't be there.

J: I don't know what will happen to them. I don't think they'll cope though, a lot of them, especially the older ones.

DS: Well I suppose um, the idea is to find other accommodation in various places. A lot of people will be going back to London. Um, you know they come from Brent and Harrow mainly. But supposing, supposing you got a letter from the er local Council saying, they wanted to build a hostel for patients from Shenley next door to you. They're knocking these two houses down and they're going to build, or they're going to convert them into a hostel for about a dozen people. What would you think about it? How would your family and you, respond?

J: I don't think it would matter if it was a hostel for patients or a hostel or shops, they wouldn't want them houses knocked down anyway I dont think it would really bother them, not really. Cos you'd know they were, pretty capable if they were being allowed to stay in a hostel anyway wouldn't you. **

> DS: Right. So it wouldn't, wouldn't worry you too much?
>
> J: No. I mean, if there was any *trouble* then we'd do something about it then, but I think we'd try first I'm sure [they] would. (p12)

This extract proved to be eminently analysable in terms of the apparent contradictions contained within it, but a full analysis would overburden this text. I choose therefore to present a small number of points. The first is that the extract draws upon the repertoires of (in order) Humanist Concern (Care); Relative Balance; and Own Interests. The repertoire Relative Balance ('pretty capable') is used affirmatively and hence clashes with the earlier repertoire Humanist Concern (Care) ('They always came back though; I don't think they'll cope though a lot of them...'). This clash can be resolved by a speculative interpretation which focuses upon the putative functions of different repertoires as used here.

The conjoining of 'go out', 'coming back' and 'came back' in Jean's first paragraph, with Humanist Concern (Care), may be read to suggest patients going out and coming back from an outside world. This world is not elaborated in the text, but the fact that patients *always* return from it, suggests that it may be not as helpful, or enabling as it might be, or that it is simply too demanding for patients to be able to cope with. This outside world becomes implicitly contrasted with a corporate village-hospital, in which the hospital part is not entirely competent. Hence it makes sense for Jean to talk of patients coming and going as if they are going from or coming home to *her*. Patients need to be looked after by the hospital-village. In this context the use of Humanist Concern contributes to this division between a corporate 'us' and outside Others.

On the other hand Jean's later use of the Relative Balance repertoire, as in 'you'd know they were, pretty capable if they were being allowed to stay in a hostel', in conjunction with 'not really bothering' the villagers, functions to promote a view of the village as accepting of patients in contrast to a potentially heartless outside world; and also presents a view of the hospital as competent in contrast to the first part of the extract. This village acceptance almost inevitably flows from the notion of a corporate hospital-village. And if patients are being rehoused within the village then in this sense they are not leaving hospital at all. Relative Balance is used therefore to generate the inside aspect of the divide. The patients' capability *enables* the 'not being bothered'.

A number of other interpretations are possible. One suggestion made in discussion of this extract was that Jean simply wanted to please me, or to appear unprejudiced, by professing village tolerance and acceptance, at the cost of coherence. This interpretation itself raises a host of issues. Elsewhere Jean had not been slow in disagreeing strongly with me about several other points. But if she had wished not to appear as a prejudiced villager then this is of course still of interest, suggesting once more that prejudice is not something to admit to (see the section on prolepsis in chapter 12 above).

In her last paragraph Jean throws 'trouble' into the discursive ring. I read this as the manifestation yet again of that uncertainty which elsewhere has generated a hint of danger or violence. Villagers are finally represented as accepting but strict, in that they will be tolerant or accepting within clear limits, although the precise nature of the half-anticipated 'trouble' is not made clear, and the limits are not here defined. The dilemma lies between 'giving it a try' and potential 'trouble'; between 'tolerance' and 'discipline';

between freedom and order; between the individual patient and the society-village; between expressing prejudice and wanting to appear or be unprejudiced.

In the next section I consider in more detail how 'others' are used with particular discursive effects.

8: Other Times, Other Places, Other Persons.

In the process of arguing a point or position and displaying interpretative repertoires in the recorded interviews, respondents regularly made reference to an 'other' or 'others', with discursive effect. This section is concerned with the discursive use of 'other' in the research dialogue. It therefore shares an interest with broader forms of discourse analysis such as those of Foucault (1961/1971, 1975/1979) or Said (1978), the anthropological critiques of anthropological others (e.g. Clifford and Marcus 1986) and the analysis of media-assisted social processes of labelling and moral panic in which various deviant and undesirable others become raised to perfection (e.g. Cohen 1973, Hall et al 1978, Moorhouse 1991, Giulianotti 1991).

However in contrast to these analyses this chapter considers some of the more subtle procedures in which 'other Others'[34] are discursively referenced. These others do not usually display the tenor or countenance of threat, terror or barbarism and so forth which may sometimes be found for example in the mad other, but are more delicately and locally placed within the interview texts. As such this analysis has more in common with the work of van Dijk (1984) who has used the term 'displacement' to refer to the strategies by which others are portrayed as more prejudiced than the interviewee, as in 'I don't mind so much, but the other people in the street, they

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[34] For Weil (1987) 'other Others' refers to the often unarticulated part played in anthropological research by one's relations, spouse, friends etc. The 'others' that I am addressing here might then be called 'other other Others'.

get angry about that' (p131), which van Dijk portrays as a move for positive self-presentation[35].

The heading of this section refers primarily to the way time, place and person can be regarded as basic categories within which, or better, in the guise of which, an 'other' is created and deployed in the process of building a functionally significant contrast structure (D.E.Smith 1978). Although presented below as analytically separate, these categories often overlap in use, and as examples will show, the attempt at separation sometimes becomes strained. In addition the heading alludes to those common psychiatric and other medical practices whereby the cognitive orientation and functions of patients and candidate patients may be tested in time, place and person (Tredgold and Wolff 1970/1975 p11-12, Rubenstein and Wayne 1976/1980 p13). The category 'Other Persons' is most often used in the interviews and will therefore receive the greatest attention below.

The overall aim of this section is therefore to demonstrate how 'other(s)' is commonly used in conjunction with different repertoires and to begin to hypothesise about the different kinds of function which 'other(s)' might serve within the stream of argument. In addition however this chapter maintains a primary aim of continuing to develop and elaborate the interpretative repertoires.

Other Times

At a theoretical level, time has been implicated within anthropology as a crucial category in the definition of the

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[35] And compare Billig et al (1988), for whom 'reasonable prejudice' requires an 'unreasonably prejudiced' Other from which to distance and define itself (p114 *ff*).

anthropological other by predicating 'primitiveness' upon a unilinear timescale, or by using temporality as an ontological distancing mechanism (Fabian 1983, and see Harris 1991 for a recent overview of the use of time as metaphor for otherness within anthropology).

As Polkinghorne (1988 p92 *ff*) shows, in literary theory or narrative analysis, the use of narrative time assumes an important position for structuralist analysis (e.g. Genette 1979), and a central part in Ricoeur's hermeneutics-based attempt at understanding the place of narrative in human life (e.g. 1979, 1981). Similarly in Thompson's (1984) sociology or critical hermeneutics, time becomes an aspect of ideology critique[36].

My interest here is fairly specific and it concerns the place of temporality as 'other' in interview transcripts. The majority of recorded interviews contain references to the history of the village and hospital, no doubt in part because of my interest in hearing people's historical accounts. Indeed both past and future jostle for place, the latter in relation to the projected closure of the hospital, and the building of a new housing estate, the former in terms of reminiscence. The references within the transcripts to 'Other Times' are therefore extremely frequent. However my focus here is upon the discursive or argumentative relationship between Time as Other, Hospital/Patients, and Village/Villagers. Or put another way, my interest is in how time is implicated discursively or argumentatively as 'other' in the relationship between village and hospital, villagers and patients.

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[36] Time has already featured in a different fashion in ch 8 above. Bergmann (1992) has recently provided an overview of the literature on the sociology of time.

Because a previous analysis (Strange Alliances, p320 *ff* above) has dwelt upon the use of time in this manner, I shall only provide one further example here[37].

The following excerpt shows how repertoire use is supported in argumentative context with the help of a temporal other. Jean's talk about patients being presently mostly 'alright' is counterposed to the repertoire Own Interests (Major):

> DS: So they wander around the village. Is that alright do you think? Do you think, people who are patients ought to be allowed to wander, around?
>
> Jean: Yeah. Cos most of them are voluntary anyway. They don't go in there, their own will. Most of 'em are alright. There's been the odd mishap and they've had to call people out to, to get 'em, there's people escape that shouldn't have done and the alarm used to go off. We used to stay in when the alarm used to go off, when we were younger.
>
> DS: There really was a, a
>
> J: It was like an air-raid siren.
>
> DS: I didn't know that.
>
> J: Yeah. It still goes off every now and again but I don't think it's 'cos of the patients. Don't know what they use it for. We used to, I don't, I don't even know if it was, that reason. If one of the dangerous ones used to get out this siren used to go off, (laugh) like an air-raid siren. That's what we always used to think it was, somebody got out.
>
> DS: That's interesting (2) So it, it may have gone off because somebody had got out or it may have gone off
> ⌐for other reasons?
> |

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37 However the focus on time as other raises a potential problem. For the very presence of the ordering scheme of time in the extracts mark them out as good candidates for the predicate 'story'. See footnotes 5 (p305) and 11 (p322) above.

> J: └For another reason. I'm sure it was that, I'm sure it was. Cos often there used to be a helicopter come over afterwards, after the alarm went off. (p8)

A straightforward and unsophisticated translation of the above shows how Jean contrasts a past rendered dangerous because of escaping patients (Own Interests, Major), with a less dangerous present, a contrast which functions to support her contention that it is alright for patients to walk around the village. The precise manner in which the present is less dangerous, in which time has done its work, is not made clear, and indeed it might relate to a change in patients, to a change in escape opportunities, or to a change in perception of behaviour which *used* to be, but is no longer, regarded as dangerous. And it is possible to work out an interpretation in which not the social context but Jean herself has changed, in so far as she is no longer a child who imaginatively or wisely, if incorrectly, hears the siren as warning.

But of special interest here is the function of the siren, around which debate revolves. That the siren did and still does sound, and that it issues from or relates to the hospital, is not in doubt in this text. Between us, however, Jean and I have problematised the function of the siren which Jean asserts has changed over time. The siren used to signal escaping and dangerous patients.

Jean is left however with an argumentative residue or anomaly, of a siren functioning in the present for no obvious reason. Her argument may be read to the effect that although the siren still sounds, the present does not sufficiently provide for the hearing of the siren as relating to escaped and dangerous patients, in the way that the past did. In this manner the stated changed function of the siren consolidates the view of

the present as safer, while the extant use of the siren challenges this interpretation.

In this glossed reading, time can be seen to be used interactionally in a similar way to place (cf. Eglin 1980), so that both particular places and times provide for particular readings, while the readings themselves consolidate the time/place as the kind of thing which generates that kind of reading in the first place (or time). The outcome here however is muddied by the residue of the siren sounding in the present, which may function to undermine the contrast structure between past and present, between dangerous and harmless, and implicitly between present acceptance and past exclusion. One may speculatively hear this siren as a reverberation of the past, a reminder that even though patients are now harmless, they were once (and may again be) dangerous. Danger it seems is difficult to dispel.

Other Places.

To a large extent the discursive use of 'other place(s)' is more straightforward than the use of time. In relation to place, the 'other' is regularly attributed negative qualities in ways which we have already seen above. In particular, other places may be coterminous with the unscrupulous outside world, in contrast to the tolerant village. 'Other Place' then acquires the function of helping to render the village and villagers sympathetic, accepting, unexploitative and so forth. It may therefore enable the use of the repertoire Humanist Concern but an additional repertoire candidate is also highlighted here. The following extract comes from the interview with Kev. I had been asking him how he would feel about a hostel being built next door:

DS: People do, people actually do, oppose um developments like that.

Kev: That's right, yes. No I couldn't. But there again if I was (2) as I say, if it was just a normal, in say another village where it was being built and you hadn't had the experience of, of patients, then perhaps it would be different. I mean I think if, you know, if, if there were places say being built for people in this village, you'd get less objections than if you put them in a village, not London Colney whatever because they've got Napsbury, but you know in another village somewhere else, the other side the County and they were if you like getting them to live in a village and people hadn't been used to them, then they might. You'd get more complaints than, than this village * because it's just, I suppose people, I don't know, perhaps fear them or whatever, or something like that. But whereas here, I say because they, it's been here since, you know everyone's been you know about that they wouldn't think anything of it, really. Because you, right from children, I say you're brought up with them so you know, you do get used to them. But it's, it's like anything I suppose. Change. People if you like don't like change and they wouldn't necessarily like it. But er, you would get a few people complain but I don't think it would be too bad in, in Shenley just because of the fact that we're used to them (3) You'd get more complaints, you know, if it was gypsies or something, really, than patients. (p14)

Other places are used here to contrast to the village in a conspicuous manner, and are tied to the village by certain arguments involving fear, socialisation, and the taken-for-grantedness of the hospital in local life. In this way the village becomes an place of near sublime understanding and enhanced rationality. This discursive reference to a special and specific kind of local practice and identity is common in the transcripts and often has an almost timeless quality to it, witness the following excerpt from the interview with Jean:

DS: But generally speaking you think it's alright for people * to wander round the village without, being accompanied?

> Jean: I think in a small village yeah. Cos most people in a small village have always lived there just like Shenley, although it's got bigger now, people moving in. (p8)

References abound in the interviews to villagers being 'used to' patients, growing up with patients, taking them (patients) for granted, knowing patients, and to patients and hospital as 'facts of life'. Time (history, change, diachrony) and timelessness (changelessness, synchrony) become interconnected themes. In this manner a new repertoire can be identified which plays a part in respondents' talk about the hospital and patients. I have called this 'Local Identity', which incorporates identity in time, place and person[38]. This repertoire has a correlate in other people and places located outside the village, or commanded by a different structure of rationality. On occasions such places are explicitly linked to exploitation as this extract from the interview with the Greens shows:

> Harold: Well I think the hospital was there for the mental pa, was built for the mental patients and as I say these have been institutionalised all these years and to go out into the outside world, they're going to be lost and I think that there'll still be people needing mental care. More so with the stress of the world today really. I think that you know you need a place like that and I think a purpose built place like that, they'd be far better looked after even if they were only there for a year or six months and then go out rather than sort of sending them out now into homes where they've got to try and go to the market place and people are going to be taking advantage of them. I mean because I'm sure people would do, really. (p7)

On other occasions the inhabitants of other places are depicted as simply unknowledgeable by virtue of their location, as in the extract from the interview with Kev above.

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38 This may have already become apparent in my discussion of a village-hospital corporate identity in 'Humanist Concern', section 7 above.

The hospital and patients as 'fact of life', absorbed into the local social body; the taken-for-grantedness of the affair, which I have synthesised into 'Local Identity' may be taken, regardless of its truth-value, as discursively functional. The discursively created fact of the almost timeless 'fact of life', is, we might say, part of a dominant discourse in which 'everything, at present, is fine as it is' (cf. Bourdieu 1990 p52, Thompson 1984, 1987 p521)[39].

Other Persons:Inside and Outside

That the notion of a local villager identity can clearly be a useful one in the cut and thrust of local life, has been recently touched upon by Strathern (1984) in relation to the study of the Essex village of 'Elmdon' where local people draw upon different criteria in their definitions of a 'real villager':

> (Thus) the very strength of the idea of a locality is set against ambiguous and overlapping categorisations of who in social terms can reckon themselves as 'locals'. And thus the 'village', so evident with its nucleated houses and signposts, cannot match any particular demographic configuration. All that people agree upon is that the village is divided into 'villagers' and 'non-villagers'. (p46-7)

In this last section I shall focus on the way that other people are referred to in the transcripts, in conjunction with various

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39 This may be particularly evident in the debates concerning the closure of the hospital. Witness the following statement from the Clerk to the Parish Council at the 1987 Public Inquiry: "Shenley Hospital has been in existence for over fifty years and during that time has been part of the village of Shenley and part of village life. Patients of the have been, and still are, treated with much respect and understanding and their sickness is understood and appreciated...It was with some dismay therefore, that the Council learned that the hospital was to be 'run down'...".

interpretative repertoires, and speculate further upon the functions such talk performs. It is important to restate that there is a considerable overlap between the use of 'time', 'place' and 'person' as 'other', and this will be evident here.

The range of other persons referred to includes other people who live outside the village (place), people who lived at an earlier time both inside and outside the village (time and place), people who live within the village, i.e. other villagers (place), and 'other patients' i.e. patients who do not hail from Shenley hospital and who therefore qualify as 'other Others' (place).

Other Persons: Outside Others

Several younger respondents spoke of how 'the mickey' had been taken at secondary schools outside the village by other pupils who also lived outside the village, as the following extracts from interviews with Lou, Mike and Jean show:

> DS: If the hospital were to shut down next week and all the patients were moved off to another, hospital or hostels somewhere, would you miss them? (4)
>
> Lou: Some of them I would. Some of them with a lot of character, humorous. Yes I suppose you would. It's sort of, it's the way you think of the village. When you speak to people and you say where you live because when I went, first went to school, and * said Shenley it suddenly clicked [about] the hospital.
>
> DS: What did people say then? (2)
>
> L: * They were acting as though I was ashamed to, which I wasn't. And you have, you know, people joke about it but they don't mean it, you know. It's just something they think of on the spur of the moment and you, they apologise afterwards saying that they don't, they hadn't been thinking... (p13)

And

DS: So you're saying some people, presumably you mean at your school, (L: Yes) would feel so strongly that they, they would go out of their way to avoid (2)

Lou: Some of them because they'd be so very, very apprehensive. There are a few people who I've invited back and they've been, you know, they've sort of questioned you. Sort of they'd think about it and you know what they are considering and you have to try and tell them there's nothing wrong, it's just, it's like living near um, a city hospital. (p14)

I had been asking Mike whether he felt it would make any difference in terms of others' responses if he had had a psychiatric hospital admission:

DS: ...Would you imagine then that there would be any difference at all in the way people responded to you?

Mike: Um, I think it depends on the level of maturity really.

DS: Yours or other people's?

M: Other people's, because I mean, being young, growing up with, growing up living in an area with a mental hospital, I take a lot of stick, because I live in the same area as a mental hospital.

DS: Have you? Other people have said this, to me as well.

M: You know, at school wherever and they say 'Where do you live?' And I say 'I live in Shenley', and then, then the (2) laughter arising from every corner of the room.

DS: A few jokes I suppose?

M: Yes, but, I mean, it gets to you to begin with but then you ignore it. It's, it's a case that they're, they're so stupid, immature that they don't actually understand what a, a mental hospital is like and they don't understand what it's like to live with one in the same area as you. If they knew then their attitudes would be different (2) I suppose that's the same with, with a breakdown. People, if they were mature enough would, would treat you in the same manner as they did beforehand but people who weren't so, so mature may start ridiculing you and treat you in a, a strange manner (p16)

I had asked Jean what it had been like for her living near a mental hospital. She replied that she had not given it a thought 'unless people take the mickey out of you':

DS: So what kind of things did they say?

Jean: It was, nothing nasty. They just used to take the mickey and, 'Shenley nutters', they used to call us all 'the Shenley nutters', the three of us that went to * It's quite funny, they still do now. It's like they do about Napsbury as well don't they. Take the mickey out of people that live round there.

DS: Did they say any more than that? Would they make any other comments about it?

J: No, not that I've heard, not really.

DS: So it was a fairly um, something you took for granted then? Until, until you went to Borehamwood?

J: Yeah.

DS: Did that come as a surprise to you when, when they started taking the mickey?

J: Yeah, it did. I remember it did yeah. Cos I didn't think anything of it. It's funny, if I had friends up to Shenley as well. We used to go for a walk and they'd say 'I'm scared' you know, walking down the road.

DS: They really were scared? (J: Oh Yeah) Or just pretending to be?

J: No, they were scared, you could tell (laugh). Cos there's the er public toilets next to the bike shop down there and the patients always used to use that when there were a lot of them. They used to sit along that little bench, yeah. And whenever I had friends up they didn't like walking that way, we had to walk all down the road way, the other way. Yeah. (DS: Good heavens) Mind you I didn't like walking down there either cos you can never see. If you're coming from this way, and you're going down that alleyway you can't see what they're doing can ya. (p2)

From the perspective of discourse analysis the accounts of Lou and Mike above can be said to display some disapproval at the

way outside others make jokes at their expense. The message here is that it is wrong to do this and in the second interview that the perpetrators are stupid, immature and 'don't understand'. In contrast to these unthinking others, the speakers become more mature, more rational and considerably more tolerant.

In the third extract Jean's friends are initially presented as peculiar in that they are said not to have liked to walk along a particular alleyway. The outside others, we are told, are scared. But immediately after my response of 'Good heavens', as much as to say 'how very odd!', Jean goes on to rescue her friends by 'admitting' that she too is apprehensive. The repertoire in use here is Own Interests (Major) which is at first attributed to the others. The subsequent attribution of fear or trepidation to herself is supported by reasons, 'you can't see what they're doing can ya', and succeeds in recasting her friends as, after all, rational and reasonable people.

'Others' also feature in a similar fashion with older respondents. In an unrecorded interview one of the publicans for example told me how people who came into the pub from outside "like those two", indicating two suited men from Borehamwood, have left "when they've seen them" (patients) or "when they've (patients) been in here". This was attributed to ignorance.

These extracts all refer to the way other people and place are connected. Coming out of frame for a moment, from a 'realist' position they suggest that place helps to organise discourse and interaction (Eglin 1980). There is a sense here in which the symbolism of the hospital extends out geographically in terms of others' apprehension. Or conversely, that the great edifices of the asylums themselves may be seen to act as

semantic black holes in the grid of cultural meaning, in which meaning is sucked in and held prisoner. This has been expressed well by Ignatieff (1983, p169): ''Total institutions' work their effects on society through the mythic and symbolic weight of their walls on the world outside, through the ways, in other words, in which people fantasize, dream and fear the archipelago of confinement.' As Arthur said in my interview with him and his wife Anne:

> Arthur: No-one would * away because of them or anything like that. It's only if you're out anywhere and they say where are you from - Oh, Shenley. Oh, yeah, you know, I mean Shenley's well known for mental hospital, like, for miles around. You can be 50/60 mile out and they know Shenley. Shenley relates to mental hospital, like. (p24)

In a similar fashion Jill, aged 59 and retired, who had lived in the village for 6 years tells us:

> Jill: Knowing one or two people who have been in Hill End, I don't think I would think any differently from them being in any other sort of hospital. It's just a different form of illness isn't it. But what we have noticed, um, it's not the people in the village who worry about Shenley, it's other people. Occasionally when you talk to people and 'oh where do you live?' and say Shenley. 'Oh that's the nut house isn't it'. You know you get that sort of feeling from, it's an association of ideas, that people associate Shenley with a mental hospital and perhaps don't even realise there is a village with the same name. But I think local people I suppose come to accept it. I mean there are so many of these hospitals of various sorts around here that it's become accepted and certainly um...(p10)

The use of recounted speech (Tannen 1989) in a number of these extracts serves to bring the issue alive here, lending presence (Edmondson 1984, Perelman 1982), and serving to make the speaker clear about others. In the last extract above, Jill reports how 'we have noticed', thereby also supplying the legitimacy of intersubjective (objective) agreement. There is

some tension however in her location of 'others'. On the one hand they are to be found outside the village. On the other they are located outside the wider vicinity: 'there are so many of these hospitals of various sorts around here, that its become accepted'.

In the next extract from the interview with Anne and Arthur, the other person's status as insider is ambiguous, but suggests a transition from frightened outsider to tolerant insider:

> DS: So, it didn't put you off? (Anne: No) You didn't think to yourself, Oh my God I don't want to go and live in (Anne:No) a village thats got a mental hospital?
>
> Anne: No. One of the girls who er lived in, moved in at the same time was terrified, erm of even you know going out, but she now works at the hospital.
>
> DS: She was terrified even of going out, of the house?
>
> Anne: Yes, yes. Going, not out of the house but up into the village where she might meet them. She er didn't like the idea. But she now works at the hospital, you know she's...(p3)

Other Persons:Inside Others

But 'others' are not always from outside the village. Maggie, aged 48, had been resident in the village for 7 years, and worked in the village store. She had been talking here about others who both lived and worked in the village:

> DS: Do you remember what your response was when you found out there was a psychiatric hospital just down the road. Did you have any thoughts.?
>
> Maggie: No not really. No it didn't bother me to think that there were patients. I think it bothered other people, people I worked with, previous to working in the shop... (p2)

And here I had just asked Val about the hotline. Val, aged 52, had lived in the village for 7 years, and was a member of the Parish Council:

> Val: There is a hotline and it is always given in there for the residents to call. We've had one or two incidents that I have dealt with where an elderly patient's exposed himself especially in the summer where you have a lot of children around. But on the whole, we don't have too much problem with the patients. Some of them walk round and talk to you and that's all they want is someone to talk to and listen to their problems. Many have sat on my front lawn giving me the history of their life. My old man can't cope with it though. We're two different people. If they become involved with him, he calls me out. (p4)

Val persists throughout the interview in portraying herself as not-bothered and not-frightened in contrast to some local others who cannot 'cope' with patients. This 'acopia' may be taken as an instantiation of patients as nuisance, the Own Interest repertoire. In addition Val demonstrates discursively a willingness to help by listening to patients talk, an aspect of the Humanist Concern repertoire. In this extract the two repertoires are articulated together with the help of an 'other'.

And in spite of his earlier portrayal of the village as being 'used to' patients, Kev can still allow for a dissident minority of village others:

> Kev: Oh (3) As I say if it's somewhere like Shenleybury where they can look after themselves and if you like aren't violent or whatever, I don't think, I wouldn't complain or anything. If it was right next door I suppose, and you've got say people from the flats who started to, I don't know, get petitions going up or something like that, I mean, you might get people doing that sort of thing. But I mean I'd never do anything like that. (p14)

In these three excerpts, others are portrayed as fearful, bothered, or as being unable to cope with patients. Again the difference is created between the speaker who is portrayed as competent or tolerant and the others who are faulty or somehow even morally inferior. There are few exceptions to this trend. However on occasions people will acknowledge that other villagers are 'better at dealing with patients' than the speaker. Maggie for instance had been recounting a story about an episode in the store involving a patient who had been 'screaming and yelling' and refers to another villager who was in the store at the time:

> Maggie: And Brian said 'well, if you want to die, don't die here. Go back to the hospital and die'. I think he knows better than me how to talk to them, you know. He just said that and he shut up, well, he did keep on about he wanted to die, just depressed. Very, very nervous. (p3)

Even here, Brian, acknowledged as more competent, is not completely successful and as a result Maggie is not a complete failure.

Other Persons?: Village Children

A particular category or group of village 'others' who attract a good deal of comment are local children, especially within the context of my question about whether some people in the village might be more or less accepting of patients. In this sense I more directly help create the 'other', but the responses are nevertheless of interest:

> DS: So (1.5) you don't think it's a problem for other villagers. Um, do you think other people in the village are accepting, *accepting* of patients, or tolerant of patients or, do you think erm (2) there might be some people that don't want to, anything to do with them?

Brenda: I haven't come across it no, other than the, the young, the children I think they can (2) (cough) intimidate the patients, they can shout at them, and er (2) I think that's the only thing, really.

DS: Have you seen that yourself?

B: I don't see it so much now. I mean when I was, the children were younger, you'd get it. I mean if a patient came down the road the children would shout (2) you know, "There's a patient, there's a patient, run", you know, that sort of thing. (p11)

In this next interaction Irene and Tom dispute my allegation that youngsters might 'take the mickey'. They appear to disagree on this issue but resolve the problem by differentiating between 'our crowd' and others:

DS: I've heard some stories about sometimes youngsters might take the mickey.

Irene: Oh, yes. I've seen that happen

Tom: I've not heard, yes

I: I've seen it happen

T: I've not seen any *baiting* going on or anything like that you know

I: But not with our crowd that we had.

T: I've never seen any lads causing distress to them. (p8)

Mike however, aged 16, is in no doubt that younger village people are more likely than other villagers to 'discriminate' against patients. At the same time *he* is not included in this set:

DS: ...Have you ever noticed or ever, d'you remember anyone, anyone else doing something or saying something about, the patients?

Mike: Yes. Actually a couple of days ago there was a, a boy who lives further up the village. He was outside the shop [windows], and there's one patient who goes through the bins and he started calling out things to him. Calling him a dirty old man.

DS: What, this young, this boy did?

M: Yes. Insulting him. (DS: Did he?) Yeah. I mean the, the reaction wasn't, the man didn't react to him. But, this boy was willing to have a go at him.

DS: That's interesting because I've not, I've not heard or seen that at all.

M: There are a lot of cases of the younger generation having a go at the patients. The people I used to know around here, they used to throw acorns at them and they could be very nasty to them but it's, it's something I've never really done. I've never had a go or tried to make fun of a patient at all.

DS: How old would that um, that boy have been who you saw, you know, a couple of days ago outside the shop?

M: He was, he must have been about 18. He was older than I was.

DS: I see. (3) And erm, in the past then, the, the er, people that were throwing acorns, would they have been, in their teens or, younger or=

M: =Yeah, they'd have been about my age (6)

DS: What do you think about that yourself?

M: Er, I don't think much of it at all. I think they do it for, a cheap thrill if you like. I mean I respect them as individuals really. They are people. They deserve to be treated as people.

DS: I was going to ask, come on to another question later about how you feel that the villagers react to the patients but it seems from what you say that there are certain elements, or sections in the village that would behave differently to others.

M: I think the teenagers do discriminate against them more than the other generations do. (p5)

It may be of interest that local children and adolescents are offered up as one, and perhaps the prime, example of local people 'discriminating' against patients. Regardless of the truth of the matter as presented in the texts, the discursive identification of village children as 'others' arguably serves a number of functions. At the normative level (one's normative rightness in so speaking, and the rightness of norms themselves) it is clear that a claim is being raised here about the moral injustice of such behaviour. This in turn feeds back into the sincerity claim, rendering the speaker, at the level of impression management, not-prejudiced and rational. But at the same time the kind of damage that may be done to the village identity by acknowledging prejudiced members, may be mitigated by the fact that these members are 'only' children and thus not completely communicatively competent (Habermas 1970) or entirely responsible for their actions, and as such are on a kind of par with psychiatric patients themselves (see section 6 above, 'Discursive Dependence, Qualified').

The following extract explicitly compares patients and children in terms of where responsibility should lie for unacceptable behaviour:

> DS: Did your parents say anything to you about the patients? Did they, or maybe teachers as well. Did they give you any warnings, say?
>
> Penny: No, I don't think so. I think they just used to say, like I said to my kids at the school, you know, don't torment because you know they can turn[40] and don't take the mickey, you know.
>
> DS: So there was an idea that they could turn?

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40 An obscure note: Compare patients 'turning' with de Certeau's (1984) link between walking and rhetoric (trope; *Gk;tropos*, turn or style), pp 165 (footnote 8), 183 above. Also consider the link between rhetoric and madness proposed in Appendix D.

P: Oh yes. I used to say that cos the kids, I used to go past the school and the kids would be laughing at one of them who used to walk past and calling him names, you know. And, what do you do if they're coming out of school and a patient turns on them *they're* going to get blamed for it and yet it's the kids that are geeing him up. It's the same as anyone. It's not only the patients. If someone winds you up, you know. (p2)

This speaker expresses a kind of sympathy for the people who are patients and a desire for justice which is occasionally seen in transcripts, shrinking the distance between villagers and patients. The suggestion here is that the problem may not *only* lie with some essential unpredictability or violence of patients - 'they can turn' - but rather that any violence might be directly provoked in a manner which can be readily understandable. The irrationality here is located, is placed, not just with patients but also with village children. This passage then serves to balance up accounts a little between patients and villagers but in a manner which implicates not exactly villagers but their temporarily-less-than-rational offspring.

On the other hand, in the following extract from the interview with Ralph and Nancy, the responsibility is shifted back again from both children and patients to hospital in a familiar fashion:

> Ralph: Provoked by kids. Unwittingly of course, the kids didn't realise it. They thought it was great fun seeing somebody with bloody trousers halfway down their legs. I think that was the hospital's responsibilities to see they was dressed properly if they were allowing them out. (p11)

Not everyone however acknowledges that children provoke patients. In an interesting reversal Anne and Arthur told me how children only 'tormented' a non-patient villager. The effect of this is unclear however especially considering Anne's

comment that children will 'torment anybody that's not=', suggesting that whatever 'not' refers to, it is possible that it includes patients:

> Arthur: There were only one, he wasn't connected with Shenley hospital was he, he used to live round here and er, oh dear.. * moving from Radlett into Edwards's old house. Geoffrey, he wasn't a patient but the kids used to torment him like and he didn't retaliate. He used to run away from them.
>
> Anne: Kids'll torment anybody that's not=
>
> Ar: =Oh, the little kids and that used to be quite cruel to him. Throw sand in his face.
>
> DS: For any reason? Did he look different?
>
> Ar: Just a bit, you know.
>
> An: Yes, he did look different. He did look sort of down and out. He was always drinking like. Always half puddled.
>
> Ar: Yes but I mean for all that he wouldn't harm=
>
> An: =Well I mean the kids used to go after this one (details omitted).
>
> Ar: (details omitted) there's a lad there, he's a bit backward but, a hell of a nice looking lad, very harmless lad he is. The kids used to er torment him, like. He used to get upset, he used to get emotionally upset. But he's a very friendly sort of lad you know.
>
> An: But of course, then, he's not a patient. But I haven't seen the kids, I have never seen the kids do that with the patients. I think they accept them as being what they are. (p15)

Other Persons?: Other Patients

Finally I want to consider how some of the others referred to in interviews are other, non-Shenley, patients. The implications here are of interest in so far as these 'others' function to render Shenley patients relatively sane and I shall

later discuss other forms of interactional 'balancing devices'. If Shenley Hospital patients become more 'normal' as a result, what are the implications of this for the village and villagers? Perhaps Shenley village itself becomes a more 'normal' place. We could say that the village, the villagers and the patients all become more rational. Locating the 'real' problem somewhere else in this sense has a distinct payoff. Of course in a different discursive situation or argumentative context, Shenley patients may be represented in different ways, as chapter 9 above has shown. Here, however, we might say that prejudice is displayed in the process of countering prejudice. Shenley appears whiter but its prejudice has run into the rest of the wash. The villagers at once become both reasonable and prejudiced (Billig et al 1988) as the following extract suggests. The differentiation of types of patients into 'normal', 'very ill' and 'bad' can also be witnessed again here. Consider the following excerpt from the interview with Anne and Arthur:

DS: You say it's an open hospital. There's no restrictions on people.

Arthur: Nar, they (2)

Anne: Only, only the ones that=

Arthur: =Yes but Shenley's not as bad as the others. Not quite as bad as the others. It's only the very ill like, they keep them in, keep doors locked but, but the real (1.5) the real er bad ones are down the other hospital.

An: Harperbury

Ar: Harperbury, they're the, you know, they. I mean the ones that's in Shenley are normal p, you know, normal just maybe had a breakdown like. I mean one of the regular ones, quite a regular one is er Spike Milligan. That's his regular that's his second home is that one. Just comes in for a few weeks and off he goes again. But you never see him wandering round village like. Just comes in. Just sort of hides away from everything and, gets the treatment and off he goes again. Yeah. In fact I think once, they had

him on television and he was still in his, same gear as he has, you know, in hospital. Just, you know he was dead scruffy looking. Er (1.5) well it weren't his pyjamas, something that looked like a pyjama. Sort of top and trousers, and slippers on I think. Just as he was and he, and he, done the interview and then went back. Stead of going back to his home he come back here. (p12)

The discursive use of Spike Milligan also serves to support the argument in its balancing work. This example suggests initially that if celebrities and prominent people in our society are admitted to Shenley Hospital then the hospital and patients cannot be as bad as one might otherwise think. On the other hand of course it may be taken to read that these celebrities are worse than we ever imagined.

In a similar vein Jill answered my question about a hostel next door:

DS: I was wondering, erm, what your reaction might be if, if somebody said to you - We're knocking the house down next door, we're converting it to a hostel for patients from Shenley? What would your response be to that (4)

Jill: (Choking-sigh sound) Difficult to say isn't it because er. It's like most things when it's on your own doorstep you'll feel differently from what you do when it's, further away, but er. It would depend I think on what, you know if it's a sort of er (2) I suppose you were thinking in terms of a sort of halfway, house. (DS: Yeah) Well I think probably sort of I mean if they were patients from Shenley, knowing what we do of them, I don't think we would be *unduly* concerned. I think we might be more concerned if we *didn't* know who was going to be there. The prospect of it being someone who would be a nuisance and=

DS: =So what would your main concern be or your main fear be? Would it be in terms of nuisance?

J: Yes I think perhaps somebody being unduly noisy or being a nuisance if you were sitting in the garden chatting to someone, you know, shouting at you over the fence, and um that kind of thing I think I'd be more concerned about. (p9)

Here, other hospitals' patients give grounds for apprehension, whilst Shenley patients are 'known'. We could therefore talk here of a sense of 'Our Patients'. Psychiatric patients from this perspective do not constitute a problem *in toto* but rather only those others who are unknown.

The stuttered and hedged reply from an otherwise articulate woman suggests that this question posed a problem for her. Her argument that 'It's like most things when it's on your own doorstep you'll feel differently from what you do when it's further away' cannot sustain close inspection, for the problem is not 'most things', but a mental health hostel, and clearly it is likely that we would all like *some* things to be 'on our doorstep'. My suspicion here is that it has become possible to use reference to the NIMBY argument in a rhetorical fashion. That is, Jill is not just saying NIMBY but using NIMBY as a ready-fashioned discursive resource[41]. She then moves on to a position of 'It depends' which again implies uncertainty and hesitation. Her reference to 'Other Patients' serves as a rationale for her self-rescue from the problem. She is in effect saying, as a resolution to the problem, 'It could be worse'. It is difficult to resist the interpretation that Jill is reluctant to voice explicit rejection of the siting of a mental health hostel next door. In her effort, the repertoire Own Interests (Nuisance) becomes attached to Other Patients.

This notion of 'our patients' has also been recounted in an (albeit now dated) newspaper extract.

Group Secretary, Mr A.J.Paice said:

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41 In other words it is being used in the fashion; 'We all know now that we'd all prefer not to have patients in our back yard.'

> I sympathise greatly with villagers having a mental home imposed on them. But I don't have much time for outsiders who come here knowingly and then complain. I think they try and make it out to be worse than it really is..."It's a great deal easier coping with the patients today. Because they are not locked up there is far less aggression than there used to be." "The majority of cases here are schizophrenics or stress cases, we have no sub normal ones - they're the unpredictable ones, liable to attack people. (Evening Echo, 29th Oct 1968)

And yet the discursively flexible and historically ubiquitous nature of this form of argument can be seen in a more recent letter which appeared in the Herts Advertiser (10/8/1990). Headed by the Advertiser 'A plea from normal people' and signed by several people who were patients at a St. Albans 'learning disability' hospital, the letter protested about the objections from Chiswell Green residents to the siting of a group home in that area. As part of their argument concerning their normality, the authors contrasted themselves favourably with 'mental' and 'mentally ill' others.

Conclusion

In this section of chapter 14 I have shown how 'other(s)' is used with discursive effect in a variety of ways and in the interaction between researcher and interviewees. Out of this analysis I have suggested that the repertoire range be extended to include 'Local Identity', which reciprocally implicates other persons, times and places, and which contains the notion of 'Our Patients'.

Nevertheless, at other times and on other occasions, as some of the previous pages and chapters have testified, Shenley patients are complained about in a manner which is difficult to reconcile with the notion of 'Our Patients'. And this further exemplifies one of the points of the thesis that

patients will be talked about in different ways according to the argumentative context. In this analysis of 'other(s)', they have become 'Our Patients'. At other times they are 'Not Our Patients'[42].

The use of 'others' then functions to recreate identities (e.g. of certain villagers as reasonable people). However, these descriptions of 'others' also constitute moral work in which the boundaries of correct behaviour become redefined. These rhetorical moves may be said to point to, or highlight, normative issues about the correct ways of acting in certain situations in relation to patients.

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42 A further example of this can be found when my respondents explain the fact that villagers do not have very much to do with the hospital because the patients 'are not ours', i.e. do not originally come from the village.

9: On Telling the Difference

This section furnishes a fast track account of the way villagers go about telling how they can 'tell the difference' between villagers and people who are patients at Shenley hospital[43].

'Telling the difference' may be taken in tandem with those discursive devices which villagers use to minimise or erase difference between themselves and people who are patients, and which are analysed in some detail in the next chapter.

This focus upon Telling the Difference began as a study of the discursive use of 'knowing' by villagers in interviews. That study was wider and more complex than that of the present section and some of its themes have since been incorporated elsewhere in the thesis. For example 'knowing', in relation to 'Discursive Dependence' where 'acceptance' may depend upon 'how well I know him'; or in relation to 'Others', where reference to local knowledge can be seen to be used in the reconstruction of local identity. Thus perhaps some of the more interesting aspects of the analysis of the discursive use of telling local knowledge have been subsumed and recounted elsewhere. This leaves me with a residue of the content of 'Telling How I Know', a rather limited list of the ways villagers tell me how

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43 As the heading implies, 'telling the difference' also concerns telling that there is indeed a difference; that is, that this telling is a moment in the processual re-establishment of a categorical difference. Of course there exists a wide range of discursive methods of 'telling difference', such as argument, description, narrative, syntax and lexicalisation (for example the use of the word 'patient' in opposition to that of 'villager') and it is to this range that the project as a whole is in part addressed. This section therefore does not constitute an exhaustive analysis of 'doing' difference.

they tell the difference between patients and villagers. The rather clumsy term 'telling how they tell' is occasionally replaced here by 'telling^2'.

But one of the problems for adopting a discourse analytic approach to this question, i.e. of 'How villagers tell the difference', is that in the transcripts a brief answer frequently follows straight after a question from an interviewer obsessed with this question, and may to some extent be disconnected from the surrounding text or argument. In this sense its functional use may also be disconnected. This seems to me to limit the use of such analysis, except in very general terms.

Kinds of Evidence

To a large extent the kinds of evidence offered by villagers are predictable. They do not include direct reference to ESP or divine inspiration, nor do they make use of the notion of villagers' drug-induced trances, nor consultations with the oracle, Azande-inspired chicken innards or otherwise. Villagers' explanations of how they know are highly conventional in a contemporary Western sense. Translated onto the grid of contemporary epistemologies and social scientific methodologies, villagers' explanations might be said to partake principally of the empirical/empiricist and the hermeneutic /dialogic, with a dash of rationalism (as in thoughtful contemplation), intuition, traditionalism and practical knowledge linked to routines and tasks at hand.

In the process of telling^2 (see the top of this page) the difference, villagers are arguably also displaying their own rationality. The stakes here could be high. Villagers have been intent upon providing constatives (Habermas 1979) in the form

of generalisations supported by examples which describe states of affairs involving patients. While these are given in generalities such as 'some patients go to the store', any recourse to direct perceptual experience such as 'I saw a patient in the store' even more directly implicates the observer in the knowledge claim[44]. If the villager turns out to be unable to provide good reasons to support his or her identification of another as a patient, then the identifier's credibility is placed at risk. As Kuhn (1991 p44) puts it, an inability to answer the question 'How do you know?' suggests that the previous assertion should not have been made[45]. Or in the language of Habermas, communicative action is grounded in the reciprocal expectation that reasons will be provided in a communicatively competent manner, to support the raising of validity claims in arguments, a kind of 'security reserve' (Habermas 1982 p269).

Nevertheless it may in fact be acceptable for villagers not to be able to tell the difference between residents and patients as long as this incompetence is incorporated as a part of a non-prejudiced scheme[46]. For instance in telling us that he cannot easily tell the difference, Kev also makes it clear with my help that there is not much difference to him between patients and non-patients, and also that it is difficult to generalise about patients:

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44 Although as Pomerantz (1984 p609-10) points out, telling "in my experience" may be a way of distancing, of suggesting the existence of a state of affairs without directly asserting it.

45 Or in other words this is an especially face-threatening part of the interview.

46 In case this seems obscure, what I mean here is that such 'incompetence' is acceptable as long as it does not clash with other statements. For example it might be less acceptable for a villager to say 'I can't stand those patients. By the way, which ones are they?' Compare this with 'The patients are OK. In fact it's difficult to tell who they are.'

> Kev: ...Um (3) but that can only, you know, that might only cover a minority. Some of them you know have got a good background, got plenty of money and buy their own clothes. But er (1.5) you know, and others with, perhaps a bit slower, through, you know with money. But again, but again I mean that's not, there's no, I don't think there's a general rule. Again some, you know, some are, are better at others than that. You know, some, you know, they're very different they [don't] know their money but some do, but. But that's the same with, with everybody who isn't a patient. Some people are slow with money if you like.
>
> DS: That's true, and dress sense varies as well?
>
> K: Yes. It's very hard to say really you know who is and who isn't. (p10)

It is therefore arguably the case that the kinds of methods which villagers tell within the interview world will render them more or less accountable and rational within that setting. In the process of providing reasons the interviewee raises claims to truth with referents beyond the interview world.

However, not only does the interview talk refer to some 'thing' purported to exist outside the interview, but the evidence recounted within the interview which refers to the world outside also sets up a further relation in this 'external' world between 'the evidence' and some state of affairs being evidenced. The evidence in other words also documents an underlying reality (Garfinkel 1962, Heritage 1984).

How then do people answer the question 'How do you tell?' I shall quickly run through the range of telling[2] as evidenced in the interview transcripts.

By asking for evidence I ask for grounds for believing that given assertions are true. As Pomerantz puts it '...requesting, giving, considering and evaluating evidence are practices which

are within the repertoire of social actions that are performed by competent people within a culture' (Pomerantz 1984 p607). From the point of view of Habermas (1979, 1984) my request for evidence, grounds or reasons from the interviewee constitutes the beginning of a shift from everyday talk to 'discourse' in which, in this case, the truth of the matter is thematised, but in which normative validity claims are also implicated.

Direct Experience

Telling from direct experience is proposed by Pomerantz (1984) as a principal way in which people tell that they know something in an unproblematic fashion and with certainty, such as 'I've just seen a terrible accident on the motorway'. However, when the state of affairs is called into question, Pomerantz argues that people then routinely consider the 'source' or 'basis' of believing in a state of affairs. *Pace* Pomerantz, even when this direct perceptual experience is challenged, it may still be possible to hold on to direct experience as an appropriate warrant. So, for example if I am asked if I'm sure that there is a lion in my garden I may say 'Of course, I can see it there, and it's looking mean'. I may be asked whether I might not have confused the creature with a large dog, and I reply 'Don't be stupid, I've just seen it eat the large dog', and so on.

However, direct perceptual experience provides only a limited warrant for distinguishing between people who are patients and others, for what can possibly constitute direct experience of an essence of psychiatric patientness? Interestingly no-one replied to the question 'How can you tell the difference?' in the fashion 'You can tell a patient because they're mad', or 'because they're mentally ill'. Such warrants would indeed be beside the point as Katz (1975) has also recognised:

> Actors cannot directly observe the states of being they impute by their use of nouns. Characterologies of all types -criminality, sexual orientation, addictions, levels of intelligence - none of these essences can be verified by direct observation. (p1372) ...In short, when a person imputes an essence rather than an act by making his identification in terms of the present rather than the past, by using nouns instead of verbs, and by referring to inherent qualities and not expressed activities, he does not directly observe or experience but assumes his knowledge of the designated identity. (p1374)[47]

To ask someone in the normal course of events how they can tell whether an animal is a dog, or a lion, is to invite scorn and ridicule (notwithstanding the issue of whether a dog is a dog or a bitch). This is not the case with people who are patients in a psychiatric hospital. No-one was astonished by the question. Many considered it thoughtfully. Some people remarked that it was a good question, while others suggested that while *they* could tell the difference most of the time, *others* performed poorly in this respect. This can be seen in the extract from my interview with Brian, aged 35, who had lived in the village for 5 years, and worked at times in the store:

> DS: How would you say you know that they are patients?
>
> Brian: That's another big thing. That's a very interesting question. I mean when I'd been here about 18 months there were still people coming in that I wasn't sure if they were patients or staff. I can think of one or two people, retired staff. They are lucid and have travelled the world but are very eccentric certainly. (p5)

and in talking about another assistant at the store who lived outside the village:

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47 And of course we may say anyway that we never have direct experience of the 'thing in itself' whatever it may be. Rather, what is to count as empirical evidence must be located within our systems of discourse and practice.

Brian: She certainly thought she was dealing a lot more with the patients than she was. They weren't patients at all. Probably ex-staff. There are some very eccentric people there. I know I keep on about it. And then you get people coming in. Certain people have come and gone and I never did know. (p10)

The identification of psychiatric patient-ness or patient status may therefore be regarded as problematic in this sense. Some of the confusions which can arise have been outlined in chapter 9 above. Nevertheless villagers do on occasions refer to attributes and behaviours which for them identify others as patients, and in this sense direct experience does play a significant part in 'telling how I know', by reference for example to things seen, heard or smelled.

What happens is that certain signs are often offered by villagers which are considered to be indicative of psychiatric patient-ness. By way of explanation, the interview question may be said to be cutting violently into the documentary method (or the hermeneutic circle, cf. Giddens 1977 ch 4, Ricoeur 1981). The relationship between the surface sign and the underlying reality (patient status) is variously configured by the interviewee according to the particular extra-interview context, e.g. the kind of particular knowledge and gaze which one acquires serving in the shop or living in the village. We might say that there is no inherent link between the kinds of signs offered below and patient-ness and that the sign can only be read in this way because of what we already know about patients, this place, and so on, in circular fashion (cf. Garfinkel 1962, Heritage 1984, ch 4).

Nevertheless the aim here is less to look at what mechanisms are 'really' at work in villagers' knowing, but rather with how they tell[2]. In the following pages I shall first consider some of the ways of telling[2], then consider how villagers explain

'getting it wrong', and by way of conclusion examine the implications of such telling[2].

The Place of Attributes and Behaviour

> DS: Um (3) Right so some might um, might er steal (5) Do you know if somebody *is* a patient from the hospital?
>
> Anne: Yeah. You can tell.
>
> DS: Do you know how you can tell? Is it something you can um=
>
> A: =Er, usually they're, the *look* on their faces, right? I mean, they have a sort of, that look, you know er, not quite, not quite with us, you know. Not quite. Also their dress. They're dressed in, up first, dressed first you know, anything they can, they can get erm (4). Yeah I think you can tell. (p5)

And

> DS: How do you know whether people are patients, is it easy?
>
> Harold: Oh I think it's very easy
>
> Wendy: Very rarely that you wouldn't know, very rarely indeed. So it's something peculiar.
>
> DS: What is it d'you think?
>
> H: Well, I don't know. I think its' something to do with the eyes, the dress
>
> W: They're well dressed but I always used to if I was in doubt look at their collars and things. Somehow there was something different yes. (p3)

And

> DS: I mean apart from kind of knowing them by name over the years is there anything about people do you think that would help you identify them as somebody who's a patient?
>
> Jean: Probably their clothes more than anything, the way they smell. Yes, I suppose. (p6)

In the next extract the sign which is referred to is not so much an attribute of the patient-designate, but rather the 'patient(!) tone' of the shop assistant.

> Jill: But er it's things like that and sometimes in the shop where they're trying to get something for which they haven't enough money - and 'Oh, I'll bring it back to you this afternoon' and you know very well by the patient tone of the shopkeeper that's it's something that happens every week and they know very well they're not going to get their money so you know they just have to dig their toes in. You get the odd sort of incident like that that draws your attention to people I suppose. (p1)

In this extract there is some kind of transformation or construction here of the moral order of the village. Clearly Jill cannot reliably know this from one incident. But one incident is altered to become a common practice and the practice is attributed to a moral weakness in the patient. Her account of how she knows is, here, rather shaky, we might be inclined to say, in that her grounds are not very solid.

The following extract refers to behaviour and came earlier in the same interview.

> DS: I was talking about the people that come from the hospital and walk through the village and was wondering whether you see them as patients, how you think of the people who come from the hospital?
>
> Jill: Well I suppose I have sort of mixed feelings in a way because some I know through the connections with the hospital. Some I recognise and speak to, and others I don't. I don't consciously think - oh that's a patient, that's not a patient. It's not a thing where I have two different groups. But um I mean sometimes it is clear perhaps by behaviour that somebody *probably* is a patient but it's not something that er I especially think about.
>
> DS: What sort of thing, what sort of behaviour would bring someone to your attention or someone's status to your attention?

> J: Um, well I was thinking of an instance yester erm, on Sunday when I came along. Somebody coming out of church and the way they were sort of talking not just to themselves but sort of shouting as though somebody else was there and they were having a sort of argument with someone. Well it's not what you normally regard as behaviour that somebody would indulge in walking along, so I suppose it's something that probably you just wouldn't think about in another area perhaps, but here inevitably you're going to think - oh that's probably a patient going back to the hospital. (p1)

This extract is of further interest insofar as it links together behaviour with place. It is this *place*, Jill is saying, which organises the way people are seen, thought about and known. The knowledge is, we might say, place-related. Obviously Jill's idea is highly congruent with my own in this respect, although we may also ask how this reference to place functions in the text, i.e. view it from a discourse analytic perspective. In this respect Jill's reference to the way place organises her perception arguably acts to show that if, in spite of her denial, she does 'have two different groups', then this is entirely understandable because of the way her perception is automatically organised. In other words she should not be held accountable as discriminatory, or better, her discrimination must be seen as reasonable. This passage from Jill could be compared to another which follows immediately and in which her earlier position is reversed:

> Jill:...this is one of the things I think that worries us about the possibility of, them being sent back into the community. Because this is not a local hospital. *Their* community would be back in Brent or Harrow in areas where they're *not* known, not normally around, and they would find it very very difficult that, the way they behave here we accept, we're used to them but if they did that in a strange area I think their life would be very uncomfortable. I don't think people would accept them, I think [they'd have] a lot of unpleasant reactions. I think it's very [sad]. (p2)

Here, in drawing upon the theme of Local Identity, other places become heartless worlds in which patients are not only noticed, *contra* her earlier assertion, but rejected, in contrast to the village. We might say that the conjunction of the two passages serves to present the hospital-village as the patients' rightful place.

Place is further implicated in the next extract, where we are told that simply being in a particular place can be used in telling patient-ness:

> DS: So for you then it's been very much a kind of taken for granted thing? (J: Yeah) Um, do you ever wonder when you're walking round the village if you see somebody you don't know, would it ever occur to you to, to think to yourself 'Is that a new patient or'=
>
> Jean: =Yeah. All the time, yeah. When you see people walking, walking along London Road. Especially if they're walking, I don't know why, but especially if they're walking on the opposite side to where the houses and shops are. Cos all the patients used to walk along that road. And sitting on the benches along there. I used to wonder.
>
> DS: So you might kind of consciously wonder to yourself?
>
> J: Yeah, yeah. Often. If they're sitting on the benches along there as well. Especially if they've got a drink in their hand or cigarettes. Or look in the bins (laugh). (p6)

There is a further way in which place becomes intertwined in talk with behaviour and attributes, in terms of the practical problems at hand (cf. Schutz 1964/1976, 2, p235), related to a particular place, in this case the village store:

> Brian: Very interesting question that (laugh) A lot of, this must be part of the basic illness, but, perhaps the way they're trained to go out, but they have a very deliberate way of stating things, don't they? They will come in and they will say um 'I'll have um four second class postage stamps'. Postage stamps. 'I'll have um, two boxes of safety matches'. So that they're putting in=

DS: =It's an unusual way of speaking then, or, ┌or the words that are used are, unusual?

B: └Yes a lot, a lot of them have a, a very deliberate way of putting things. An eye for detail, which, most people, would accept, wouldn't do that, they'd expect to say something else. Have you noticed that? (DS: Well, yeah, mm) Can't think of, I was talking to somebody at Christmas about it actually. They were asking me about it. And er I, I couldn't immediately think of more than those two examples. But there are other things where, everyday things that they're buying, they describe, in a in a very meticulous way [as though]. I'm not quite sure why that is. There's one, there's one patient who comes in. Again he's got very poor, very slow and deliberate speech. An Asian. Very (2) Major speech problem. Now he'll always come in. He'll always pick up a basket, and sometimes he'll just pick up one packet of chewing gum or one packet of peppermints. Put it in the basket and bring it to the till.

DS: That's not usually done is it? I ┌mean people don't do

B: └That's not usually done. I mean there are baskets there, but 90 percent of people coming in the shop they don't want a basket. They're, they're just coming into the shop for a paper, cigarettes, sweets, one or two items. They're not going round the whole store. Erm, but they or he's obviously been taught that the basket's there, you pick it up and put what you want in there and then go to the counter and pay for it. And er it's things like that you notice when you (1.5) you know, when you first, first come. (p5)

The message concerning the relevance of the tasks at hand is reiterated by many of the workers in the store who tell me that they get to know who patients are because of their work in the store. This may be in the form of routine and regular interaction as in:

> DS: ...Can you tell who er, who are the pa, who are patients in hospital and who aren't? (M: Erm) Can you tell the difference (1.5) do you think?

Mike: I, I think I, you do get to know, I don't know if you can tell automatically, it's just that after a while, by the pattern of the person's behaviour. Cos patients seem to be regular in what they do, and so I mean, some, you sort of start seeing at certain times of the day, and by their behaviour after a while you start to realise that they are, you know, they are from the hospital. (p9)

or via reference to documents, which include names, addresses and so forth, such as pension or benefit books, which are passed to and fro over the post office counter. These documents provide evidence for staff about the identity of the owners. In addition however there is reference to a relationship which may be built up over time in places which allow for such interaction, in which people including patients get to know each other, as the following example testifies. The central aspect here is 'telling a relationship', although the form in which it takes is one of difference and differentiation:

DS: Is it easy for you to know who the patients are?

Irene: Mm. Yeah I walked up the road getting the papers yesterday and I thought, that's five I've passed by this morning. (laugh).

DS: You made a mental note did you?

I: Oh, I often do when I'm walking up. Think, gosh that's five to one or six to one. I'm the one. But I know them. I know, I mean I, through having worked in the post office I got to know their names, a lot of them. And they got to know me. I mean some... (p11)

The Place of Dialogue and Behaviour

On other occasions respondents have spoken about other ways of knowing. Mike, for example, casts doubt upon the generalizability of empirically based criteria such as dress, smell etc, and recounts a story which enables him to clarify his position:

DS: Other people have suggested dress for instance as being an important factor, the way people dress?

Mike: I don't think that really applies. Some of them may wear a jacket, shirt, trousers. I mean I wear a jacket, shirt and trousers every day. I mean, I don't think, I think some of them do dress in the same way regularly. Like Jack always used to wear a green hat. You sort of got, his trademark if you like. I mean there are certain cases which do dress in a very similar way but I don't think it happens all the time.

DS: So it might be something else then? Something that's difficult to define?

M: I remember, this is another one when I was a lot younger. We were out the front. It was one of the hot days and there was me and my brother who were playing out the front and he had taken his sandals off and then we turned round and his sandals had gone missing and there was this girl up the road and, you know, I don't think really you would *know* that she was a patient but she had his sandals in her hand so we got a little suspicious. She came round and said she wanted to see our mum. Auntie [Rosie] talked to her and that's when, you know, we realised that she was a patient.

DS: So she came back with the sandals?

M: Yes. She came back with them because they didn't fit or something. She came back and asked to see our mum. That's when we realised that she was a patient.

DS: When she started talking you realised that?

M: Um. I don't know whether it was, yes, not so much in the way she spoke but in what she said. The conversation was very broken, unclear in places which is one thing you do get with many of the patients. But otherwise you wouldn't really know that she was a patient. (p10)

In the above example the person finally becomes an identified patient out of a rather ambiguous combination of behaviours which possibly included aspects of the patient's verbal behaviour. In the next extract Tom provides a similar mixture of evidence in conversation with his wife Irene. He had just been telling me how he would not normally speak to people unless he knew them:

Tom: No. Not unless they addressed me. Then, one has to make one's mind up then at the time.

DS: How would you do that? How would you have done that?

Irene: (laugh) Easy.

T: Well you'd soon be able to tell if they spoke to you because they'd probably come out with some inane remark or on the scrounge for something.

I: Scrounge more than anything

T: Yeah that's right.

I: Scrounge. Cigarettes, money.

T: For example I was um [at] the pond in the front garden, I was doing something there and one Sunday morning all of a sudden a woman plumped herself, sat down beside me. (laugh from Irene and DS). And I, the way she spoke, you know, initially was that er, you know she'd got a pond very similar and she started going on about this pond. Well I did have a little bit of difficulty at one stage and in the end I did determine that she must be a patient and er my wife did confirm that (laugh). It took a little bit longer because she was very good at um, she was quite knowledgeable. Very knowledgeable, you know.

DS: How did you know then. You had a suspicion?

T: The suspicion um was that er (laugh from Irene), I don't think, one, a normal person would have taken it in their own head to come into anyone else's garden * and sit down beside them, on the ground. That was that was the first inkling and er the way she really did chat on over the top in the end. Although she, you know, she didn't let up and I thought, well that's not quite, ┌putting the two together *

I: └In fact she * to dangle her feet, didn't she, in the end (laugh) (p12)

The combination of both observation of behaviour and talking with the putative patient is drawn upon here to provide grounds for telling the difference. At the same time a further indicator is offered, which I shall address below, in 'Getting it Wrong'. Jean also offers similar grounds:

DS: But some, some people are normal then, but you'd still be able to tell somehow?

Jean: Well, most of 'em. Some of them look pretty normal but there's, you know. There's one that's, he's got a lot of money, I think. He must have. He comes in in a suit and umbrella and he's, he's violent. You can tell by the way he speaks to you, that he's a patient. He can get angry with you if you don't get things right. * He's been around a long time.

DS: Wouldn't that happen as well with other people who aren't patients? I mean might they not also get angry with you if you don't get things right?

J: Yeah. It doesn't happen in Shenley but it's happened in [Marks], just normal people getting annoyed.

DS: Say people are travelling through the village or something. People from Borehamwood popping in the shop. Would they ever get annoyed?

J: Only if I short changed 'em I think (laugh). Gave 'em something wrong. (p6)

The above extracts draw upon particular ways of knowing or telling, many of which implicate place in some manner. In particular there are the obvious references to patients being bodily in the wrong place as in Tom above, or bodily in the right place, as in Jean earlier. Jill refers directly to the way place organises her perception, while shop staff refer to the practices and procedures of the village store as a site of interaction. Finally behaviours, both verbal and non-verbal, may be considered to be wrong, or 'out of place'.

The notion of 'anomalies' upon which Dorothy Smith (1978) builds can also be expressed in these terms. In her analysis of the account of K's behaviour the latter was portrayed as anomalous in a manner which was congruent with readers' schema of mental illness; in other words the contrast structures which were authorially created between anomalous and 'correct' behaviour allowed the reader to read 'mental illness' into K's

behaviour. Behaviour which is predicative of mental illness becomes essentially behaviour which is 'out of place'. My suggestion is that the use of place here has advantages over the concept of anomaly. As well as anomaly it demonstrates the moral-practical and context-relatedness of insanity ascriptions or in the present case patient status ascriptions. But in addition 'place' may more clearly suggest a hierarchical aspect of insanity ascriptions, in terms of the way people 'ought to know' their place in bodily, social and discursive terms, as Goffman (1969/1971) has indicated.

Getting It Wrong

In the course of telling[2], villagers were often pressed by me about whether they had ever 'got it wrong', either by believing that a patient was not a patient or vice versa. Many villagers acknowledged this possibility and agreed that they had on occasions got it wrong, while maintaining that most of the time they get it right. But in those instances when people recounted that they had in fact got it wrong, the method recounted by which they had been corrected (i.e. had come to know that they had got it wrong) was clear and ubiquitous, if unsurprising and unoriginal. Villagers recounted that they had found out because someone else had told them the truth of the matter, a 'reliable and authoritative source' in Pomerantz' (1984 p 608) terms. This more reliable knowledge came, not out of observation alone, but out of a form of discourse, as the following examples indicate:

DS: Have you ever mistaken someone as a patient who later turned out not to be a patient?

Penny: Yeah, who was it? I can't remember now what happened. There's a couple of people that come in the shop. There's a little old man that comes in and buys bacon, wanders round for about 10 minutes and he went outside one day and got on his bike and I said, you know

> - 'I wonder how long he's been at the hospital' and 'that's not a patient, he lives in * Road'. Somebody's father. But I mean he was acting like, do you know what I mean. He whistled away as he walked round and he looks a bit shifty, keeps looking up at you, you know. I thought he was a patient (laugh) (7 seconds) (p10)

And

> DS: ...So you can tell, but have you ever mistaken someone for a patient who turned out not to be a patient?
>
> Anne: Yes, yes, yes, yes. Say cor, I thought she was a patient, you know. Yeah, we've said that a couple of times. Cor I thought it was a patient.
>
> DS: And how did you find out that she wasn't?
>
> Anne: Er (4) Probably by asking. Probably by saying er to [Tony] or one of the girls, you know 'is that a patient?'. 'No, no that's Mrs so and so', you know. (p5)

The notion that someone who is actually a patient at the hospital may be incorrectly identified as a non-patient is especially problematic. It immediately suggests that the person in question does not display any of the signs provided above as evidence of patientness. Their behaviour, talk, or person, that is, is not out of place, and villagers would have little reason to raise the issue at all. In this case clearly then villagers would be forced to the correct conclusion only following the provision of other kinds of evidence. Anne tells us that this happens but does not say exactly how the problem is resolved:

> DS: So you might have thought on occasions that somebody was a patient when they weren't, have you ever thought the opposite, that somebody wasn't?
>
> Anne: Yes, we've had, we've had quite a few well to do er people who, you know. Gor, you know, you know wouldn't believe that they were a patient. Cos they could have been just a voluntary, you know, just staying for, well, what was it, somebody used to say um (4) the newsreader, one of the newsreaders used to go to Shenley hospital for a

> six, for a rest, didn't he, every six months. I've heard that Spike Milligan used to go there for a, just...(p5)

Lou however indicates that the discovery has come out of conversation with others:

> Lou: Not so far. No. A lot of people that I hadn't thought were patients have been but not the other way round.
>
> DS: So you haven't thought they were patients because their dress has been OK presumably to start with. How would you then have found out that they were patients?
>
> L: I don't know (laughter). Through the grapevine. Somebody would say - Oh that's a patient and you'd stop and think - oh, really (laughter), are you sure? People in the village seem to know, to be able to tell the difference. I don't know * (laughter) * the majority of them * (p4)

The shift by villagers from knowledge which is related, albeit complexly, to sensory experience, to a clarification of the situation based upon social interaction and language can be seen to mimic in lifeworld microcosm some of the philosophical issues addressed earlier in the thesis. In the face of doubt there is recourse to discourse. The linguistic turn in philosophy and social science might be said to find its lifeworld correlate here. Thoughtful observation, it appears, is insufficient on its own as an adequate criterion of truth.

Conclusion

It may be clear from the above examples that many of the grounds which are offered within the interview world for telling patients from non-patients involve more than just truth claims. The 'empirical' grounds ('Telling from Experience'), at least, also implicate normative claims concerning the correct or right way to be or to behave.

To say for example that one can tell who patients are because they wear short trousers is, in this context in which rationality is involved, necessarily to make an evaluative judgement about their behaviour, dress etc, just as 'psychiatric patient' itself is a category with essentially moral significance (Goffman 1961/1968). As MacIntyre (1971 p258) has put it: '...to characterise actions and institutionalized practices as rational or irrational is to evaluate them. Nor is it the case that this evaluation is an element superadded to an original merely descriptive element.' And for Habermas, of course, understanding in general is tied inherently, if not uncontroversially, to rationality and evaluation, in the sense that to understand is to understand reasons, and to understand reasons is to take, at least implicitly, a position on them (Habermas 1984, 1985 p204 and cf. McCarthy 1985).

The normative component of insanity ascriptions is an old theme (e.g. Coulter 1979, Ingelby 1982, Laing 1971, Scheff 1966 and see Busfield 1986, p84-5 for an historical review) and one which I have amalgamated into a scheme drawing upon the work of Habermas (see Southgate 1992c). I share with Coulter the idea that 'Psychiatric determinations, just as lay insanity descriptions, are thoroughly normative, even where the diagnostician or ascriber does not openly articulate or even recognise his participation in the normative order of action-description and appraisal' (1979, p145).

However, it may be that the conflation of arguments about rationality are dubiously placed in this chapter about the identification of *patients*. At any rate several of the above examples make it clear that the signs involved are those which are disapprovable of. This was commented upon explicitly by Ralph and Nancy in their criticism of the hospital:

Nancy: We were told that there really wouldn't be any violent ones but you did get the odd one, liable to hit you if=

Ralph: =The point is they sometimes, well not so badly now but they used to dress those patients and make them look stupid. They'd come with a jacket with the sleeves down here and the trousers half way down their legs. Well it's human nature for kids to poke fun at something like that. And that depends on how the patient felt and some of the trouble was caused by that wasn't it.

N: Yes m, yes

DS: They were provoked you mean?

R: Provoked by kids. Unwittingly of course, the kids didn't realise it. They thought it was great fun seeing somebody with bloody trousers halfway down their legs. I think that was the hospital's responsibilities to see they was dressed properly if they were allowing them out.

N: Allowed out, Really what we didn't quite like.

R: That's right, yes. (p11)

The sequence involves the use of reference to particular attributes, short sleeves and short trousers, in a now familiar attack upon the hospital. The speakers may have had good grounds here. It is clear that in this context not only are these attributes disapproved of but they are portrayed as directly leading to trouble.

What might save patients in this respect is the possession of an institutionalised framework at their back as it were, which normalises particular kinds of dress or behaviours. Labourers for example may wear their clothes in an inimical style without passing muster, indeed as a kind of uniform. But the only institution the patient has at his or her back is the institution of insanity which is by definition 'out of place.'

'Telling[2] the difference' therefore displays, I argue, not simply an orientation to impression management, in which the villager can impress as rational for the practical purposes of the interview, but also acts to re-establish the normative correctness of everyday village life, by contrast with the 'out-of-placeness' of psychiatric patients.

In addition however there is one further point. Validity claims to normative rightness can be thematised in another way. We may ask for instance whether it is normatively right for people (ourselves) to generalise about patients as we do, for example by giving as grounds that one can distinguish a patient 'because of the look on their face' and so on, or to invoke such answers in interviews.

To be sure this may be a difficult question and one resolution hinges upon making a distinction between the telling, and the reality. If, in other words, patients really do sport a particular 'look' or wear short trousers, then it may be right to say so. And if I as a researcher have grounds to believe that villagers do make such distinctions, then it seems reasonable to explore their methods.

However from the point of view of discourse analysis the question might be shifted to; 'What are the hypothesised discursive functions of particular embedded generalizations?' Clearly one answer is that the identity of the group generalised about becomes set apart from that of the speaker. In reply to my question the answer, 'it's impossible to generalize' was rare (but see section 10 below) perhaps because arguments had already been predicated upon being able to differentiate between patients and non-patients. At the same time the focus upon telling the difference was engineered by

the researcher and it may have been difficult for respondents to resist this invitation.

In the next section I shall consider the means by which this differentiation, this difference, is countered by villagers; the discursive methods used by villagers which function to shrink the distance between themselves and those others who are patients.

10: Balancing Devices

The title of this section came out of my interest in certain recurring themes within interview transcripts, not necessarily viewable as repertoires, coupled with the notion drawn from work on discourse analysis that interpretative repertoires may be managed or mediated by specific linguistic devices. For example Potter (1987) has documented the use of what he has called, following Eglin (1979), the Reality/Appearance (R/A) device, and which is used to separate a warranted from an unwarranted version of events or readings, by undermining one version in the process of producing another. And Gilbert and Mulkay (1984) have given us the TWOD[48] which is used in the mediation of competing and textually propinquitous interpretative repertoires.

These themes or devices are not so much made up, like repertoires, of *sets* of lexical items, maxims or tropes, but rather constitute short pithy phrases, commonplaces, or individual maxims, or otherwise consist of discrete rhetorical schemes or tropes[49].

My suggestion is that the following devices perform various functions. They serve to balance the relative status of villagers and patients, to shrink the social distance between them, a distance which may otherwise have been conveyed in that

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48 The 'Truth Will Out Device', one member of an anticipated '...family of 'reconciliation devices' arising from scientists' movement between interpretative perspectives' (1984 p92).

49 Nash (1989 p112) distinguishes between two kinds of rhetorical figure: the 'scheme' which refers to syntax, to word-order and syntactic patterning; the 'trope' which refers to semantics, to figures which play on the sense of words. Examples of the latter are metaphor and irony. 'Proplepsis' is probably best categorisable as a scheme.

part of the interview, or in the interview as a whole. They constitute what appear to be discursive endeavours to ameliorate, to soften and to mitigate, and limit anticipated interpersonal and identity damage. They can often be seen to express a puzzling over normative issues and to partake of an hypothesised dilemma facing villagers within the interview world: of a desire on the one hand to maintain difference between themselves and patients, while on the other a desire not to be seen as prejudiced and to signal the morally doubtful nature of discrimination. Many of these methods may therefore be seen as deeply ambiguous.

The devices identified here are no doubt common in all talk, and in theory and practice may be utilized in a wide range of contexts. As in the previous chapter 'Discursive Dependence and Relative Balance', the use of 'Balance' in the title here is meant to implicate rationality, as in villagers' becoming more balanced and hence more rational and reasonable as a result of using these methods.

There are of course many ways in which villagers can achieve this balance effect, not least, as I have shown, by the judicious use of different repertoires. In this respect the central figure of speech has been the proleptic manoeuvre by which ostensibly competing repertoires can be juggled with an apparently moderating effect upon the message. This rhetorical figure constitutes the major balancing device. In this section however I wish to extend the notion of prolepsis - work which was begun earlier in 'Discursive Dependence', where the use of 'It depends' was documented and compared briefly to prolepsis and the 'Two Hands' manoeuvre identified by Billig et al (1988).

My argument here is that the anticipation of objection and criticism may appear in a number of guises, and is not confined to the 'not...but' form, although it is perhaps most explicit

in this form[50]. In the following pages I begin by tracing two further types of proleptic manoeuvre. Although they do not always, as it were, define themselves as proleptic, as in 'I don't want you to think I'm prejudiced, but...', they are nonetheless identifiable in terms of the kind of work I shall argue they perform within the transcripts.

The balancing devices proposed below consist of two principal types. The first ('Reflexivity', 'Not Only, But Also') may be identified as proleptic, two-handed and potentially ambiguous. The second type ('As Sane As', 'Direct Credits') may be less clearly regarded (at least in terms of the local text) as proleptic, and consists of those more straightforward means of challenging difference. Another way of putting this is to say that for the latter group, content takes precedence over form[51]. In addition, however, I have identified a further device, 'The Thin Line', which receives extensive examination. A path can be found into the extended world of prolepsis via reflexivity and it is to this that I now turn.

Reflexivity and the Research Interview

Within the human sciences the concept of reflexivity has a long history and a number of meanings (cf. Babcock 1980, Lawson 1985, Platt 1989 and Steier 1991). In modern times reflexivity may be located in a variety of traditions: for example, in Mead's (1962) essential condition for the development of mind;

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50 All language in action is anticipatory in some manner: the completion of a sentence is anticipated in its opening; talk (and writing) throws us into an anticipated future of mutual comprehension (or intended incomprehension). Where we wish to be understood we may actively engage in a continuous effort to forestall misunderstanding. This is not quite the same as the anticipation and interception of criticism.

51 I have come to regard this latter group, primarily 'Direct Credits', as a mixed-bag of particulars and generalities which do not necessarily fit in elsewhere (into repertoires), but which seem nonetheless to perform interesting functions.

Garfinkel's practical reasoning (a social setting should be seen as 'self-organising with respect to the intelligible character of its own appearances' 1967 p33); philosophical reflection which finds its postmodern pinnacle (or nadir) in the reflexive deconstructions of Derrida or Adorno (see Dews 1987 for a comparison); in the critical theory of Habermas - the reconstruction of the historical and normative conditions of critical theory which have culminated in *The Theory of Communicative Action,* and in which his emancipatory critique is arguably capable of reflexively locating itself; and it finds a central place in the sociology of scientific knowledge (e.g. Woolgar 1982, 1988b), as well as cybernetics and systems theory (e.g. Bateson 1973), and not forgetting Foucault's *critique* of reflexivity as 'the tyrannical twin of the liberal ideal of individuality', as Connolly (1987 p108) puts it.

From a structuralist perspective (e.g. of de Saussure), language is reflexive in the sense that meaning derives from differences between signs within the linguistic system as a whole (Culler 1976/1986). And talk may be said to have a reflexive moment in that it presupposes an involvement with its co-text in the production of meaning. Or, from the view which asserts the centrality of an active and ordering subject, language in action is often continually and reflexively monitored for comprehensibility and effect.

Within the context of this section the emphasis is not so much upon the way respondents may in general be said to reflexively monitor their talk, but rather upon their statements which explicitly display the fact that they are reflecting upon their answers, in confronting difficulties in the research interview and in dealing with the topic at hand: people-who-are-patients. Such comments about being reflexive often proleptically achieve the effect of waylaying possible criticism.

The form this kind of talk can take is varied. For example in

my interview with Brenda I had raised the issue of the siting of a mental health hostel next door:

> Brenda: I don't really know. Until you're sort of confronted with that sort of thing you don't know, yeah.
>
> DS: It's difficult to know how to respond. I know, that's true, yeah, um
>
> B: I think generally people aren't too pleased about that sort of thing. It's a good idea but in the middle of a, an estate or something, I've mixed feelings about that one. (p15)

The initial comment about the difficulty answering that kind of question is quite valid but then functions to distance Brenda from her subsequent articulation of disapproval.

On other occasions people reflect upon and emphasise the truthfulness of their statements in a way which suggests that they are orienting to the truth in spite of appearances to the contrary or doubts about whether they really ought to be so doing (and see chapter 12 above). For example I had just asked Anne and Arthur about the reception patients might receive at the local Women's Institute:

> Arthur: Knowing, I'll be honest, knowing the people that go to the do's, the women's thing, I honestly don't think they'd, they wouldn't say no but they wouldn't give anybody any encouragement (p17)

The issue of how subjects *ought* to reply to my questions is sometimes directly and explicitly addressed by respondents themselves in a manner which appears to give voice to the dilemmatic quality of their very thought processes, expressed here in terms of competing 'levels' (and cf. the R/A device). My question concerned the siting of a hostel next door:

> Mike: I've lived next to a nutcase for several years. He was a bit strange. He wasn't a psychiatric patient but he had a worse sort of infliction being petty minded and jealous. Yes I suppose the ideal thing to say would be yes

but, and I wouldn't mind at all if they built one, but (3) to think deeply (p14)

And

Andy: On the face it should concern me but deep down I should think, well blow me down, these people have got to live somewhere. You know, you've got to think that (3) It's no good isolating yourself from the world. (p14)

However one respondent in particular provided an interesting variant on reflexive talk and I want to look more closely at the interaction. The extract concerns explicit meta-talk (Schiffrin 1980), the respondent's explicit reflexive comments upon her own, and our joint, talk, as they relate to the topic of people-who-are-patients. It may perhaps be worth recalling that many proleptic manoeuvres involve such meta-talk as in 'This may sound silly, but...', while meta-comments may be used (are perhaps essentially used) proleptically. Karen and I had been discussing the idea of patients attending the village society meetings:

Karen: Yes I mean how would one, would they be able to cope with the complexities of planning applications and things which is basically our main business and would they want to get involved in that kind of thing * I suppose in theory there's nothing against it. But um, the other thing about coming along to jumble sales and things like that, I've never really noticed one do that and there again I suppose if they weren't going round taking things and disrupting then *. Very difficult isn't it? You don't know what's a right answer.

DS: There's no right answer.

K: Well.

DS: Do you think there is a right answer, that you ought to be saying X,Y and Z?

K: I don't know (laugh). Er, not exactly I mean sometimes when you actually put these things into words it sounds terribly er (2) er (1) I don't know what the word is. You know however much you say oh they're perfectly alright, you're going to say no they're loony, go away (laugh) You're not really being fair to them.

DS: It's difficult to put into words isn't it?

K: Whatever you say it sounds as though they're second class citizens which shouldn't be *. Haven't really thought about them really. It's very difficult to put it into words.

DS: So you hadn't thought that way but somehow when you come to talk about it it comes out=

K: =It comes out like that. Um

DS: That's interesting.

K: It sounds terrible, you know. You don't really want to say that but er you can't help feeling that's the way it sounds (7) (p12)

At the meta-level Karen is thematising the implicit claim about correct ways of talking. 'Whatever you say it sounds as though they're second class citizens which shouldn't be * ' provides a comment upon patients, herself, the interview process and the normative rightness of kinds of talk. What are the effects here?

To begin with there is an effort to make a correction concerning the way patients have been talked about within the interview. Karen is saying in effect that 1) this is not what she really means and/or 2) she is inexorably driven to talk like this by virtue of some hidden structure or logic of discourse itself (R/A, structure/appearance). In the process of telling that talk does not sound right, she is distancing herself from her talk. A kind of hedging, it serves here to mitigate her position, to render her, we might say, less prejudiced.

At the same time the status of patients may also be affected. To meta-comment upon the whole process of this or any such talk as talk which *does not allow for* a positive interpretation, Karen is saying that patients are getting a bad deal here, in this kind of interview, and that perhaps they are not as bad as they seem to be.

On the other hand, however, Karen manages in this discussion to use the word 'loony' which she had not used in the rest of the interview. In other words her meta-talk about the unfairness of it all manages at the same time to compound the problem. We now have 'loonies' as well as 'patients'. As Billig et al (1988 p5) have pointed out, the Enlightenment's prejudice against prejudice may itself serve to enable the expression of prejudice.

The above examples show how reflexivity can be used as a resource in discourse in a manner which may be both illuminating and mystifying. As Eagleton (1991 p61) puts it in discussing liberal humanism:

> '...a true liberal must be liberal enough to suspect his own liberalism. Ideology, in short, is not always the utterly self-blinded, self-deluded straw target its theorists occasionally make it out to be - not least in the cynical, infinitely regressive self-ironicizing of a postmodernist age. On the contrary, it can rise from time to time to 'metalinguistic' status and name itself, at least partially, without abandoning its position. And such partial self-reflectiveness may tighten rather than loosen its grip.'

In so far as the above comments also apply to my own text, there is a whirl of recursive logic here which threatens to draw us into a reflexive madness. It may then be prudent to break off this particular analysis at this point.

To conclude, explicit meta-talk in the above example may be said to render the speaker more rational. At the same time it also challenges the status of patients as provided for by the kind of talk which is depicted as allowing no positive interpretation. In this sense it poses a dilemma of normative rightness, of the right way to talk about this kind of issue. In the end however the discursive position of patients is not greatly improved in relation to villagers.

Not Only, But Also

In my search for items and ways in which villagers minimise difference between themselves and patients, the phrase 'It's not only patients' or 'Its not just patients' almost leaped out as it were from the transcripts. The phrases are used, it appears, in a straightforward fashion which has the effect of an attempt at limiting damage to both the speaker's and patients' status and identity, and in a manner which suggests that discrimination is wrong. In the following excerpt which takes a narrative form, Penny has been drawing upon the interpretative repertoire of Own Interests (Nuisance), mediated by some concern for patients' welfare:

> Penny: ...But it was a shame because after a while they had to get rid of him because he started getting too friendly with people and he was tending to get on their nerves. People started complaining. He was waiting for them to finish their drink and he was up there taking the glass straight away, you know. He used to come up to me. 'Hello you work up in the shop' and he'd chat. They're alright as I say for ten minutes but then when they, they stay. It's like any, it's not only patients, ordinary people if they sort of dump themselves on you they can get on your nerves, can't they. (p20)

Penny had been telling me about a man, a patient at the hospital, who used to work in a village pub collecting glasses. Her talk had not been flattering to patients and exhibits a facet of the Own Interests repertoire, in that 'they' in general and this man in particular, can be a nuisance.

Her use of '...it's not only patients' serves on the one hand to render patients perhaps not quite so separate a group of people, not quite so different after all; while on the other hand it impresses upon the hearer the notion that the speaker is in fact not prejudiced against patients in spite of the negative portrayal. It is a device which retrospectively, and

in a discourse analytic sense, might be said to discursively 'cool the mark out', to use Goffman's (1952) phrase. The target or mark having been 'hit', is cooled down. The real time correlate here is between the speaker and hearer: 'Just in case you're beginning to get steamed up with the notion that I'm prejudiced, just listen to this'. The 'mark', in this case the potential stigma, is ameliorated. The social status of people who are patients is brought into line with 'ordinary people' albeit as an apparent afterthought.

In terms of the implicit anticipation of criticism, this device can also be said, like the instance of meta-talk above, to constitute a *prolepsis*. In the following excerpt Kev talks in a similar fashion about staff at the village store:

> Kev: ...Yeah, I mean I know. I mean some of the staff, you know they wo, they won't walk through the alley. But I suppose that's not just the patients, that's through, through er, you know er, it could be anybody if there was going to be an attacker...(p21).

But 'Not Only' is not just confined to the repetition of a formulaic 'Not Only' or 'Not Just'. It also takes other forms, such as the following extract where discussion had centred upon 'problems with patients' over the years and in particular the issue of danger:

> Wendy: I don't think p, people were frightened of the patients. I think you'll get an odd few say they were or the children were, but erm. I mean I wouldn't have left my child, children with a group of patients. No, I would n't do that. I, you don't know. But um, no they weren't frightened in the village and most of the patients, the trouble was, that, there again it was, children were part of the family and they loved the children and really it was more that they'd try and pick up your baby or try and make a fuss of it so you wouldn't like that to happen so you keep=
>
> DS: =You wouldn't like it to happen, because (1.5) why?

Wendy: Well, I mean you wouldn't mind them sort, talking to your baby. I mean certainly you wouldn't mind, you wouldn't stop them. You wouldn't like them talking to your children, you wouldn't mind them talking to the children, but I wouldn't leave my baby in a pram out there for them to be (1.5)

DS: Because something could happen?

Harold: Something may happen but er=

W: =Yes, that's right.

DS: A sense of not being sure?

W: But then I wouldn't leave my baby outside a shop in the town for, for any other person to grab at would you so I'm not thinking that they're necessarily any erm, you know, I think they're more loving really. (p9)

This excerpt demonstrates again the way that identities are discursively created according to the argumentative context. Patients are initially not to be feared. Doubt about this creeps in, but the argument is saved when patients are categorised with 'any other person', and finally emerge in fact as 'more loving'. Patient status is rescued and perhaps elevated. The message 'It's not just patients' balances patients up or brings them into line with 'any other person', thereby countering the implicit message that patients constitute a danger or threat. The Own Interests (major) repertoire is challenged in the process.

And in the following talk with Kev:

Kev: ...Um (3) but that can only, you know, that might only cover a minority. Some of them you know have got a good background, got plenty of money and buy their own clothes. But er (1.5) you know, and others with, perhaps a bit slower, through, you know with money. But again, but again I mean that's not, there's no, I don't think there's a general rule. Again some, you know, some are, are better at others than that. You know, some, you know, they're very different they [don't] know their money but some do, but. But that's the same with, with everybody who isn't a patient. Some people are slow with money if you like.

> DS: That's true, and dress sense varies as well?
>
> K: Yes. It's very hard to say really you know who is and who isn't. (p10)

On other occasions patients become balanced with others in terms of their sanity as the following section suggests.

As Sane As

Although not employed proleptically, this next device does perform a balancing function. We have come across it in a previous section, when Ralph recounted how the 'psychiatric people' are as 'mad as the patients' and 'some of the patients are a damn site saner than (the staff)' (p321). There is a clear attempt here to bring patients and staff together in terms of their (ir)rationality, and indeed to elevate some patients in the process. This was used overall to impugn the reason of the hospital authorities in the argumentative production of trouble. Other respondents have also used this method:

> Irene: ...And some of the doctors that would come in were as, well you would say were as barmy. You really would. I mean there was a doctor who used to come in to that post office, between you and I, and he would send telegrams to the queen you see (p28).

Again the talk is amusing and at the same time points to some contiguity between patients and their carers, the kind of thing which has been noted in chapter 9 above.

Direct Credits

In this subsection I want to consider the more direct and less ambiguous ways in which villagers may on occasions propose that there is no difference between patients and villagers. The

methods are straightforward and perform a particular function. Thus Lou tells us that patients are 'just ordinary people':

> DS: ...Say you were walking down the street and you saw somebody you hadn't seen before, would you ever think "I wonder if, I wonder if that's a pa, a new patient?"
>
> Lou: No. (Laugh) No. I'd just think it was someone * to the village.
>
> DS: Right, right. So the patients in hospital don't, don't maintain a very high profile in your, ┌in your perceptions or in your view?
>
> L: └No. They're just, just ordinary people... (p5)

And in talking about an hypothesised psychiatric hostel next door:

> DS: Would it affect your family life in any way?
>
> Lou: Um (3) Not really (1.5) They'd just be other people who'd be living nearby (3)
>
> DS: You were saying yes and no * and I'm trying to get at (2) what the um, dilemma might be (1.5) about it (3)
>
> L: Well people who didn't know the area, and they came to visit us, and they realised that you were living near patients. Some people would resent it and they wouldn't return because they'd think it would be (4) um * , and they (1.5) they wouldn't like it. (p8)

Here, Lou at once demonstrates herself as accepting and portrays unspecified 'others' as potentially intolerant (cf. section 8 above).

In a similar fashion in Kev's use of 'not just', he also states clearly that in terms of generalising about patients in certain respects 'I don't think there's a general rule':

Kev: ...Um (3) but that can only, you know, that might only cover a minority. Some of them you know have got a good background, got plenty of money and buy their own clothes. But er (1.5) you know, and others with, perhaps a bit slower, through, you know with money. But again, but again I mean that's not, there's no, I don't think there's a general rule. Again some, you know, some are, are better at others than that... (p10)

And in my discussion about her work in the village store with Carol, aged 35, who had lived in the village for 10 years:

> DS: You obviously have contact with the patients here in the shop. What's that like, dealing with the patients from the hospital?
>
> Carol: I like it because they are very honest. They know exactly usually what they want. I feel a lot of compassion for them because feel that it can happen to anyone. The situations they're in. Yes, they're alright. They're a bit amusing some of them. I don't know if they mean to be but they are, yes, it's nice. (p4)

On one occasion however the attempt to provide a direct credit to patients' identities became complicated, as the following example shows. Wendy Green was talking about an incident when some patients had become upset at something a villager had said:

> Wendy: ...You know it was not a kind thing [ ]. They did hurt some of them, yes [I feel], I think really. Just the same as human beings really. Oh they are human beings but they're the same really. There's some nasty and some nice, and some mean, and some dishonest. (p5)[52]

In the process of attempting to directly state the similarity between people who are patients and others, the words become tied up in a temporary knot. The outcome ends up as at best an

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52 And compare the following extract: Val: 'On a Tuesday afternoon is carpet bowls but they are people not patients.' (Val p8).

ambiguous message, and at worst as a message which could give us cause to speculate about the speaker's 'real motives'. The same speaker also provided a further ostensible direct credit which turned out to have questionable undertones:

> Wendy: As we always said the patients are no more trouble than, most of the public are quite nice but you get them, some of them that you see them coming and they're all a damned nuisance. There's no difference really is there? We always said their money was as good as anybody else's and they needed kindly treatment and er, generally speaking. Not all of them but some treated as children. Some are highly intelligent and of course it's the highly intelligent ones that can be very sarcastic at times to you. (p5)

From the commentary position of critical social theory there is a clear link here between the maxim 'their money (is) as good as anybody else's' and the critique of political economy. Money is the ideal expression of the exchange abstraction. According to the idealised world of circulation, of exchange, of the market, the exchange abstraction provides an expression of equivalence and equality. All are equally free here to buy and to sell, according to their inclination. And yet as Marx showed there is a whole realm which is displaced and repressed, the realm of production, of sensuous human activity, in which a structured inequality and lack of freedom is concealed. And so by analogy it can be found here in this maxim. Hidden here is difference. Their money may be as good as anyone else's, but the question is, are *they*?

Direct Credits continued: Intelligent, Cute, and More or Less Friends

The above excerpt also illustrates another feature of interview transcripts, the attribution of intelligence to people who are patients in what appears to be a direct credit, which I want

to suggest has the effect of balancing up the relative status of patients and villagers. At the same time it may function to lend to the speaker the kind of hypothesised and thoughtful identity which a person who acknowledges these differences has.

In the above extract the reference to intelligence follows directly upon the heels of 'Not all of them but some treated as children', and also in the following abstract from the interview with Wendy and Harold:

> DS: There's a sense I've had that patients are seen as children or should be treated almost as children?
>
> Wendy: Well some do but I mean that wouldn't be the truth wouldn't be right with all of them no it wouldn't really I don't think, do you?.
>
> Harold: No I don't, no, no. I mean you ** There's one,
>
> Wendy: They're more intelligent than us by far really. (p5)

Harold goes on immediately here to provide an example in narrative form of how a particular patient provided him with an almost profound insight into his human lot, thereby demonstrating the person's wisdom, although as a direct credit the example may be ambiguous:

> Harold: There's one that walks through the village now, he's not a very, he's, I'd say he's 40, 50 something like that. He's not an old patient, [not] seen him recently but I was walking along with my grandson this year and er he came along and he said 'Hello' and I spoke to him and he said 'What a lucky man you are' and I said 'Am I?' and he said 'Yes, you've got a little boy, a little grandson to go' and um I've spoken to him since because it was, I realised what a lucky man I was. He wasn't the lucky man you know, in his case, you know, that he hadn't got a, and that was what he was trying to infer. And I've spoken to him many times now because we've sort of made that, he speaks and er, um, I think they respond to ⌐kindness and er (p5)

Within the interviews villagers often gave examples of patients they had known who were intelligent or talented. John and Susan Smith had both lived for a time within the hospital grounds and John had worked at the hospital. His account, which trades on our shared comprehension that the couple had a special understanding by virtue of their close and prolonged contact with patients, serves to rescue both patients and other villagers. Patients become 'more or less friends':

> DS: ...I've talked to various people and it seems from what I can gather that um very often people have said the villagers don't particularly want very much to do with the hospital and don't go very often to hospital functions for instance.
>
> John: Very likely not, yes. No, no, no, I can quite understand that because they don't understand. This is another thing. You've got to get used to mental patients. Matter of fact you find some very, very good people among, I mean to say he painted that, this one painted this one behind here. You had some very brilliant people as patients. Oh yes people, you've got to understand them. I used to talk to a lot of them and made more or less friends with them. They used to love to come down the garden, do jobs and things like that. But you've got to get used to them. You've got to, you know, talk to them.
>
> Susan: You've got to humour them (p4)

In the following excerpt I had just asked Wendy and Harold whether they had made any friends with patients over the years, and they began talking about a "very intelligent man":

> Harold: =He run the newspaper and he translated Russian. He was very good at Russian and he used to do this translation and er, he had his own little, room and did that and he was musical and very good. He was the patient's representative on the, League of Friends. (DS: I see) But um then unfortunately, he was told that you know he was one of better ones and he would probably have to go out, and he's gone back er in a very bad state.
>
> DS: He's still in there is he?

H: Still in there, yes I'm sure. Yes cause we were talking about him recently.

Wendy: He could have come out, he has been here and er he would talk to=

H: =He has been in here, we've been in, to us, he's been in, come in, like er, but he was very friendly and very polite and I would have had no qualm of any, problems with him like (p2)

This passage provides an oblique commentary upon the appropriateness of discharging (even intelligent) patients, and is therefore consonant with the couple's expressed position on this matter. Other villagers provide similar accounts concerning intelligence. I had just asked Kev if he had any thoughts about why people were admitted to Shenley hospital:

Kev: Um, well, on why they're there?

DS: Yeah, why they're there.

K: Well (1.5) Nervous breakdown, I would say, you know? [Let's have a think] It's, if you, I don't know, if you find out little bits of information from, perhaps staff or something about their background, I think some of it is quite interesting. I don't know if that's a nice thing to say[53]. [You feel] er (2) You, you do, you know, and some of them, you know what I mean, they obviously had fairly good jobs * Couple of professors or

DS: Is there? Right.

K: Yeah, I think, you know. Then I know there's a couple of er, there's a couple who used to be boxers, you know. So you get to know a bit of their back, ground, but I just I just yeah envisage people sort of really, I, I think really yeah, nervous breakdowns. (p6)

This whole hedged excerpt can be read in terms of the function of minimisation of social difference between people who are patients and others, linked to a reflexive proleptic meta

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53 This is another example of meta-talk with a proleptic form.

-comment. That is, the elevation of status, as in professor or boxer, functions as evidence that patients are not disbarred from having reached such occupational heights by virtue of their present patient status. The status of patients is being balanced we might say with that of villagers. Difference gives way to similarity. Kev repeats his position later in the interview in his argument that a psychiatric breakdown 'can happen to anybody':

> DS: So you could imagine, hypothetically at least, it could happen to you as well as other people?
>
> Kev: Yes, oh yes, oh yeah. As I say there are professors and things, I mean, well it can happen to anybody. And even, I don't know, I mean, I'm not under a lot of pressure at work but I can, I can see it happening to lot of people say on the stock market, or something like that. You know, where there is an awful lot of pressure on. (p20).

On the other hand it is perhaps the case that the definition of *some* patients as intelligent serves to *reduce* the status of the rest of the hospital patients in comparison with their intelligent associates.

For example, when Kev tells us 'I don't know if that's a nice thing to say' (p445 above), he is reflexively referring to his statement that some of the information he had found out about patients 'can be quite interesting'. There is an explicit reference here to a possible interpersonal discursive offense. The meaning I infer here is that Kev is concerned that he might be 'damning with faint praise'.

Of course the suggestion that some patients are intelligent may simply imply that patients might exhibit the same range of intelligence quotients as that exhibited by the rest of the population. Nevertheless there is also the sense that patients

may be viewed as *less* than averagely intelligent, for example when in the extract already presented above, Wendy, Harold and I mark out what appears to a division between patients as children and patients as intelligent[54]:

> DS: There's a sense I've had that patients are seen as children or should be treated almost as children?
>
> Wendy: Well some do but I mean that wouldn't be the truth wouldn't be right with all of them no it wouldn't really I don't think, do you?.
>
> Harold: No I don't, no, no. I mean you ** There's one,
>
> Wendy: They're more intelligent than us by far really. (Wendy and Harold.5)

However, even when their precise level of intelligence is less than clear, patients are often portrayed as demonstrating an almost 'native' cunning, so that they may still be depicted as coming out on top in their negotiations with villagers[55]. For Irene and Tom below, 'cute' means crafty and devious:

> Irene: They're cute.
>
> Tom: Oh they're very, some of them are very cute.
>
> DS: How do you mean, cute?
>
> Irene: You've got one, that will, uh, every time you see him (in unison Tom) 'Got 10p for a cup of tea?'
>
> Irene: 'No sorry'.
>
> (Gap)

---

54 Compare 'Discursive dependence, qualified', p361 *ff* above. Of course we may also call children 'intelligent'. Being seen as children, or as childlike, or in need of care etc, does not therefore logically preclude patients from also being regarded as intelligent.

55 These negotiations are often depicted in story form within the interview world; see below, and especially the short stories of Anne (p204 above) and Ralph (p322 above), and Southgate (1991).

I: ...there was one patient, I suppose he's in his thirties now I don't know, um, but he would watch, to see if **'s car was there and he came around for a roll, of a cigarette-tobacco.

T: He made the mistake of giving him one, one day (joint laughter). From then onwards he was considered a soft touch (laugh).

I: And he used to watch for him. 'Is he there today?' 'No, no.' 'I thought that was his car'. So you see he knew the car, didn't he. They're very cute some of them. Very cute. (p6)

And in the next excerpt Wendy and Harold had been talking of how patients should not be discharged into the community:

Wendy: They'll always need care though. I mean even, there's ones being born [every] day and I'm sure they'll need care. I don't think it's. Quite honest I feel very strongly about it. I don't think they should be put out into the community, just. Some of them, those that want to go probably. I don't think a lot of them will ever be able to care for themselves. They know their money usually though. They're quite careful most of them. Not careful but they know

DS: So they know what's going on?

W: They won't let you do them, certainly, I don't think they'd let you do them. They'd do you if they could, some of them would you know.

DS: They would would they? (W: Oh yes) They'd take advantage of you?

W: Well they will, they'll give you fourpence instead of sixpence especially if they think you'll say, oh it's not worth it, let it go, sort of thing. (p5)

It is perhaps quite remarkable that 2p can be the criterion of advantage or disadvantage in the 1990's, and it may be that it is precisely the poverty of the interactions between villagers and patients which is being expressed here. From the discourse analytic perspective of this chapter I also find here a

movement towards a discursive levelling, if not of status then of power, but in a terribly minor and pathetic fashion.

What then of Direct Credits? My suggestion here has been that on the one hand these portrayals function to lend power to, and improve the status of, people who are patients, within the interview world. At the same time they arguably render the speaker more reasonable, rational and accepting of patients. One the other hand however the attribution of a quasi animalistic cunning is a double-edged affair which renders patients both 'winners' but also 'losers'. Indeed the implied notion that 'patients may be mad, but they're not stupid' contains also an implication of a kernel of rationality which may be extremely useful for villagers on occasions to ascribe. Such a kernel allows for some attribution of responsibility and accountability to patients, providing a resource and rationale by which villagers may more easily hold patients responsible for their actions should this become necessary. In other words it may become a useful 'reasonable prejudice' device.

On The Border

The final analysis of a balancing device is perhaps the most important in terms of the thesis as a whole, for its implications extend beyond the extracts presented here to the organisation of the experimental Appendix D. This section focuses in particular upon one of a number of spatial metaphors which have been used by villagers in their depiction of difference between themselves and people who are patients, and between madness and sanity: the thin line.

Like many other metaphors to do with madness such as 'over the edge', 'round the bend', 'very far gone', 'over the top' etc, the 'thin line' expresses a spatial relationship. Spatial

metaphors are quite common in everyday life as Lakoff and Johnson (1980) have shown, and indeed the metaphor of the thin line is also found in everyday use. For example the 'thin line' can be used in many a context of potential dispute, such as, 'there's a thin line between euthanasia and murder', in which the message is proposed that the opposing sides could easily be reversed, and one could be taken or read as the other; the tenuous membrane of the line might easily be breached[56].

A variant of the thin line can also be found in a transcript offered by Wetherell and Potter (1989) in their study of accounts of 'violent police behaviour' during the South African Springbok rugby tour of New Zealand in 1981:

> '...they had to decide between, the fine line between do we stop or do we go in. (Yes.) (8) And, er, that would have been a decision which I wouldn't have liked to have taken.' (p211).

Here the fine line refers to a decision which the police have to make about how to respond, a decision which is portrayed as extremely difficult.

It may be possible to draw an equation between the thin line and the metaphors of 'drawing the line between', 'stepping over the line', being 'out of line' or bringing someone 'into line'. In all of these examples there is posited a boundary and an issue which is more moral or normative than factual. Where the 'thin line' points to uncertainty and indecision, 'drawing the line' and the other examples, perhaps represent efforts to draw boundaries more firmly. Indeed in his account of the position

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[56] Compare also the notion of the 'thin blue line' to describe the police presence and role (see the Errol Morris 1988 documentary/film 'The Thin Blue Line'), or the 'thin black line' to refer to the marginalisation of black people (see R.Fortnum, 'Widening the thin black line' Guardian 20/2/91).

of Habermas, Pusey (1987 p57-8) provides some notion of the stakes here in relation to the world of philosophy:

> There is no external reference point which guarantees objectivity or provides a basis for 'presuppositionless description'. Nor is there any ready methodologically guaranteed line between observer and observed, author and text, knowledge and interpretation, fact and value, explanation and understanding. We must face a fundamental ambiguity of the human condition in which 'the other is there both as an object for me and as another subject with me'.

In this sense the lack of a philosophical 'dividing line' may be used to point to the thin line between madness and sanity in so far as the absence of philosophical certainty propels us towards the possibility of a kind of madness (cf. Bernstein 1983 p16-20, 1986 p10, Lawson 1985 p124)

Within psychiatry itself, Scott (1973a) has also drawn upon the metaphor of a 'well-ill line' in a powerful depiction of psychiatric and interpersonal 'closure', and the treatment 'barrier'.

In the interview transcripts the thin line and its variants are used on several occasions. I shall document some instances of their use here and then go on to suggest ways that their use may be interpreted. It is important to note that this is only one of the metaphors used to talk about this subject, but one which has I believe a special place as a balancing device. Spatial metaphors concerning an explicit difference between madness and sanity occur in 12 recorded interviews with villagers and the 'thin line' or variants, in which both a barrier and fragility are conjoined, occurs in 5. The balancing work which they do can also be achieved by other means as indicated above. Other spatial metaphors which villagers have used to suggest such a separation include for example 'edge',

'border', and 'length', as the following sequences illustrate. Brenda had been talking about a time when she too had been feeling distressed:

> Brenda: ...I mean, I mean I can talk to my husband but he said "Go and see the doctor and see what he can do", you know, but.
>
> DS: Did you think you were close to a breakdown then?
>
> B: No. I don't think I was close to a breakdown, I was just feeling very, very low, tearful and you can't (4) You're not in control of anything, you can't do anything. You (2) I mean you feel, you know up there that you need some sort of help. You don't know what sort of help. I just thought going up the doctors, he might be a bit ss, sympathetic, he might be able to do something for me, because you don't like feeling, like it, you know, that's um, and that's the only response I got from the doctor (2)
>
> DS: Do you think anyone can have a breakdown?
>
> B: Yes
>
> DS: Do you?
>
> B: Yes (laugh)
>
> DS: Do you think you, you could. I know you weren't having one then, but, do you imagine there could be a circumstance when you could?
>
> B: I think most people can. I think it's something that just (1.5) that's just like that isn't it, just happens, yeah. Doesn't necessarily have to come on over weeks, months, years. I think it can just, something just snaps.
>
> DS: Right, it doesn't have to build up necessarily?
>
> B: No. Well that's the impression I get anyway. Anything could trigger it off.
>
> DS: Yes I see (little chat with the dog here). That makes it sound a bit precarious almost. Like you don't know when, I mean it could happen to anyone just like that (laugh).
>
> B: Well, life is like that. It's like living on a knife edge really isn't it. (Laugh). (p19)

Brenda's use of 'snaps', 'knife edge' and 'trigger it off' promotes a vision of suddenness, possible pain and violence, but also a sudden movement from one 'place' to another[57].

In another interview I had asked Anne and Arthur whether they would hypothetically mind others knowing if they had been patients in a psychiatric hospital:

> Anne: ...I mean even on health things they ask you, don't they, have even been, you know. Have you ever had a nervous breakdown, you know. Well anybody can have a nervous breakdown, can't they.
>
> Arthur: Oh, yes.
>
> Anne: But er, you know, once they've got that on your, on yer form, they go - oh, you know.
>
> DS: So they might think that you're a nutcase[58] or something.
>
> Anne: It could happen again, yes, yeah. You can go over the edge like, you know. You can, you're on the border.
>
> DS: You're on the border, it could happen again? Right.
>
> Anne: Do you want another coffee? (p19)

Anne repeats here the notion of a border or edge which a person might be expected to recross and this is given as a reason for not disclosing a former-patient identity. Finally, Susan and John suggested:

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57 The 'knife edge' can itself be regarded as possessing a property of the 'thin line' in so far as the edge of the blade is 'thin'.

58 Anne had just used this word in a previous passage: '...you'd want to keep it quiet I think, in case they thought, oh, we've got a nutcase here.'

Susan: Well anybody can er, in *our* lives er, it's the simplest thing. When you think of the brain. It's only just a little er, length, and anybody can be mental, can be like that.

John: Oh yes. I think er, yes it's one of those things. I don't think so much today but in olden days I think it was - 'oh, a mental patient' you see. But some of them was remarkable people. (p4)

The Thin Line

An explicit reference to a line or divide of relative width can, as I have suggested, be found in five interviews with villagers. In the first example the metaphor came out of my direct question in a way which links the patients who frequent the village and Brian's own intra and inter-personal problems:

> DS: I, I don't know if, if you have any ideas about what the difference is between um, being sane and er insane, if you like?
>
> Brian: (laugh) Well I (4) Well I suppose all I know is that it's a very, narrow dividing line (2) And er (2) You can, you can see in yourself, um obsessions if you like that could easily get out of control but er * You know when I was working all those hours, and the affect on the marriage you can see, you can see that * I always think 'for the grace of God' (2) I think it's a very (2) very narrow division indeed. People (1.5) go (1.5) you know, the, the other side of it and come back, temporarily or longer term. That's (1.5) about all I can say about. Some go over and never come back, [depending on the circumstances]. (p10)

Brian replied by referring to problems he had experienced. In the process, sane-insane refers to a line which people might cross. In the next excerpt I had been asking Kev why he thought people might be admitted to a psychiatric hospital in the first place. When he suggested 'people sort of really, I think really yes, nervous breakdowns', I then attempted to find out what 'nervous breakdown' might mean to him:

Kev: (laughter) Er I, I don't, I suppose there's a, they say a very fine divide between, you know, between it happening and er (2) I don't know, how it would happen but er (1.5) I suppose, with a lot of people it's the perhaps pressures at work or something like that and if it did all get too much to you and you did have a nervous breakdown, I suppose you'd have to say that, I mean they're all voluntary patients aren't they. But perhaps you would go in and try and sort yourself out perhaps (1.5) I suppose it's pressure really (1.5) either at work or at home or something like that. Just severe pressure and it just I mean, I suppose it, it's a slow build up but it can you know, but eventually it's just a, perhaps in a couple of days [whatever], you find it's all too much.

DS: Over a couple of days you'd sort of break down, over. Build up over a long period?

K: Yeah build up over a long period I suppose of being erm unhappy and all the pressure getting to you, but then I don't know the actual stage of it actually happening. I can, I can you know see it quite clearly how it does happen and the slow build up to it perhaps and * but after that the actual erm, if you like, when it does happen, I don't know, I can't really picture that at all to be honest. (p6)

Kev provides a causal model here in which the crossing of the line is related to 'pressure', in a manner similar to Brian's account above[59].

From Sanity to Insanity

The metaphor of the thin line is used several times in one particular interview, with Maggie, and it is interesting to trace the way its use develops.

DS: Let's come back to the patients. Do you have any thoughts about, about erm why they might be admitted to, to Shenley in the first place?

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59 Also, Kev's account is heavily hedged, and his reference to a 'very fine divide' is preceded by 'they say'. These hedges serve to discursively distance Kev from the views he expresses.

Maggie: Why?

DS: Yeah (2) I mean would you see them as being ill? Would you see them as suffering from an illness or, would you see them differently?

M: Well mental illness, yes. Well, well I think, haven't they all been, had something to do with mental illnesses, breakdowns?

DS: Well, well that's right, except that people talk about it in different ways. Some people might talk about mental illness. Other people might talk about breakdown,
⌐some people might talk about stress.
M: └There's a very fine line between (DS: There's a fine line), yes there is between being normal, and not being normal (2) because I knew that when, when I had my breakdown. I, I could have easily have gone over the line. I just had to be strong. It depends on the people who are helping you to get better anyway.

DS: So you say that there's a thin line between

M: Normal and abnormal (laugh) if you like. (Maggie.7)

In this example Maggie draws upon her own experience in outlining the nature of the difference between being normal and not being normal/ being abnormal. Maggie went on to talk about how she had remained out of a psychiatric hospital and overcome her problem with the help and support of friends. We are told that a breach of the line could have been easy. Maggie tells us here that she is close in some respects to people who are patients at Shenley Hospital, in that she has been close to the line, and could have 'gone over' to the other side. In this way Maggie suggests that she and patients are not so very different after all.

But at the same time a difference lingers in so far as Maggie did not actually cross the line, while patients implicitly have or do. And this difference is reinforced by her explanation of events in terms of her own personal *strength*. An alternative

for Maggie might have been to use the word 'lucky'. This explanation and the presentation of the self as 'strong' more effectively separates Maggie from 'abnormal' patients who are by definition 'weak'.

However, Maggie adds an afterthought: It depends on others trying to help 'anyway'. This tends to mitigate the otherwise inevitable conclusion that not only are patients weak but also perhaps to be held responsible and to blame i.e. for their weakness (Kirmayer 1988 p80).

The salient feature here is not the fact of breakdown per se, but strength. Strength and normality are related. One has to be strong to remain normal. There is another implication: if defences or barriers are lowered, the line may be crossed. The metaphor moves here to personal invasion, battle, resistance. To take this further it is as if the realm of the abnormal lurks ever ready to take advantage of lowered defences.

Later in the interview Maggie again refers to this 'fine line':

> DS: Does it ever concern you or is it ever an issue for you that, about whether you can identify somebody or whether, um wanting to know whether someone is, or, or someone isn't a patient?
>
> Maggie: Do you mean does it concern me that I can't tell the difference d'you mean? Or can I tell the difference? Em (2)
>
> DS: Well yes, if you like, does that (1.5)
>
> M: Does it bother me? (DS: Yeah) (2) Probably that's what I mean about a very fine line, you know. You know what I mean don't you. Very, very fine between patient, and, patients and myself really *
>
> DS: You've had a clo, closer experience of this haven't you, with your family, with yourself and your mother. (p11)

And later again Maggie was talking about a villager who frequents the store:

> Maggie: ...He's he's a nervous wreck if you like. You know, he * and shakes. And he's. Oh, oh it's terrible. He makes me feel a bit like that when I'm, I'm er in his presence, you know. He's so strange. He, comes in and gets a paper, holding his money out. He wants your attention straight away * but he isn't a patient. You see what, you see what I mean about a thin line don't you?
>
> DS: I see what you're getting at, (M: Mm) yeah.
>
> M: Yeah, the, the, the older they get I think. Not everybody but a lot of people do get impatient. They get nasty, you know. Can't wait a minute. I know a lot of young people are like that as well, it's because they have to, they have to go to work. They haven't got much time, it's rush rush. But the older ones that are retired ┌haven't got that. (p19)

But the issue of the thin or fine line and (ab)normality is also drawn into the debate concerning Maggie's mother who had actually been admitted to a psychiatric hospital. Following immediately after the first extract:

> Maggie: I sort of got myself better with the help of, well, my mother funnily enough. Um, even though you know a lot of it was to do with her she did help in a way. Because sometimes she was quite, quite nice, quite normal. She was a very loving mother and it [sort] of feels like a mum, you know.
>
> DS: You were 16 weren't you?
>
> M: Yes about 16, 17.
>
> DS: And how old would your mother have been then?
>
> M: Mm, oh dear, let's see, she was about 56, 57 maybe.
>
> DS: So it was about three years after that that she was admitted, after you were married presumably?
>
> M: Yes, they had to do that, she had to be admitted to get treatment because she was wouldn't go into hospital. She hated hospitals. I don't think, when I used to visit her,

it was such, so strange. It seems, all seems strange to me now to see her in that environment. Because she seemed to be the only sane one amongst, all the others. As if she shouldn't have been there. She wasn't insane, she wasn't insane at all. It was just the sort of illness that made her, go off the rails a [little] bit.

DS: What would you see the difference, between, between er you know, being insane and er, if you like being mentally ill? Would you see a difference between the two? Um (2)

M: The way I see it. Is there a difference between, um (2) um what, a mental illness and, insanity? (DS: Yeah, yeah) I don't really know, I don't know whether. How do you know, I don't know anyone that's insane, not insane.

DS: What about the patients at the hospital?

M: Do you consider them as being insane?

DS: (laugh) I don't know, um (2)

M: I thought anybody that was insane wasn't let out of the hospital. I don't think that they have the freedom that patients here have.

DS: Right, so they'd have less freedom (2) OK.

M: But I think if my mother had lived, I think she would have come home eventually. She hadn't been in there very long before she came home one, one day and died. I mean it, well I hope she wouldn't have been in there. It's very difficult * I mean with her dying we'll never know whether she was, she was insane or not. I don't think she was.

DS: No I don't want to suggest that she was. I'm just trying to get at some of the ideas you might have about it. You said that she, it was the menopause really that um, triggered things off for her and that she was a bit, she got up in the middle of the night. She used to come and, come out in her nightdress, come to see you. (p7)

I want to suggest that we have been witnessing here a negotiation concerning the identities of Maggie and her mother in relation to people who are psychiatric patients, and in a way which implicates the metaphor of the fine line which Maggie has had recourse to. She had already positioned herself this

side of the fine line, as finally strong and normal. Her mother is described as having been initially sometimes 'quite normal' but then being admitted to hospital, where we are told she is the only person who is not insane. The other patients were insane, and 'insane' is something Maggie does not know, is beyond her knowing. Her mother by contrast in this passage was 'ill'.

The term 'illness' functions here to separate mother from 'insane' others and relieve mother of the responsibility of becoming 'not-normal'. However it conflicts perhaps with the earlier implication that normality is tied to personal strength which may also imply moral strength and responsibility. This confusion perhaps highlights the ambiguity or contradictions of 'illness': If one is 'ill' then one is not responsible. On the other hand one's lack of moral strength may result in illness and hence one remains, in a certain sense, responsible.

It appears to be the case that in the negotiation over identities 'insane' becomes another and 'further' step beyond the metaphorical fine line separating normal from abnormal. 'Insane' finally comes to mean 'those who are not let out of hospital'. In this sense the patients from Shenley Hospital who frequent the village are not insane.

What is happening here is that Maggie (with my assistance) sets up three contrast structures. The first is between 'normal-strong and normal-?strong-breakdown'. The second is between 'normal-?strong-breakdown and abnormal-weak', separated by a fine line. The third is between 'abnormal-weak and insane'. Insanity is discursively produced with the effect of rendering Maggie and especially her mother as both sane, or at least not insane.

The thin line has led us on a journey in which insanity becomes the most distant, unknown and unknowable territory. But it is there only for unknown others and not the self or one's loved ones. Schematically the metaphorically spatial relationship can be configured as follows:

(Normal/strong

v.

[Normal/?strong/breakdown/Maggie

———————————————————————The Thin Line

Not Normal/weak/breakdown/illness/Shenley patients/ Mother])

v.

Insanity/not normal/not known

The final line of Insanity is left unlinked by brackets to other categories in order to emphasise its (utter) disconnectedness.

My argument here is that the metaphor of the thin line functions by virtue of the very thinness of the line to provoke a sympathy or empathy with others who have crossed that line, such as people who are patients at Shenley Hospital. In this sense the thin line constitutes a balancing device.

However at the same time it may be no accident that the thin line and other spatial metaphors are most often (but not entirely) used in the context of villagers' recounting of

personal experiences of emotional problems, psychiatric breakdown, near-breakdown, or hypothesised breakdown, as the examples above show. Perhaps to confine the discursive demonstration of understanding and empathy to one's own situation or problem in this way bespeaks a reciprocal lack of acceptance or empathy for people who are patients. In the earlier examples above, respondents used spatial metaphors in a way that kept them the 'right side' of the border and thus preserved their sanity. In the case of Maggie the borderline was shifted across, or pushed back, so that Maggie, who agreed she had had a breakdown, still remained the right side of the border, and her mother who had been admitted to hospital remained the right side of insanity. The crossing of the line, and *a fortiori* the further lands of insanity, are not for us but should be left for others, while ironically in Maggie's case Shenley patients were also caught in the net and dragged *back* from the border with insanity. This discursive analysis of a boundary negotiation might well be compared to results from other empirical studies (e.g. Townsend 1979 for a review, Schwartz 1957, K.Smith et al 1963, Yarrow et al 1955a,b) which suggest that families may resist the definition of a member as mentally ill until the 'last straw'. As Townsend (1979 p211) puts it, the public's recognition threshold for family members is high 'partly because they do think of mental illness in stereotyped terms', i.e. as something nasty to be avoided[60].

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60 Compare the 'general public' respondents of Askenasy (1974), over threequarters of whom distinguished between 'nervous breakdown' and 'mental illness', the latter considered to be generally incurable and requiring long hospitalization (ch 19). And in their interesting study, of 'first-contact' psychiatric pre-patients, some of whom were diverted from hospital and others later admitted after assessment, Townsend and Rakfeldt (1985) showed how their subjects managed self-identity by using contrast structures, such as 'normal' patients v. 'really crazy' patients.

The extract above shows how this boundary can be shifted in discussion.

At the same time as promoting similarity, the metaphor of the thin line as barrier therefore also promotes a distance or difference, a separation by virtue of the line itself. Clearly such separation can be achieved to some extent by a villager, merely by providing a sympathetic comparison from the safety of his or her own fireside in contrast to the location of an interview on a psychiatric hospital ward. From this view, separation is achieved simply by being resident somewhere other than a psychiatric hospital (I am excluding staff here). However my point is rather that the metaphor itself provides the double-edged meaning by its conjunction of both quasi-identity (thinness) and difference (the line).

No doubt any border or boundary metaphor can be said to implicate both identity and difference as some of the above examples suggest, but it is the qualification of 'thinness' in the use of the maxim-metaphor 'thin line' which provides for the possibility of a particular reading in which closeness and similarity become stressed or dominant within the interviews[61].

Conclusion to section 10

In this section I have shown how villagers set about discursively shrinking the social distance between themselves and people who are patients, via a number of devices which have included 'reflexivity'; 'not only patients'; 'as sane as'; 'direct credits' (including 'intelligent, cute and more or less

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61 Although this priority could be reversed in a different argumentative context. For example 'It may be thin, but it's still a dividing line'.

friends'); and certain metaphors which configure the relationship between the two parties. Several of these devices however also turn out to be double-edged. I have suggested that 'reflexivity', 'not only patients' (and from an earlier chapter, 'It depends') are particularly strong candidates for the predicate prolepsis.

These methods may be used flexibly in conjunction with the interpretative repertoires which I have earlier identified, and they may be compared to the analysis of methods in the previous chapter 'Telling the Difference'. The 'thin line' is also drawn upon in Appendix D.

11: Discussion

In this chapter I have identified a small number of interpretative repertoires. I have also shown above how these repertoires may be used flexibly with a variety of effects or functions. For example, I have suggested that they are often conjoined in discursive manoeuvres which serve to criticize and attack, while simultaneously presenting the speaker or the village as a whole as tolerant, helpful and accepting of patients. These repertoires therefore function in defence and attack, in the cut and thrust and the exigencies of everyday life and the interview world, in the raising of truth claims, in impression management and in the expression of moral-practical issues.

All the repertoires may be used in arguing that patients should be, and should remain, in the hospital. The repertoires of Humanist Concern (Help) and Relative Balance have an orientation which looks out and away from the hospital but at the same time are often used in a subordinate fashion to Own Interests, so that they may readily act as the bit-players in a proleptic manoeuvre which serves to increase the discursive power of the other (Own Interests) repertoire.

It is possible to imagine a reversal of this scenario in which villagers and others draw upon all repertoires but in arguing for the hospital to be closed. Villagers *could* say for example, 'The patients may be a nuisance for us sometimes but many of them can cope well on their own with support and we should encourage them to settle in the community' and so on. Thus the functions of the interpretative repertoires vary according to the way they are qualified and according to their sequence and positions within the argumentative structure.

The rhetorical figure 'prolepsis' has occupied a central place here in the management of criticism and prejudice. In this way, as Billig et al (1988 ch 7) note, the denial of prejudice may be used to express prejudice. We may then follow Billig et al (ibid p114) in speaking of 'reasonable prejudice', and I have shown how respondents will often compare themselves to less enlightened, less reasonable and less tolerant 'others'. At one time I came to regard the dilemmatic and two-handed responses of villagers as constituting, and perhaps representing for patients, a kind of social 'double-bind', in which one hand beckons while the other is held up in refusal, like a policeman stopping the traffic and urging it on at the same time.

However there are several ways of understanding these 'two-handed' responses. For example, we may consider them as displaying a universal aspect of thought processes; that is, as illuminating the argumentative and rhetorical nature of thought (Billig 1987). Second, to the extent that one hand is asymmetrically weighted to the detriment of patients, we can read this as a display of knowledge concerning the (putatively) socially acceptable way of expressing 'reasonable' prejudice. Third, we can understand this two-handedness as an expression of a very real dilemma for villagers concerning the correct way to act towards people who are or have been patients[62].

At the same time I have recast this dilemmatic form in terms of problematic validity claims, as critical windows through which further opportunities for dialogue and discourse can focus. By representing discourse in this way I have tried to

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62 And so 'dilemma' may itself be read as referring to (a) the dilemma about how to be critical of patients in a socially acceptable manner, or (b) a more profound dilemma concerning the correct way to act towards patients themselves.

show that the analysis of villagers' talk within the interview world may be linked theoretically and analytically to Habermas' critical theory.

However, in relation to 'practice', to prescriptions about how villagers *should* react or should have reacted to patients, my own claims in this respect are quite limited. I am not proposing here an ideal and utopian state of affairs, nor that villagers are always prejudiced in their criticisms of hospital and patients, although from time to time there is reason to believe this to be the case.

Critique is an ability of the social scientific layperson, as Habermas makes clear, and in this respect it is possible to regard the identification of problematic validity claims within the interview world as something which the villagers are also themselves doing, albeit not necessarily consciously. Their reflexive comments which anticipate criticism may at times obfuscate and function to impress, but they also reflexively point back to themselves to suggest moral dilemma, and in a manner which can invite criticism of their own position[63]. Villagers assert their own interests but in a way which also acknowledges some of the interests of patients. Together perhaps, within the interview world, we have been deepening and enlarging possibilities for discourse.

For Habermas, as I have shown, the very criticizability which, so to speak, is built into these formal pragmatic validity claims, links them up directly to the anticipation of an ideal speech situation, and to a critique of structures of distorted

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63 Habermas (1984 p105) suggests: 'The interpreter can...uncover the systematically distorted character of processes of understanding by showing how participants express themselves in a subjectively truthful manner and yet objectively say something other than what they [also] mean [unbeknownst to themselves].'

communication. However, a full appreciation of the degree to which discourse may be distorted by institutionalized and imbalanced relations of power needs to be grasped by way of a socio-historical analysis oriented to the model of the suppression of generalizable interests[64] (and cf. Thompson 1984). For we must also ask how the dynamics of contemporary capitalist societies themselves help to define and structure the matrix of interests and responses of villagers, patients and hospital, and in this way the understanding of the dilemmas of villagers may be broadened. From a Habermasian perspective the dilemmas facing villagers may be configured in terms of an analysis of the relation between the lifeworld structures and system imperatives of the village-hospital. Reasons offered in debate about the legitimacy or otherwise of public reactions may then be evaluated in the context of such wider analysis and in the light of a counterfactual reconstruction[65].

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64 'Such a counterfactually projected reconstruction...can be guided by the question (justified, in my opinion, by considerations from formal pragmatics): how would the members of a social system, at a given stage in the development of productive forces, have collectively and bindingly interpreted their needs (and which norms they would have accepted as justified) if they could and would have decided on organization of social intercourse through discursive will-formation, with adequate knowledge of the limiting conditions and functional imperatives of their society?' (Habermas 1976 p113). This constitutes a proposal for a way of criticizing interests which unjustly present themselves as general interests, while not claiming that a general interest is always at stake in real life (Habermas 1986b p175-6).

65 For example, Habermas (e.g. 1987a) encourages us to understand the reification of the lifeworld in terms of the metaphor of a battle-front, 'a line of conflict' (ibid p392) continually raging between lifeworld and system. But this conflict, we may say, is dilemmatic to the extent that in a complex society the lifeworld is dependent upon an efficient system, while at the same time coming under threat from the rationality of that system. The further metaphor which Habermas offers here, the 'colonization' of the lifeworld, may lend itself by analogy to an understanding of the experiences of villagers as they relate to hospital and patients, as system correlates which disrupt, challenge and invade the privatism of lifeworld domains. But at the same time the hospital has provided

The recurring references within interviews to danger, fear and threat are also susceptible to differing explanations. On the one hand for example we may be witnessing the expression of an implicit understanding about the way madness as unintelligibility can disrupt the structure of social action itself (cf. ch 2 above and Southgate 1992c). On the other hand the overall dominance of the repertoire Own Interests, at least as it refers to the defence of property, may be said to reflect the enduring status of civil, vocational and familial privatism as major motivating factors in our society (Habermas 1976).

I have therefore painted a picture in this chapter of ambivalence, uncertainty, doubt, dilemma, and sometimes guarded prejudice, and have indicated the difficulty which villagers sometimes have in seeing patients as 'people' at all. And yet on other occasions local residents have spoken of establishing a rapport, of becoming 'almost friends', with some patients. Within the interview world, patients have also been defended by villagers and the discursive distance between villagers and patients has been reduced. To this extent perhaps, the picture is less than completely bleak.

As Barham and Haywood (1991 p150) recently put it, the challenge is to consider how these people may be brought back into the (life)world, how 'personhood' can become perhaps once again the organising principle of our understanding. Yet I do not expect responses to change simply from 'education' or closer 'contact' with patients or former patients. Rather, the

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work for local people and once offered an emancipation of sorts from traditional forms of dependency upon employment on the large estates of the time. And in this discourse on interests, norms and needs, we may propose viewing patients as abstracted from the communicative rationality of neighbourhood, home, family and friends, having been pushed (another Habermas metaphor) or pulled out into the state psychiatric system, the psychiatric space, as Scott (1979) described it. These issues have been explored further in Southgate (1992b).

degree to which we accept, encourage, and help others inevitably refers back to the kind of society which we are.

Habermas proposes that reactions against the colonization of the life-world by system rationality may take a number of different forms, and he distinguishes between old and new conflicts (Habermas 1981a, 1987a). The former concern for example the 'old middle class' protests against the threat to neighbourhoods and property, a concern primarily with 'security' (1987a p392). The latter involve conflicts around, for example, quality of life, equal rights, individual self-realization, participation and human rights, often organised around a critique of economic growth. From this perspective we might say that the kinds of response which patients receive in the future will not simply be a function of 'distribution', but concern at the same time 'the grammar of forms of life' (Habermas 1981a p33).

Epilogue

Perhaps expressing an ambivalence of my own about finishing (off) this project, my attempts at constructing a final Conclusion have repeatedly foundered. This Epilogue constitutes the last of a long line of previously unsuccessful attempts.

As I pointed out earlier (p10), it has not been the immediate concern of this research project to highlight the unmet needs of people who are psychiatric patients, nor to proffer suggestions for the reform of psychiatric services. The primary focus of this project has been upon villagers rather than patients and the aim has been to investigate the topic of 'public reactions'. Were the Secretary of State for Health to request a copy of this thesis in the expectation that its findings would have clear and detailed social policy implications which could be immediately implemented, I fear she might be disappointed.

And having understood social research as a jointly-created and reflexive venture, suggestions directed to the summary specification of significant 'findings' have, anyway, not been entirely welcome[1]. Neither have I felt a desperate need to make

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1 The provision of 'findings' strongly suggests that reality may be discernible in an unmediated sense, tends to diminish the research *process* and the methodological debates, and deflects attention from the creative moment in social research. It may also contribute to a process of reification by which social research becomes understood in a limited instrumental fashion. Nevertheless, on pages 465-470 above, I have incorporated a summary of the discourse analysis chapter which may be read as research 'results'.

recommendations for future research, over and above those already contained within this thesis. And so to some extent this Epilogue constitutes a detour of sorts from conventional paths and places.

On the other hand, and notwithstanding my understanding that social research can take various forms and be conceptualized in different ways (e.g. as social critique, as dialogue, as the achievement of instrumental knowledge, as art, as self-exploration or therapy, as direct intervention and social action), it may nevertheless be disingenuous to attempt to entirely detach the project from a social policy perspective, not least because it initially emerged from issues of psychiatric practice and because it contains otherwise *implicit* prescriptions for such practice and policy. But before addressing (in a minimal fashion) these implications, some comments upon earlier chapters are in order.

It may be the case that in the light of the long last chapter, *Arguing About Madness*, chapters 8 and 9 recede in significance. I hope that these earlier chapters still retain some power of their own, but they also provide a backdrop which I believe facilitates the reading of *Arguing About Madness*. It was partly the problems I encountered in giving epistemic priority to one version of events over another in ethnography (see chapter 5 above), that led me to adopt the discourse analysis approach. I have made it clear however that I have not been entirely happy with this approach either. Notwithstanding the centrality of language and linguistic forms of representation for social research, there is a danger that an analysis which declines to go 'beyond the text' (see p261 above) might distance the study from the real lives, fears and hopes of real people. I hope that chapters 8 and 9, together with my incorporation of the work of Habermas into the discourse analysis perspective, have to some extent forestalled this possibility.

This thesis has emphasized the often subtle, equivocal and dilemmatic nature of public reactions to insanity while showing that at other times, especially where 'violence' is raised as an issue, responses may be unambiguously negative. However, I have also suggested that 'violence' may itself be used as a method or resource around which less clearly articulated troubles, fears, disapproval or enmity may be crystallized. But subtle responses should not be taken to mean that they are necessarily more benign than frankly negative reactions; on the contrary, the very 'reasonableness' of some judgements may lend them power.

The model of crisis intervention in psychiatry, from which this research received impetus, is based upon the premise that in a crisis a person's ordinary means of dealing with problems are no longer adequate to a changed situation. This is a time for some people of confrontation with madness, mental breakdown, etc, but also a time in which possibilities become opened up for further emotional *growth*. And it is at this time of emotional disequilibrium and turmoil, personal doubt and lowered defences, that the labels which may be attached to the person's behaviour, perceived as problematic in some way, can assume special significance for those involved. In this thesis I have argued that psychiatric labels and stigma retain their importance, albeit in often subtle forms. At the same time, the ability of villagers to transcend stereotypical notions, to respond at times positively (if not always unambiguously) to people who are patients, suggests that there are no simple or necessary public reactions to insanity. Given the willingness to enter into a thoughtful debate about another's (or one's own) plight, stereotypical notions can be challenged. Psychiatric crisis intervention can (and does) make use of this possibility by attempting to mobilize resources which include such positive and hopeful views of self and others.

It is clear from this research that the building of Shenley hospital has, in various ways, had a profound effect upon the village. I have suggested that the influence of the hospital has extended out beyond the village and that the very massiveness of its space-time presence has acted to reproduce and reinforce negative images of madness. Nothing I have learned from this project has led me to abandon my belief that the old mental hospitals should go. Some people may at times need asylum but the form this takes can be vastly improved.

I wish to turn now to a few words of advice for others engaged in social research, advice which could have saved me many frustrating hours. Tape-recorded material is most efficiently transcribed directly onto a computer using a word-processing program, rather than a type-writer. This allows for much easier correction and recorrection of transcriptions. But make sure you keep back-up copies of files.

Health Authority Ethics Committees may require substantial reassurance that a project is, as far as it is possible to tell, benign. A personal appearance at a Committee meeting may perhaps be one way of providing this.

I had been warned about bibliographies. But even though I had kept notes along the way of titles and dates of articles and books, these were not in the end sufficiently comprehensive to enable an easy and stress-free compilation. As a result, the bibliography put up a good fight which lasted several weeks. It finally succumbed with the help of a Polytechnic (now University) librarian. On the problem of which books and articles *not* to read, when so many appear on the surface to be relevant and full of underlying promise, I have not yet found the answer.

But to return once more to Shenley. Although divided in many respects, there is, I believe, one thing upon which the majority of both villagers and patients would have agreed, and perhaps vehemently, if they had sat down together to discuss issues of mutual concern. In this counterfactual and hypothesised *rapprochement*, both parties would have been (and would be) grateful for action by Hertfordshire County Council to impose more substantial speed restrictions on traffic passing through the village and past the hospital. A pathetically small request, one might think, but one so far resisted by the Local Authority in spite of demonstrations and publicity by villagers[2]. One or two patients asked me to make this point in my final 'report', and this Epilogue has provided the opportunity.

I hope that the methods adopted in this project have enabled me to convey something of the flavour of life in a particular place. One older village resident asked me not to be 'too hard' on Shenley village. I hope I have provided a fair account. And as I write (August 1992), building work on the new housing development at the hospital site has already begun. No doubt Shenley will never be the quite the same again.

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2 Although quite recently a mini-roundabout has been constructed at the junction of Green St and London Rd.

Appendix A

Transcription Conventions

I have adopted the following transcription conventions in relation to extracts from recorded interviews:

1 A number in brackets indicates a noticeable pause timed to the nearest second e.g. (3), and normally longer than one second.

2 A number in brackets preceded by a 'p' e.g. (p3) indicates the page of the transcription from which the extract came.

3 The sign '=' at the end of one speaker's utterance and the beginning of the next speaker's utterance indicates no discernable gap between speakers.

4 The following sign '[' signals overlapping talk.

5 Where words are contained within square brackets e.g. [muddy the analytic waters] then this signifies doubt about the words' accuracy. The use of square brackets which do not enclose text e.g. '[ ]' indicates that some material has been deliberately omitted.

6 Round brackets perform a variety of functions. They contain clarificatory remarks e.g. Harold (a villager), laughter e.g. (laughter), and brief interjections e.g. (DS: Mm).

7 The use of asterisks e.g. '*' indicates that I had been unable to understand what had been said and unwilling to make a guess.

8 The demarcation of completed sentences in the text involving the use of full stops and capital letters is used in a conventional manner in order to render the transcripts more reader friendly. Their application is creative and intuitive. Commas are used to indicate hesitations or short pauses normally less than one second in duration.

Appendix B

Reproduction of Herts Advertiser article 4/9/1987[1]

Headline: Patient sit-in stirs fear

Report by IAN BROWN

FEARS were revived this week over the safety of "wandering" hospital patients in Shenley.

The concern comes from the village vet Raymond Gee and his wife Sheila, after a young hospital patient walked towards their house and sat in the car of some friends who were just about to leave.

The man asked for the keys so that he could go to London and it proved difficult to get him out of the vehicle.

A call to the hospital for help proved fruitless. The man was physically ill and, when he smoked a cigarette he had asked for, he swallowed a still smouldering butt.

Mrs Gee, who said that police eventually came to help after they dialled 999, said the incident lasted about 45 minutes and it was only the couple's experience in dealing with medical emergencies that stopped it becoming more serious and the pstient being put more at risk.

"If he had sat in a less patient person's car or if he had confronted someone violent, this could have been a very serious problem indeed", said Mrs Gee.

Mr Gee wrote to Shenley Parish Council claiming the hospital was neglecting its responsibilities.

His criticism was heightened when he told of another incident in the winter when he had found an elderly patient who had suffered cuts to his face after falling in the road. On that aoccasion, he took the patient back to the hospital himself.

"This latest event was potentially a nasty situation. It is something that could happen in the village but we felt that if someone had lost their temper they could have hurt the patient", added Mrs Gee.

This week parish councillors agreed some patients could be a nuisance but said many residents were not dialling the hospital's special hot line number to gain assistance.

That comment was echoed by hospital administrator Mrs Ann Wilson. She said: "We

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1 I have reproduced here the original double-column format and also the spelling mistakes and punctuation.

have over 800 patients here and we have to operate under the limitations of the Mental Health Act. We can only detain people who are a danger to themselves or to others. We accept there can sometimes be what the public would regard as unacceptable behaviour but incidents occur from time to time.
"if there are complaints give us the times and dates and we will look into it. It can be distrassing and we will do our best to help.
"I am concerned there seemed to be no-one to deal with this matter but I would refute any suggestion that pending our closure we are slacking our service. There are less incidents in the village now than ever." The hot line to call for help with patients is Radlett 7588.

Appendix C

SHENLEY PARISH COUNCIL [1]

Report on open meeting between Shenley Parish Council, and others, and the Chief Nursing Officer Mr. Manners, of Shenley Hospital , held in the Village Hall Shenley on Tuesday April 9th 1974.

CHAIRMAN

The Chairman of the Council, Cllr.E.C.Turner, said that, as he was employed at the Hospital, it might be thought that he was notun biased, and under the circumstances he would step down and ask the Vice Chairman Cll, S.A.Heath o take the Chair for the open meeting. Cllr.S.A.Heath in the Chair..

Cllr H ath welcomed those present, and in particular the representatives from Aldenham Parish Council, who had similar problems with Hospital Patients. He asked Cllr E.J.Broadley to open the discussion by putting the case for the Villagers.

Cllr Briadlet said that for some time past there had been concern in the Village over the obvious deterioration of the standards which allowed patients from the Hospital to leave the confines of the Hospital. Patients were in the Village improperly dressed, and seemingly under the influence of drugs, and in some cases their behaviour left much to be desired. The Villagers were worried that the 'Hot Line' was not working as in the past and appeals for help with difficult patients were not being dealt with as quickly as in the past. He instanced a case at the King William IV public House, and cases of intimidation by patients to house wives, and cases of indecent behaviour n the Village and its surrounds. He thought that not enough attention was being given to the very real concern of the Villagers when faced with these problems. Cllr Broadley stressed t the fact that in general there was a very real desire on the part of the Village to help in all practical ways the recovery of those patients who would benifit by mixing with the outside world, but it did seem that many who were allowed out were in no fit state to be at large, and they did

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[1] Because the original report was somewhat faded and did not photocopy well, I have reproduced it here complete with spelling mistakes, original punctuation and line breaks, and with the same print style (Prestige) and pitch (12 c.p.i.). However the original occupied 2 larger pages, whereas this reproduction spans 4 pages.

nothing in helping relations between the Village and the Hospital. Shenley had had the Hospital in its midst for so long that it was accepted as part of Village Life, but there were limits and if they were exceede there could well be a seriOus deterioration in thos relations which would not be for the good of the Hospital or the Village. If requests for help were dealt with promptly it would go a long w y to restore confidence, but when such requests were not answered for long periods confidence was broken.

The Landlord of the King William said that on one Sunday he had had two patients, dressed in pyjamas and dressing gowns only enter the bar, and ask for cigarettes, they had no money, and were asked to leave the bar, he went to phone the unlisted number of the Hospital for help, and the call took some time as there seemed no one at the Hospital who would, or could take action, on returning to the bar the two patients were back, and begging money from the customers to but cigarettes, at the same time there were two other patients in the Bar, one of whom asked for drink, thinking that the patient looked to be under medication the Landlord asked if it were proper for him to drink alcohol and was assured it w ould be right the drink was served, and after the patient had drunk some of the liqour he vomited across the table he was sitting at, and ser ously upset other customers in the Bar. Help came from the Hospital after a lapse of forty minutes, The Landlord said that in his case when he asked for help it was wanted immediately, such delays made his job impossible. He also asked as to the practictability of patients being provided with drink at the Hospital, where supervision could be kept on them, and those who should not drink be controlled.

A representative of the Aldenham Parish Council asked if were true that there were patients from Broadmorr in the Hospital who were allowed out there had been similar cases in Radlett with Patients, and while it was agreed that all assistance possible must be given it was also thought that there should be a stricter screening of patients who were allowed out that those who were likely to cause annoyance, or who were a danger to themselves and the Public were under control.

Cllr M$_{u}$rray said that he had attended meetings between the Parish Council, and the old Hospital ^{M}anagement Committeeand it seemed to him that the points raised were the same as at those meetings, there did appear to be a distinct break between the Doctors and Nursing Staff at the Hospital and the Village, perhaps if this could be overcome relations between the two would improve as each got to know each others problems.

Cllr.Woolf said that there was no doubt in his mind that all the trouble hinged on the fact that there appeared to be no screening as the suitability

(2)

Open Meeting 9.4.1974 continued

of patients who were allowed outside the hospital grounds, he had been told that this was impossible, but it was the only reasonable solution, and ways and means should be found to make it practicable.
Mr.Jeferies said he was concerned regarding the possibilty of children being frightened or interfered with on their way to and from school and enquired as to the preqautions taken by the hospital on this point.
Mr. Manners in reply to the points raised said that, the responsibility for allowing patients freedom lay with the Medical, and Nursing Staff of the Hospital, and they fully appreciated this responsibility, they made decisions on the facts as they knew them, and their own appraisal of the persons concerned, there was always the possibilty of a mistake being made, and all were very concious of this, however the decisi ns reached were honest, and the best that could be arrived at.
Regarding the emergency line, he said that there had been difficulties, which he hoped were in the main removed, it should be understood that the Nursing Staff were fully occupied and there might be times when it was not possible for anyone to get away immediately, he could give no assurance as to how long it would be before a request for assistance was met, but every effort would be made to keep it as short as possible. A car was now always at the disposal of any Charge N[u]rse called to the Village, and this would help to make the delay shörter. The Hospital and ts Staff wished to keep the realations between the Hospital and the surrounding Villages on a friendly basis, as this would help in the work of the Hospital in re-establishing patients. That there were diffulties he agreed, there were long saty patients in the Hospital who had not been in the outsid world for many years, and in was to be expected that these when first let out would be difficult, and starnge, it should be apprec iated that things were as strange to the patients . He made no excuses, but assured those present that every consideration was given to most of the points raised at the meeting. There was now in operation at the Hospital a system of internal communication which made it quicker to contact Staff Nurses. Regarding the supplying of alcohol to patients this could not be done owing to the cost. As regards the school children, the patrol was always in the Village at the times when Children were entering or leaving school.
Arising from Mr Manner's statment the following points were made,
Patients were said to be on licenced premises for up to nine hours per ady, spending up to £5.00 per day.

The Hospital was asked to look at the possibility of screening patients at the gates as they left the Hospital that those improperly dressed could be turned back.
That every effort should be made to ensure that prompt and effective help be sent immediately to any request made on the 'Hot Line'.

The me ting closed with a Vote of thanks to Mr Manners for his attendance and his answers t 8.30p.m.

Appendix D

'An Appendix, Its Introduction and Its Annexure '[1]

Introduction to 'Appendix: Patients Talking From an Often Unenviable Position'

The main body of the research has detailed, *inter alia*, the way that people who are patients deviate on occasions from their particular pathways through the village to appear in 'back regions' of the village such as kitchens, bedrooms and so forth. It also highlights the way that villagers respond, and in particular how they talk about patients. Of special relevance here is villagers' use of the metaphor 'a thin line' to describe the relation between themselves and people who are patients. This metaphor is drawn upon in this Appendix.

The key to the methodological and textual conventions which have been adopted here may be found in an Annexure to the Appendix, which also explains the broader rationale for this Appendix itself.

Transcription conventions may be found in Appendix A.

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1 This was presented as a paper to the Discourse Analysis and Reflexivity Group (DARG) Workshop at Brunel University in April 1992. However I have abbreviated the Introduction here, and slightly modified other parts.

APPENDIX

PATIENTS TALKING FROM AN OFTEN UNENVIABLE POSITION

This book is neither fict nor faction. It is both friction and fraction. It is shorter because I had longer. It is worse because I am better. (drif field 1991 preface)

Meaning on the schizophrenic's level is precisely that state to which all Post-Structuralists aspire. (Harland 1987 p174)

Of course you'll have trouble making sense of what they say but then that's why they're here. (Shenley Hospital Charge Nurse)

But in fact these extracts make perfect sense (Southgate 1992a)

This Appendix attempts to open a small space from which patients' voices, excluded from the main body of the thesis, may be briefly heard.

From a review of interviews with patients it seems that many of the concerns of villagers are shared by patients. At the same time, just as villagers' accounts may be variable at one level, so people who are patients may express variable views in the same interview. That these transcripts also yield ambivalence and dilemma can be seen in the way that goodwill towards the village is often coupled with complaint about villagers' behaviour. And on occasions these hospital residents offer acute interpretations of the issues involved.

In the following pages I have reduced my own analytic commentary to a bare minimum, preferring here to let the people tell their own story[1].

> Miles: When I dress up you can't tell I'm a patient. Put my collar and tie on or my er, my sports shirt and that. But they get to know, they know me. They know me in the King Harry now.
>
> DS: What did you say to them?
>
> M: Told him to fuck off.
>
> DS: Did you? I see.
>
> M: He wouldn't serve me. He doesn't, once they find you're from the, put it this way, you know, once they've got an idea you're from Shenley they try to ignore you. I was standing there and he served about four people without serving me (inaudible).
>
> DS: What did he say then?
>
> M: He said you're banned.
>
> DS: You're banned?
>
> M: Just an excuse (p8)
>
> (gap of several pages here)
>
> DS: So it seems the King Harry is the, has been a bit of a problem.
>
> M: Yeah.
>
> DS: Why do you think it was that they didn't like um (2) patients in there?
>
> M: Er that's, that's er, that's their way. Perhaps they think if they have patients coming in there they will lose customers, do you understand?

---

1 *Villager: But of course they're not really speaking for themselves are they? I mean you are orchestrating the extracts, controlling even my voice.*

DS: That's true of course, but we'll come back to that later. Can we return to the patients' accounts?

DS: They'll lose customers?

M: Yeah.

DS: For any particular reason though. Why would they lose customers?

M: Well people might feel a bit er (2) downtrodden or feel a bit er (inaudible) to drink with patients, from the hospital.

DS: It's as if sometimes people from the, patients from the hospital should be avoided?

M: That's right, yeah. Something like that, yeah.

DS: Do you have any theories about why that might be the case?

M: No. They're just people. You can't change 'em. (p14)

For Miles it seems to be the case that this is simply how the villagers are. His statements have a conciliatory ring about them:

Miles: You see people have got their set way of living, you can't change them. You just take them as they are. I never try changing anyone, you just accept them as they are.

DS: You mean the villagers or=

M: =Yeah the villagers. They've got their set ways of living. Every night they go down and have a couple of pints. No more, no less. (inaudible) a pint of beer. His mates buy him back a pint of beer. Next night the same thing. (p13)

Miles shares with villagers the way of talking about patients as if they constitute a separate group of 'people'. But his anger is tempered by a present willingness to take the perspective of the other. This 'understanding' is by no means unusual. Many patients I interviewed made similar comments.

DS: What was the reason he had for asking you to leave?

Richard: Cos I was in hospital that's why. Perhaps one or two people upset him when they went in before me but I don't know what time it was I went in there but I mean, in the evening=

DS: =Do you mean one or two patients?

R: Could have been one or two patients annoyed him in there the way they drank, you know.

DS: I see. But why should he ask you to leave?

R: Well I was in hospital with them. I was in hospital as ell. Lots of people in.

I failed to pursue the issue of the time that Richard went to the pub, which may have been relevant, but instead gave Richard some space in which to complain about his treatment. But he refused to be directly critical of the villager who had been serving behind the bar and who had asked him to leave.

DS: Well, do you think it, it was reasonable of Clive to ask ┌you to, to ask you to leave?

Richard: └It was alright, it was in a way.

DS: Even if you hadn't done anything?

R: Yeah, I didn't do anything.

DS: That was still reasonable of him was it?

R: Yeah that's right.

DS: You didn't feel annoyed about it?

R: No, no.

This reluctance to criticise directly was common in interviews. To some extent it may be said to parallel the disclaimed and hedged accounts and arguments of villagers; the dilemmatic nature of villagers' talk about patients. Indeed just as

villagers would deny being prejudiced while locating prejudice elsewhere, many of the patients I interviewed spoke of 'other' patients at the hospital being the cause of the problems:

> Graham: There is a certain etiquette involved. I went into the King Harry with another patient. He ordered drinks but didn't have the money to pay for them. They barred us.
>
> DS: How did they say it?
>
> G: They were quite abrupt."You're barred". "Please leave now, don't come back". I walked back two years later with a fiver to the King Harry and they said okay.
>
> DS: Was their action reasonable?
>
> G: I think they had a point. You can't protest. The publican has the right. Discriminating, you know. You can't go to a tribunal about it. I think it's right.
>
> DS: Have you been discriminated against?
>
> G: Not really but I've suffered.

Local Identities

The issue for villagers about who might or might not be a patient is also grasped by people who are and who have been patients. Stewart provided an ironic commentary by way of a story:

> DS: Have any of the villagers ever commented to you about um (2) whether they know that you've been a patient. Have they ever commented, made any comments about that at all?
>
> Stewart: No, it was funny, I was standing waiting on the bus to go to Radlett and there was a woman from Shenley hospital standing beside me at the bus stop and this guy stopped his car, and said "Do you want a lift to Radlett?" and he was asking me. And, this woman came up behind me asking if she could have a lift. And he said no way. Just no way. And he was talking to me in the car and he was saying "She's a psychiatric patient". You know, "I don't want to be had up by the police for driving her away" or something like that you know. So apart from that, I don't

> have any comments like that at all. As I say I keep my behaviour, socially, or in public, as normal as possible. (p14)

Others were more blunt about it. I had asked Clare whether any villagers had ever commented about her being a patient at the hospital:

> Clare: No. No-one talks to me. No-one knows I'm a patient.
>
> DS: Would you mind if they knew?
>
> C: I don't want them to know.
>
> DS: Why not?
>
> C: They might stop me using the post office.
>
> DS: Why?
>
> C: They might think I'm infectiously ill. (p3)

And others were even blunter still. In the following interview I had been asking Derek whether any villagers had ever made a comment about the fact that he happened to be a patient at the hospital:

> DS: No-one's ever said anything to you about it?
>
> Derek: I don't know, not much to go on. I'm not, I'm not a patient.
>
> DS: You're not a patient?
>
> D: I'm not a patient (3) You're a patient.
>
> DS: Right, okay
>
> D: You're the, you're the patient, I'm not.
>
> DS: Okay. (p8)

A related anxiety can be traced in my interview with Laura:

Laura: When I first went to the village they didn't know I was a patient. Other patients talk to villagers but I've never been one of those. They're friendly and nice, a lot of it is how you treat them it seems to me. When I see the shopkeeper talking to a villager about gossip then I'm treated in a different manner, it's upsetting to me. There're areas where I just don't belong. I don't belong. I'm not able to share with them, I haven't got the history. (p2)

And then in talking about one of the local shop assistants:

> Laura: He'd be very polite. He used to ask me - How are you? He's stopped asking me how I am.
>
> DS: Why?
>
> L: I've asked myself that. Perhaps he's found out that I come from here. Or perhaps other patients have been giving me a bad name, talking about me. (p3)

From this passage it seems that being known in the village as a patient from the hospital may be an issue for some of the patients themselves. Ambivalence about psychiatric patient identities can also be witnessed in the following passage from my interview with Stewart:

> Stewart: I had a personal stereo on in the King Harry. She told me to turn it down. Now it wasn't particularly loud and people were talking louder than my stereo and the music in the bar was just as loud as mine and and I thought that was petty. I don't know, I find this area and Radlett very sort of snobbish and er they tend to frown upon you quite a bit.
>
> DS: Is that for any particular reason do you think that that happened?
>
> S: In the pubs?
>
> DS: Yeah in pubs on those two, occasions.
>
> S: I don't think, no, they didn't know I was a psy, I mean a couple of guys sitting on the bar said "Are you a nurse?" They actually said that to me.

DS: They asked if you were a nurse?

S: Yeah (inaudible) And I don't think=

DS: =What did you say, to that?

S: I said, No no (laugh). You wouldn't catch me nursing (laugh). But, no I don't think it was because I was a psychiatric patient because I don't, sort of, er this sounds terrible, but I don't look like one, you know what I mean. I don't dress badly or anything like that, and I carry myself alright. You can tell when somebody is a psychiatric patient by their behaviour, and er I act quite normally. So I don't think it was anything to do with me being a psychiatric patient, I think it was just sheer er snootiness and nastiness. (p6)

Here Stewart has used a manoeuvre which has become very familiar, a textbook disclaimer 'er this sounds terrible, but..' which acts to problematise the sequence as dilemmatic or as one which is raising a problematic validity claim. The occasioned putative offence here is one of discrimination against people who are psychiatric patients.

In another interview, Terry made the interesting suggestion, which could be directly interpreted in the terms of the labelling perspective, that the sign outside the hospital should be taken down:

> Terry: Once they've got that Shenley hospital sign up outside they don't want to know this place too much then. That's where you get the antisocial business too. (p21)

Danger and Violence

Just as danger and potential violence proved to be ubiquitous themes in interviews with villagers, so they also proved in interviews with patients. Of interest here is that although none of the patients interviewed admitted to having been violent themselves, the theme often strongly emerged in their

explanations of villagers' reactions. Thus Stewart and I had been discussing employment and stigma, topics which he had raised:

> Stewart: Well I think that some mental illness you can't see it, like a physical disability you can, I think that makes you prone to be a bit unpredictable and er. They can't see what the problem is, so you're unpredictable. And I think that=
>
> DS: =Do you think you're unpredictable? Or is it other people who think that you might be unpredictable?
>
> S: I'm not unpredictable myself.
>
> DS: You don't think, you don't think you're unpredictable?
>
> S: No, I don't think so. I'm a bit moody but I think everybody is, you know. But I think other people'll tend to, although it's going down as I say, the stigma, I think that probably people tend to em frown upon it to a certain extent. But I think everybody has some sort of neurosis or whatever in them. Everybody has problems whether they're psychiatric or whatever and I think that, I like to think that my behaviour is no different from Fred Bloggs in the street. When you see these animals at football matches I think, well I would never do that, so it depends on how you define normal. (p4)

And in the following story and sequence in my interview with Nigel:

> Nigel: I'll tell you a funny story like that. There was a guy came out of Shenleybury cottages. He said 'do you want a lift up the hill'. I was standing at the bottom and I said, 'yeah that would be great'. 'How much is your busfare' he says. I said 'usually 50p' It was before I had a pass. And he said 'right, I'll take you for 50p then'. 'Ive got to make a living somehow' he says. I thought, what a shark, you know. (Laugh)
>
> DS: That's a bit of a cheek, isn't it?
>
> N: Yeah it was a bit. But I mean that's a true story, I mean. He was on his way to Borehamwood.

DS: So did you give him 50p?

N: Yeah, thought I might as well. I wasn't losing out.

DS: That was just to go up the hill?

N: Yeah, I mean that's what it would have cost me on the bus. I think this is a, this is a problem. I think a lot of (2) not that he knew I was a psychiatric patient but I think a lot of psychiatric patients in the worl, in the outside world are taken advantage of. They talk about people, being aggressive who have a psychiatric problem but Wendy's friend, Wendy was reading eh, or a friend of hers was saying that people that have got mental problem aren't necessarily aggressive. They're not as aggressive as people normal, as quite normal people like.

DS: I think that's probably true, yeah.

N: They're very sort of meek and mild I think. They wouldn't say boo to a goose and subsequently they get trampled on, in life nowadays. (p15)

In the process of telling his tale Nigel establishes a discursive distance from a patient identity by referring to patients as 'they' and 'them'.

In my interview with Laura she had been talking about the stigma of psychiatric hospitalisation and I asked her why she thought it happened:

> Laura: Ignorance, lack of knowledge. Stigma is their problem. I get paranoid. I ask myself first - is it me? If it's not me but them then it's their problem not mine. There's a terrible contrast between the world outside and the world here. There are nice people outside. Most patients are not nice. I suppose I've turned against my own kind. I don't tolerate them so much now. I read this brochure assuring the community that they need not be frightened of patients being outside. They haven't reassured patients that they don't have to be afraid of the public. There are obvious fears, for example being mugged, a changing society outside, letting people in the door if they haven't got identification. (p3)

Laura performs a very difficult juggling act here, for like Stewart and Nigel above she attempts to steer a course between defending and criticising other patients, and between defending and criticising the 'world outside'. Her dilemmatic form of expression, of talk, and of thought, may be ordinary and everyday, but the content is arguably vital for her and her future life. There is, perhaps, a 'terrible' dilemma here about the place to speak from. Danger plays a part in her argument and dilemma, and in a skilful fashion she reverses the danger claims of non-patient others and villagers, with consequences for her own identity. Yet she is caught in a kind of limbo, a liminal in-betweenness, neither convincingly one place nor another, neither patient nor non-patient.

In another interview, Terry had been explaining that villagers had not been 'too friendly' with Shenley hospital, because it was a mental as opposed to a general hospital. I pursued this point with him:

> DS: I'm interested in that question. I mean I wonder what should it, what could it be about a mental hospital then that might make the villagers unfriendly?
>
> Terry: They might be afraid someone might attack em I should think. See what I mean. You always get that. Particularly with a schizophrenia sort of patient or like that. A schizophrenic patient might, he might turn nasty, [mad]. He might suddenly attack someone. You've got them, some of them schizophrenia patients got the attack tendency. So a patient like that, they might be afraid of a patient like that. I've got that feeling about it anyway. (p16)

Discussion

A reading of the above excerpts from interviews with patients suggests that at least in their form, and sometimes in their content, they are virtually indistinguishable from extracts of

interviews with villagers. These extracts share in the reasonableness of those others previously analysed, although to be sure the perspective is often different; that is, it is often clear that these people are speaking from another, a different, place[1].

However it may be objected that even though these extracts appear to lend support to villagers' own views, or because they are coherent and sensible, they do not properly represent patients' voices. On the other hand the same may be said of villagers' accounts by virtue of my abstraction of those passages which make most sense[2].

---

1 *Villager: I think we should come back to my earlier point. I mean that Dr Cooper tried to persuade us that the patients are like us, that they're the same as us. I said to him: "You can't tell me they're the same as us, they're ill and we're not". He wanted to give them more freedom. But I used to argue that patients had been sent there by their relatives to be looked after properly. Now you've portrayed patients as being as sane as the villagers. Your text is simply not mad enough here. I mean, what about the crazy parts of these patients' interviews, or the interviews with those patients who are quite ill? You've left this out. If you included it you'd see that you simply can't trust what they say. They're portraying the village in a poor light. Your text is much too sane to make sense.*

Patient: But I don't think he's saying that there's no difference. At the very least we are speaking from a hospital ward.

Villager: You startled me! What are you doing here? You're not supposed to be here. I'm going to 'phone the hospital.

DS: Okay. Wait a minute. Let's discuss this out in the open shall we.

2 *Villager: Are you saying now that villagers don't make sense?*

DS: I'm saying that it has been difficult sometimes to understand what villagers mean. And this is perhaps often made more difficult by virtue of the distancing involved in transcribing (and cf. Ochs 1979), scanning, etc. These transcriptions have often appeared as almost alien texts to be interpreted. The same of course can be said about my own fieldwork notes, what Gadamer (1986 p391) has called the 'vanishing point' of the text.

Drawing upon Foucault's *Histoire de la Folie*, Felman succinctly states the problem addressed here: How is it possible to give voice to madness?:

> ...how to say madness itself, both as Other and as Subject; how to speak from the place of the Other, while avoiding the philosophical trap of dialectic *Aufhebung*, which shrewdly reduces the Other into a symmetrical same; while rejecting all discourses *about* madness, how to pronounce the discourse *of* madness. Is such a discourse possible? (Felman 1985 p42)

To re-articulate this problem we might say that by re-presenting patients' voices as 'as sane as' those of villagers, I thereby include and hence confine and detract from them. On the other hand if I draw upon the madder parts of transcripts, they may be simply discounted and excluded, as evidence of mental illness, originating almost from a totally alien place. Or conversely the latter may become susceptible to a symbolic transformation by the reader and hence an incorporation into the sane world. Encouraging the voice of madness *qua* madness then becomes problematic.

In her fascinating book, Felman traces the way that madness and rhetoric are connected; how madness may be 'said' in the way that a text's statement may be estranged from its performance

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Villager: But the point here is 'difference'. These people are different from villagers and in ways which set them apart from the rest of us. Look, they even acknowledge this themselves, in some of the extracts above, when Stewart for instance tries to set himself apart from other patients.

Stewart: Just a minute. You can't use that argument without contradicting yourself.

Villager: You're becoming a nuisance.

DS: Alright. I do agree that there are some important issues here which concern precisely how we encourage or allow patients a voice. Can we pursue this theoretically in the sane light of day?

in the movement of non-totalisable, ungovernable linguistic play 'through which meaning misfires' (p252).

Clearly there is an important issue here concerning people who are patients and social research. Following the arguments of Felman and Foucault we can suggest that the two are connected (but see Derrida 1963/1978, Boyne 1990 *passim*, Gutting 1989 pp262-266 for critiques of Foucault's early structuralist view of madness as expressing a fundamental infra-rational truth of human reality. See also the critiques of the empirical content of Madness and Civilization by Midelfort 1980, Porter 1987/90 ch 1, Sedgwick 1982a ch 5).

I had intended at one point to use the allusion to methodological problems in the social sciences to build a kind of sympathy with madness. To be sure the parallels between social research and madness have occasionally been drawn (Schwartz and Jacobs 1979, Moerman 1988 p120, Clarke 1975, Lurie 1967/1987, Sanders 1980), as they have between philosophical thought and madness at least since Descartes (e.g. Bernstein 1983, 1986 p11, Boyne 1990, Lawson 1985 p125).

My rather vague plan involved using the reflexive play of the relativist problematic to turn the text into a veritable lunatic asylum of doubt and discord and in the process to interrogate the distance and dichotomy between author and text (Woolgar 1988a), sanity and madness. I have dropped this idea although I still believe it may have merit (cf. Ashmore 1989, Woolgar 1988b). Nonetheless this text still provides for a reflexivity of sorts, if not as full-blown or psychotic as I had originally imagined.

But the issue of how to re-present the voice of the Other is not confined to patients. The same problem arises in relation

to the voices of villagers[1]. For if, even in an Appendix, I have excluded a central part of patients' talk, I have also organised the talk of villagers into a coherent whole, in the main body of the text; a totality which coopts, incorporates and also inevitably excludes those parts which do not make sense, which do not 'fit' well with the rest or which have simply been overlooked. Villagers' voices then become harnessed for the interests of the 'writer' (cf. e.g. Clifford and Marcus 1986, and Mascia-Lees et al 1989 for an excellent critique of 'postmodern' anthropology from a feminist perspective).

It is true that discourse analysis is precisely grounded in these methodological problems in so far as it seeks to illuminate variation, difference and dissonance at a particular level. Nevertheless it is yet unclear whether it overcomes these difficulties.

And the problem may be pushed even further, and perhaps may be temporarily allowed to rest, on the border between madness and sanity. At this interface, on this 'line' which separates villagers from patients, a reversal may occur during which time both differences and similarities become unclear, confused and uncertain. Here on the border those voices of both villagers and patients which have hitherto been denied expression might find a place from which to speak, a place which is hardly a place at all[2].

I have a notion that if the talk of both patients and villagers can be brought together, can be re-presented together, then some extra meaning may be found. In the back places of the

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1 I am grateful to Peter Cronin for this point.

2 *Tutor: Don't you think you're being a little too allusive/poetic here?*

text, just as in the back regions (Goffman 1959) of the village, patients and villagers may come face to face. And here in the back wards of the text, Habermas' version of rationality and communicative competence may become repressive (cf. Hesse 1980, Warnke 1987 p128). From Miller's (1987) perspective, for example, Habermas' attempt to provide a non-foundational grounding for a critical theory, in communicative action, does not itself escape the philosophy of consciousness but presupposes a pre-existing autonomous, intentional and rational subject. In this respect we might say that those people who are communicatively incompetent become less than human in Habermas' scheme of things.

Communicative competence is the capacity to handle language adequately as a certain tool in the necessary attempt to reach shared understanding (Brand 1990 p124, Habermas 1970a). For Habermas this competence is an ability of the human species as such, the capacity for communicative rationality oriented to understanding and agreement, coordination and cooperation. Yet this privileging of accord and cooperation certainly plays down the negative side, the dissimulation, the discord, disharmony and misunderstanding (Roderick 1986 p159). And in this sense we might say that in the theoretical approach to insanity ascriptions offered elsewhere (Southgate 1992c), which draws upon the effort of Habermas to extend the concept of rationality, madness and the art of radical dissimulation (cf. J.C.Scott 1990 p2) is well and truly chained and subordinated[1].

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1 *Patient and Villager: Okay, (yawn), yeah. But let's come back to the issue of representing excluded voices. We can't really see how you can do this, although we thought you might have attempted it by engineering a fictional dialogue between us patients and villagers in which we at once interrogate each other and you the author.*

DS: I'd prefer not to do that, because I suspect it makes it at once too easy and too difficult. And what would such a dialogue look like anyway? My idea is different although I'm not

pretending that it solves the problem. The sane and the insane meet in several places; in the village, in the hospital, here in this thesis, and here 'in' the computer. In fact the computer can be seen as the place of arch-rationality. Its ordering of the binary numerical opposition breaks through as a very particular quality; on or off, yes or no, either/or, an algorithm, pure syntax.

And yet in the process of tape-recording interviews, transcription, scanning, and incorporation 'into' the computer, something peculiar happened. On one or two occasions, without computerised note or explanation, the predictable and ultra-sane became unpredictable, chaotic, anarchic. One or two transcripts of interviews with villagers suffered a kind of breakdown, if still perhaps comprehensible with effort. They came out of the scanner looking[1]

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[1] Brian: If it is a narrow dividinq line between beinq sane and insane as I think it is if you have a sort of mental breakdown vou. I would hoDe. that you need verY individual attention verY raDidlv to aet vou out and qet You a com˜lete cure_ Too often in the ˜ast mental hosnitals haven't been used in that way. If You've qot a Droblem with somebodY let's nut them in a mental hos˜ital and it takes manv. m˜ny months sometimes_ It's Duttina them awaY rather than workina with them- If vou were fiqhtinq to be heard for a lonq time_ I c˜n see what You're saYinq that in many cases De˜Dle do qo in and theY're sorted out verv auicklv but if that breakthrouah didn't occur verv quicklY then vou can aet stuck in the sYstem_

Harry: I'm the conservative, marxist MP for Hertsmere. This covers Shenley. I go to all the pubs in the village given a chance, I own them. I prefer the Black Swan. People are kind, they employ me in work. I meet top people in the village in the bar. It's my office. We talk. Shenley hospital is a luxury hotel, 10 star. The food is lovely. It's owned by me. Lovely staff, I want to stay here. Villagers are my friends and lovers, also my constituents. I love it here. I want to live here for the rest of my life.

DS: Does anyone ever invite you back?

Harry: They'd like me to go there but they're too shy to ask me. You publish that, you'll make millions.

ANNEXURE TO 'APPENDIX: PATIENTS TALKING FROM AN OFTEN UNENVIABLE POSITION'

Conventions and Explanations

In the Appendix, excerpts above the footnote line are taken from 'genuine' interviews with people who were at the time, or who had previously been, patients at the hospital. Most of these extracts were taken from tape-recorded and transcribed interviews but a proportion result from detailed hand-written notes taken during the interview.

These excerpts are juxtaposed to a footnoted discussion between a patient, a villager, and myself, which is 'fictive' but which on occasions draws from and reconstructs extracts from interviews with both villagers and patients.

The Appendix was intended as a reflexive meta-commentary upon the rest of the thesis; as one way of addressing some of the problems which have been 'left over' from an earlier theoretical discussion of the philosophy of social science, and which have become amplified during part two of the thesis. While the discussion in the main body of the thesis is reflexive in a theoretical sense, the Appendix attempts by contrast to build a reflexivity which is constitutive of its subject/object. It is not meant to resolve anything, but rather to 'muddy the analytic waters' (Woolgar 1991 p42) a little.

However as well as highlighting some of the aporias of theory and method of the thesis, I had hoped that this Appendix might add to the thesis in terms of further conveying a sense of

local life, of the relationship between villagers and patients; and in its textual place (at the end of the thesis) and form, provide a further perspective on questions of social closure. I had hoped that form and content might merge here.

The thesis may therefore be seen to move between different modes of representation. The participant observation study is written in a realist mode (with suitable relativist caveats); the discourse analytic study is presented as more reflexive in aim and method but nevertheless arguably still displaying realist residues; the Appendix attempts a more radical representation which could be said to challenge the previous two.

In this process a central aim has been to attempt to expose the power relations embedded in any ethnography and discourse analysis (cf. Clifford and Marcus 1986, Mascia-Lees 1989 p10). I had an idea that it might also serve to promote both ambiguity and its tolerance; the idea of systemic 'slack', which serves as a counterpoint to disciplinary control (Connolly 1983 p339), a slack which is itself rooted in the resistance to disciplinary strategies. As William Connolly puts it: 'Since the self is not "designed" to fit perfectly into any way of life, we must anticipate that every good way of life will both realize something in the self and encounter elements in the self resistant to its form; and we should thereby endorse the idea of slack as part of our conception of the good life." (ibid p339).

In particular I have attempted here to bring together method and madness, so that the rational and the irrational might be said to meet along the 'thin line' which is said by villagers to normally separate the two. Something of the developmental logic of the Appendix may be characterised in the following manner:

Patients are presented in the main body of the Appendix as rational. From a position below the footnote line and apparently separate to the main text, villagers object that this method is improper because, really, patients are mad. I attempt to show how madness may creep into even the most rational of speech by way of the very instruments researchers use to represent it. This culminates in villagers' talk undergoing a kind of 'breakdown' itself, which I set next to some of the more colourful talk of someone who is a patient. In the main body of the text the patients have then become sane, in so far as their excerpts are intelligible, while villagers have been finally pushed 'over (below) the line' by the researcher, into virtual incomprehensibility.

Finally, I suspect that the Introduction, Appendix and Annexure presented here could be better configured in relation to each other and the transcription conventions in a way which is further illustrative of issues of reflexivity[1].

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[1] *You're the patient, I'm not.*

Well, it could be said that this Annexure comprises the anchor, the key by which everything else is explained, by which everything else is put in its place. It says 'this is what the position really is'. As such it merely reproduces the realist mode which the Appendix attempts to undermine and thereby undermines the Appendix itself. On reflection perhaps this was a crazy idea.

You're the patient, I'm not.

Right, okay.

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